SENATE BILL NO. 209–SENATORS STONE, NGUYEN, STEINBECK, ELLISON, KRASNER; AND BUCK

FEBRUARY 18, 2025

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to pharmacy benefit managers. (BDR 57-534)

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

CONTAINS UNFUNDED MANDATE (§ 36)
(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 benefit managers; expanding the scope of certain provisions; prohibiting pharmacy benefit managers from engaging in certain practices; requiring pharmacy benefit managers to make certain disclosures; requiring pharmacy benefit managers to pass rebates along to certain insurers and insureds; requiring pharmacy benefit managers and the Commissioner of Insurance to prepare certain reports; providing a cause of action for certain pharmacies; requiring certain insurers to use passed-along rebate funds for certain purposes; providing penalties; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires a pharmacy benefit manager to obtain a certificate of registration as an insurance administrator from the Commissioner of Insurance and comply with the requirements that apply to insurance administrators generally. (NRS 683A.025, 683A.08522-683A.0893) Existing law additionally imposes certain requirements specifically regulating the operation of pharmacy benefit managers, which are entities that manage pharmacy benefits plans. (NRS 683A.171-683A.179) Existing law defines "pharmacy benefits plan" to refer to insurance coverage of prescription drugs. (NRS 683A.175) **Section 19** of this bill expands the scope of that definition to also refer to insurance coverage of pharmacist services. **Section 19** thereby expands the scope of provisions governing pharmacy benefit managers to also apply to entities that manage such coverage.

Sections 2-13 of this bill define certain other terms relevant to pharmacy benefit managers, and **section 18** of this bill establishes the applicability of those definitions. **Section 14** of this bill prohibits a pharmacy benefit manager that manages a plan which provides coverage through a network from requiring a person to use a pharmacy affiliated with the pharmacy benefit manager if there are other, nonaffiliated pharmacies in the network. **Section 14** additionally prohibits a pharmacy benefit manager from engaging in certain practices which are intended or have the effect of steering a person towards an affiliated pharmacy instead of a nonaffiliated pharmacy in the network. **Section 14** also prohibits a pharmacy benefit manager from discriminating against a nonaffiliated pharmacy. **Section 15** of this bill requires a pharmacy benefit manager to disclose to a third party insurer for which the pharmacy benefit manager manages a pharmacy benefits plan the amount and types of fees that the pharmacy benefit manager charges the third party for managing the plan or otherwise receives from other entities, including rebates, in connection with managing the plan.

Existing law authorizes the Department of Health and Human Services to enter into a contract with a pharmacy benefit manager to manage coverage of prescription drugs under the State Plan for Medicaid and the Children's Health Insurance Program that requires the pharmacy benefit manager to provide to the Department all rebates received for purchasing drugs in relation to those programs. (NRS 422.4053) **Section 15** imposes similar requirements for pharmacy benefit managers that manage other pharmacy benefits plans. Specifically, **section 15** requires a pharmacy benefit manager to provide the entire amount of any rebate the pharmacy benefit manager receives in connection with providing pharmacy benefit management services for a third party insurer that provides pharmacy coverage to: (1) persons covered by the third party; or (2) the third party. **Sections 22, 24-29, 32, 33, 36 and 37** of this bill require certain third parties that provide coverage for prescription drugs to use any rebate money received from a pharmacy benefit manager pursuant to **section 15** for the sole purpose of reducing premiums and eliminating or reducing cost-sharing obligations of covered persons. **Section 23** of this bill authorizes the Commissioner to require a domestic insurer that issues a policy of individual health insurance to a person residing in another state to meet the requirements of **section 22** in certain circumstances. **Sections 30 and 34** of this bill indicate that the requirement governing the use of rebates received from a pharmacy benefit manager is inapplicable to a managed care organization that is providing coverage to recipients of Medicaid. **Section 31** of this bill authorizes the Commissioner to suspend or revoke the certificate of a health maintenance organization that fails to comply with the requirements of **section 29**. The Commissioner would also be authorized to take such action against other health insurers who fail to comply with the requirements of **sections 22, 24-28, 32 and 33**. (NRS 680A.200)

Section 16 of this bill prohibits a pharmacy benefit manager from: (1) using spread pricing, which is a technique by which a pharmacy benefit manager charges a third party an amount for a prescription drug that is different from the amount that the pharmacy benefit manager reimburses a pharmacy for the same drug; (2) agreeing to exclusively cover certain drugs; and (3) making or disseminating a false or misleading statement or advertisement. **Section 21** of this bill additionally prohibits a pharmacy benefit manager from engaging in certain practices while doing business with pharmacies. **Section 21** also authorizes a pharmacy to bring an action to recover certain damages against a pharmacy benefit manager that retaliates against the pharmacy for reporting or attempting to remedy a potential or actual violation of law applicable to insurance by the pharmacy benefit manager.

