Senate Bill No. 194–Senators Ohrenschall, Flores, Krasner; Lange, Pazina and Stone

CHAPTER.....

AN ACT relating to insurance; requiring certain insurers to use evidence-based guidelines when developing a step therapy protocol; requiring such insurers to create a process by which an attending practitioner and an insured are authorized to apply for an exemption from a step therapy protocol; requiring such insurers to grant such an exemption in certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law establishes a process by which a person may request an exemption from a step therapy protocol established by his or her insurer for a prescription drug used to treat late stage cancer or an associated symptom. If such a request is granted, existing law requires the insurer to cover the prescription drug. (NRS 689A.04041, 689B.0305, 689C.1684, 695A.259, 695B.19085, 695C.17333, 695G.1675) **Sections 1, 3-8 and 11** of this bill require certain private-sector insurers to establish a process by which an insured and his or her attending practitioner may: (1) request an exemption from a step therapy protocol that applies to prescription drugs; and (2) appeal a decision concerning such a request. **Sections 1, 3-8 and 11** require an insurer to: (1) grant such a request if the attending practitioner submits certain information providing adequate justification for the exemption; and (2) make the process to request an exemption and submit an appeal accessible on an Internet website maintained by the insurer. **Sections 1, 3-8 and 11** additionally require certain private-sector insurers to use guidelines based on medical or scientific evidence, if available, when developing a step therapy protocol. **Section 2** of this bill makes a conforming change to indicate the proper placement of **section 1** in the Nevada Revised Statutes.

Section 10 of this bill authorizes the Commissioner of Insurance to suspend or revoke the certificate of a health maintenance organization that fails to comply with the requirements of **section 8**. The Commissioner is also authorized to take such action against other health insurers who fail to comply with the requirements of **sections 1, 3-7 and 11**. (NRS 680A.200)

Sections 9 and 12 of this bill provide that the provisions of **sections 8 and 11** do not apply to Medicaid managed care organizations. **Sections 9 and 12** of this bill additionally provide that the provisions of **sections 8 and 11**, respectively, do not apply to a health maintenance organization or managed care organization that provides services to members of the Public Employees' Benefits Program.

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 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. When developing a step therapy protocol, an insurer shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. An insurer that offers or issues a policy of health insurance which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the insurer concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the insurer; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the insurer shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. An insurer shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the insurer a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The insurer shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current policy of health insurance at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current policy of health insurance at the time the attending practitioner selected the drug.

4. If an insurer does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the insurer shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

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

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 689A.04041 apply.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

Sec. 2. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance

commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~[.]~~ ***, and section 1 of this act.***

Sec. 3. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. When developing a step therapy protocol, an insurer shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. An insurer that offers or issues a policy of group health insurance which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the insurer concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the insurer; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the insurer shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. An insurer shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the insurer a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The insurer shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current policy of group health insurance at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current policy of group health insurance at the time the attending practitioner selected the drug.

4. If an insurer does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the insurer shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

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

7. The provisions of this section do not apply to:

(a) Any prescription drug to which the provisions of NRS 689B.0305 apply.

(b) Any policy of group health insurance purchased or provided pursuant to NRS 287.010.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

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

1. When developing a step therapy protocol, a carrier shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A carrier that offers or issues a health benefit plan which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the carrier concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the carrier; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the carrier shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A carrier shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the carrier a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The carrier shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current health benefit plan at the time, and was discontinued due to lack of efficacy or effectiveness,

diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current health benefit plan at the time the attending practitioner selected the drug.

4. If a carrier does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the carrier shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A health benefit plan 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 the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 689C.1684 apply.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

Sec. 5. 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 4 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. 6. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. When developing a step therapy protocol, a society shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A society that offers or issues a benefit contract which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the society concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the society; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the society shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A society shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the society a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The society shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current benefit contract at the time, and was discontinued due to lack of efficacy or effectiveness,

diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current benefit contract at the time the attending practitioner selected the drug.

