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)

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

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

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

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

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

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

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

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

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

(c) Participation in drug evaluation and drug research.

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

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

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

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

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

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

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

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

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

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

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

639.0747 ~~[1.]~~ The Board shall adopt such regulations as are necessary to carry out the provisions of NRS 652.210 with regard to

a registered pharmacist, including, without limitation, regulations that ~~[~~:

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

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

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

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

639.2808 ***1.*** A registered pharmacist ~~[or a]~~ ***may:***

(a) Order laboratory tests that are necessary for therapy that uses a drug approved by the Food and Drug Administration or to otherwise facilitate the care of a patient; and

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

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

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

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

(a) ~~[Order and perform]~~ ***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; and

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

2. The Board shall adopt regulations:

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

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

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

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

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

3. As used in this section:

(a) "Collaborative practice agreement" has the meaning ascribed to it in NRS 639.0052.

(b) "Exempt laboratory" means a laboratory:

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

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

(3) In which each test performed is:

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

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

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

232.320 1. The Director:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the

Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

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

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

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

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

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

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

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 686A.135, 687B.352, 687B.408, 687B.723, 687B.725, 689B.030 to 689B.050, inclusive, ***and section 18 of this act,*** 689B.265, 689B.287 and 689B.500 ***and section 11 of this act*** apply to coverage provided pursuant to this

paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and 689B.500 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.

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

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

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

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

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

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

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

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

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

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

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

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

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 686A.135, 687B.352, 687B.409, 687B.723, 687B.725, 689B.0353, 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.1675, 695G.170 to 695G.174, inclusive, ***and sections 11 and 31 of this act,*** 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

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

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

(a) Within the authorized scope of practice of a pharmacist; and

(b) Reimbursed when provided by another provider of health care.

2. The State Plan for Medicaid must not limit:

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

(b) Reimbursement for services provided by 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. The State Plan for Medicaid must not require a recipient of Medicaid to obtain prior authorization for any services provided by a pharmacist that is not required for the service when provided by another provider of health care.

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

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

422.27235 The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for ~~[:~~

~~1.~~] Any laboratory testing that is necessary for therapy that uses a drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus . ~~[; and~~

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

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

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

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

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

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

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

4. As used in this section, "health care facility" means any facility licensed under chapter 449 of NRS.

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

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0412, 689A.0413, 689A.044, 689A.0445, 689B.031, 689B.0313, 689B.0315, 689B.0317, 689B.0374, 689C.1675, 695A.1856, 695B.1912, 695B.1913, 695B.1914, 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1737, 695C.1745, 695C.1751, 695G.170, 695G.171, 695G.1714 and 695G.177, ***and sections 15, 18, 20, 23, 25, 27 and 31 of this act,*** any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for

payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:

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

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

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

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

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

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

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

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

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

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

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

1. If a policy of health insurance 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 insurer.

2. The terms of the policy 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 policy of health insurance 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 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 coverage required by subsections 1 and 2, and any provision of the policy that conflicts with the provisions of this section is void.

5. As used in this section:

(a) "Network plan" means a policy of health insurance offered by an insurer 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 insurer. 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.

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

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

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

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

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

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

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

~~[4.]~~ ***3.*** An insurer 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 insurer.

~~[5.]~~ ***4.*** A policy of health insurance 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 policy 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 policy of health insurance offered by an insurer 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 insurer. 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. 17. 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 15 of this act.***

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

1. If a policy of group health insurance 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 insurer.

2. The terms of the policy 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 policy of group health insurance 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 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 coverage required by subsections 1 and 2, and any provision of the policy that conflicts with the provisions of this section is void.

5. As used in this section:

(a) "Network plan" means a policy of group health insurance offered by an insurer 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 insurer. 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.

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

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

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

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

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

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

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

~~[4.]~~ ***3.*** An insurer 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 insurer.

~~[5.]~~ ***4.*** A policy of group health insurance 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 policy 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 policy of group health insurance offered by an insurer 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 insurer. 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. 20. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. If a health benefit plan 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 carrier.

2. The terms of the plan 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 health benefit plan 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 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 coverage required by subsections 1 and 2, and any provision of the plan that conflicts with the provisions of this section is void.

5. As used in this section:

(a) "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.

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

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

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

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

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

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

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

~~3.]~~ A carrier may subject the benefits required by subsection 1 to reasonable 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.

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

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

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

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

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

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

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

~~[4.]~~ ***3.*** A society 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 society.

~~[5.]~~ ***4.*** A benefit contract 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 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.

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

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

1. If a policy of health insurance 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 hospital or medical services corporation.

2. The terms of the policy 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 policy of health insurance 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 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 coverage required by subsections 1 and 2, and any provision of the policy that conflicts with the provisions of this section is void.

5. As used in this section:

(a) "Network plan" means a policy of health insurance offered by a hospital or medical services corporation 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 hospital or medical services corporation. 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.

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

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

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

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

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

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

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

~~[4.]~~ ***3.*** A hospital or medical services corporation 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 hospital or medical services corporation.

~~[5.]~~ ***4.*** A policy of health insurance 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 policy 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 policy of health insurance offered by a hospital or medical services corporation 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 hospital or medical services corporation. 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. 27. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. If a health care plan 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 enrollee is entitled to reimbursement for services provided by a pharmacist in the network plan of the health maintenance organization.

2. The terms of the plan 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 health care plan must not require an enrollee 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 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 coverage required by subsections 1 and 2, and any provision of the plan that conflicts with the provisions of this section is void.

5. As used in this section:

(a) "Network plan" means a health care plan offered by a health maintenance organization 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 health maintenance organization. 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.

Sec. 28. 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, 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, ***and section 27 of this act,*** 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.

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

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

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

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

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

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

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

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

~~[5.]~~ ***4.*** A health care 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 care plan offered by a health maintenance organization 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 health maintenance organization. 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. 30. 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 27 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. 31. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. If a health care plan provides coverage for services that are within the authorized scope of practice of an 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 managed care organization.

2. The terms of the plan 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 health care plan 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 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 coverage required by subsections 1 and 2, and any provision of the plan that conflicts with the provisions of this section is void.

5. As used in this section:

(a) "Network plan" means a health care plan offered by a managed care organization 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 managed care organization. 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.

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

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

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

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

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

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

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

~~[4.]~~ ***3.*** A managed care organization 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 managed care organization.

~~[5.]~~ ***4.*** A health care 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 care plan offered by a managed care organization 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 managed care organization. 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. 33. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

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

2. Sections 1 to 33, inclusive, of this act become effective:

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

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

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