Section 17 of this bill requires a pharmacy benefit manager to submit to the Commissioner an annual report detailing certain business practices of the pharmacy benefit manager as well as certain information regarding pricing and rebates

relating to the prescription drugs administered by the pharmacy benefit manager. **Sections 17 and 35** of this bill provide for the confidentiality of the information contained in the report. **Section 17** requires the Commissioner to compile, submit to the Legislature and publish on the Internet a report once every 2 years on the overall impact of pharmacy benefit managers on the cost of prescription drugs in this State based on the reports submitted by the pharmacy benefit managers.

Existing law exempts certain federally regulated insurance coverage of prescription drugs provided by employers for their employees from requirements governing pharmacy benefit managers except where the pharmacy benefit manager is required by contract to comply with those requirements. (NRS 683A.177) In *Rutledge v. Pharm. Care Mgmt. Ass'n*, the United States Supreme Court held that states are authorized to impose certain general requirements governing pharmacy benefit managers on pharmacy benefit managers that manage such coverage. (592 U.S. 80, 89 (2020)) **Section 20** of this bill removes the exemption for such coverage from certain requirements governing pharmacy benefit managers, thereby requiring a pharmacy benefit manager that manages such coverage to comply with those requirements. **Section 20** also subjects a pharmacy benefit manager that manages such coverage to the requirements of this bill, to the extent authorized by current precedent of the United States Supreme Court.

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

Section 1. Chapter 683A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 17, inclusive, of this act.

Sec. 2. ***"Affiliated pharmacy" means a pharmacy that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with a pharmacy benefit manager.***

Sec. 3. ***"Claim" means a request for payment for:***

1. Administering, filling or refilling a prescription drug; or

2. Providing a pharmacist service or a medical supply or device to a covered person.

Sec. 4. ***"Control" has the meaning ascribed to it in NRS 692C.050.***

Sec. 5. ***"Cost-sharing obligation" includes, without limitation, a copayment, coinsurance or deductible imposed upon or collected from a covered person in connection with filling a prescription or obtaining other pharmacist services.***

Sec. 6. ***"Manufacturer" has the meaning ascribed to it in 42 U.S.C. § 1396r-8(k)(5).***

Sec. 7. ***"Network plan" means a pharmacy benefits plan offered by a third party under which the financing and delivery of pharmacist services is provided, in whole or in part, through a defined set of providers under contract with the third party. The term does not include an arrangement for the financing of premiums.***

Sec. 8. *"Nonaffiliated pharmacy" means a pharmacy that:*

1. Directly or indirectly through a pharmacy services administrative organization contracts with a pharmacy benefit manager; and

2. Does not control, is not controlled by and is not under common control with the pharmacy benefit manager.

Sec. 9. *"Pharmacist services" means the provision of products, goods or services, or any combination thereof, provided as a part of the practice of pharmacy, as defined in NRS 639.0124.*

Sec. 10. *"Pharmacy benefit management services" includes, without limitation:*

1. Negotiating the price of prescription drugs, including, without limitation, negotiating or contracting for direct or indirect rebates, discounts or price concessions on prescription drugs.

2. Managing any aspect of a pharmacy benefits plan, including, without limitation:

(a) Developing or managing a formulary;

(b) Processing and paying claims for prescription drugs;

(c) Performing reviews of the utilization of prescription drugs;

(d) Processing requests for prior authorization for prescriptions;

(e) Adjudicating appeals and grievances relating to a pharmacy benefits plan;

(f) Contracting with pharmacies to provide pharmacist services for covered persons;

(g) Managing the cost of covered prescription drugs on behalf of a third party; and

(h) Managing or providing data relating to a pharmacy benefits plan.

3. Performing any administrative, managerial, clinical, pricing, financial, reimbursement, data administration, reporting or billing service for a third party in relation to a pharmacy benefits plan.