4. If a society does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the society shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. 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 the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 695A.259 apply.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

Sec. 7. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. When developing a step therapy protocol, a hospital or medical services corporation shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A hospital or medical services corporation that offers or issues a policy of health insurance which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the hospital or medical services corporation concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the hospital or medical services corporation; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the hospital or medical services corporation shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A hospital or medical services corporation shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the hospital or medical services corporation a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The hospital or medical services corporation shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current policy of health insurance at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under

consideration, regardless of whether the insured was covered by his or her current policy of health insurance at the time the attending practitioner selected the drug.

4. If a hospital or medical services corporation does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the hospital or medical services corporation shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

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

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 695B.19085 apply.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

Sec. 8. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. When developing a step therapy protocol, a health maintenance organization shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A health maintenance organization that offers or issues a health care plan which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an enrollee and his or her attending practitioner may:

(1) Request an exemption for the enrollee from the step therapy protocol; and

(2) Appeal a decision made by the health maintenance organization concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the health maintenance organization; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the health maintenance organization shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A health maintenance organization shall grant a request to exempt an enrollee from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the enrollee submits to the health maintenance organization a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The health maintenance organization shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the enrollee;

(2) Is expected to be ineffective based on the known clinical characteristics of the enrollee and the known characteristics of the required prescription drug;

(3) Has been tried by the enrollee, regardless of whether the enrollee was covered by the current health care plan at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the enrollee, based on medical necessity; or

(b) The enrollee is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the enrollee was covered by his or her current health care plan at the time the attending practitioner selected the drug.

4. If a health maintenance organization does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the health maintenance organization shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the enrollee.

6. A health care plan 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 the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 695C.17333 apply.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

Sec. 9. NRS 695C.050 is hereby amended to read as follows:

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

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

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

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, ***and section 8 of this act,*** 695C.1733,

695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.1759, 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

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

6. The provisions of section 8 of this act do not apply to a health maintenance organization that provides health care services to members of the Public Employees' Benefits Program. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 10. NRS 695C.330 is hereby amended to read as follows:

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

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

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, ***and section 8 of this act*** or 695C.207;

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

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

(1) Does not meet the requirements of subsection 1 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees or creditors or to the general public;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in

the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

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

1. When developing a step therapy protocol, a managed care organization shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A managed care organization that offers or issues a health care plan which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the managed care organization concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the managed care organization; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the managed care organization shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A managed care organization shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the managed care organization a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The managed care organization shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current health care plan at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current health care plan at the time the attending practitioner selected the drug.

4. If a managed care organization does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the managed care organization shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A health care plan 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 the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 695G.1675 apply.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

Sec. 12. NRS 695G.090 is hereby amended to read as follows:

695G.090 1. Except as otherwise provided in subsection 3, the provisions of this chapter apply to each organization and insurer

that operates as a managed care organization and may include, without limitation, an insurer that issues a policy of health insurance, an insurer that issues a policy of individual or group health insurance, a carrier serving small employers, a fraternal benefit society, a hospital or medical service corporation and a health maintenance organization.

2. In addition to the provisions of this chapter, each managed care organization shall comply with:

(a) The provisions of chapter 686A of NRS, including all obligations and remedies set forth therein; and

(b) Any other applicable provision of this title.

3. The provisions of NRS 695G.127, 695G.164, 695G.1645, 695G.167 ***, section 11 of this act*** and 695G.200 to 695G.230, inclusive, do not apply to a managed care organization that provides health care services to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. ~~[This subsection does]~~

4. The provisions of section 11 of this act do not apply to a managed care organization that provides health care services to members of the Public Employees' Benefits Program.

5. Subsections 3 and 4 do not exempt a managed care organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 13. 1. This section becomes effective upon passage and approval.

2. Sections 1 to 12, inclusive, of this act become effective:

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

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

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