Sec. 11. *"Pharmacy services administrative organization" means an entity that provides contracting and other administrative services relating to prescription drug benefits to pharmacies.*

Sec. 12. *"Rebate" means any discount, remuneration or other payment paid by a manufacturer or wholesaler to a pharmacy benefit manager after a claim has been adjudicated or completed at a pharmacy. The term does not include a bona fide service fee, as defined in 42 C.F.R. § 447.502.*

Sec. 13. *"Wholesaler" has the meaning ascribed to it in NRS 639.016.*

Sec. 14. *1. A pharmacy benefit manager that manages a network plan shall not:*

(a) Require a covered person to use an affiliated pharmacy to fill a prescription or obtain other pharmacist services if there is a nonaffiliated pharmacy in the network;

(b) Except as authorized by subsection 2, induce, persuade or attempt to induce or persuade a covered person to transfer a prescription to or otherwise use an affiliated pharmacy instead of a nonaffiliated pharmacy in the network;

(c) Unreasonably restrict a covered person from using a particular pharmacy in the network for the purpose of filling a prescription or receiving pharmacist services covered by the pharmacy benefits plan of the covered person;

(d) Communicate to a covered person that the covered person is required to have a prescription filled or receive other pharmacist services at a particular pharmacy if there are other pharmacies in the network that have the ability to dispense the prescription or provide the pharmacist services required by the covered person;

(e) Unreasonably obstruct or interfere with the ability of a covered person to timely access a prescription drug or device that has been prescribed to the covered person at a pharmacy of the person's choice, including, without limitation, a nonaffiliated pharmacy;

(f) Discriminate against a nonaffiliated pharmacy based on the nonaffiliated status of the pharmacy, including, without limitation, by:

(1) Offering materially different terms or conditions to a nonaffiliated pharmacy based on the status as a nonaffiliated pharmacy;

(2) Refusing to renew or terminating a contract with a nonaffiliated pharmacy on the basis that the pharmacy is a nonaffiliated pharmacy, or for reasons other than those that apply equally to affiliated pharmacies; and

(3) Reimbursing a nonaffiliated pharmacy for a pharmacist service in an amount that is less than the pharmacy benefit manager would reimburse an affiliated pharmacy for the same pharmacist service; or

(g) Deny a pharmacy the opportunity to participate in a network or receive a preferred status if the pharmacy is willing to accept the same terms and conditions that the pharmacy benefit manager has established for affiliated pharmacies as a condition for participating in the network or receiving preferred status, as applicable.

2. A third party or pharmacy benefit manager may reduce the amount of an applicable cost-sharing obligation of a covered person who fills a prescription or obtains other pharmacist services at a particular pharmacy. The third party or pharmacy

benefit manager must reduce the cost-sharing obligation to an amount that is less than the cost-sharing obligation that the covered person would otherwise pay to fill the same prescription or obtain the same pharmacist services at any other pharmacy in the network under the terms of the applicable pharmacy benefits plan.

3. As used in this section, "network" means a defined set of pharmacies that are under contract to provide pharmacist services pursuant to a network plan.

Sec. 15. ***A pharmacy benefit manager shall:***

1. Upon the request of a third party for which the pharmacy benefit manager manages a pharmacy benefits plan, disclose to the third party, in writing, the amounts and types of charges, fees and commissions that the pharmacy benefit manager charges the third party for providing pharmacy benefit management services or otherwise receives in connection with managing the pharmacy benefits plan of the third party, including, without limitation, administrative fees and rebates collected from manufacturers and wholesalers.

2. Except as otherwise provided in NRS 422.4053, transmit the entire amount of any rebate received from a manufacturer or wholesaler in connection with providing pharmacy benefit management services for a third party in the following order of priority:

(a) To the covered person who receives the drug to which the rebate pertains by directly transmitting the rebate, or an equivalent credit, to the pharmacy that dispenses the drug to be applied at the point-of-sale for the purpose of offsetting or reducing the cost-sharing obligation of the covered person.

(b) To the third party.

Sec. 16. ***1. A pharmacy benefit manager shall not:***

(a) Use spread pricing.

(b) Enter into, amend, enforce or renew a contract with a manufacturer that expressly or implicitly provides for the exclusive coverage of a drug, medical device or other product by a pharmacy benefits plan or group of pharmacy benefits plans.

(c) Make or disseminate any statement, representation or advertisement that is, or reasonably should be known to be, untrue, deceptive or misleading.

2. As used in this section, "spread pricing" means any technique by which a pharmacy benefit manager charges or claims an amount from a third party for services provided by a pharmacy or pharmacist that is different from the amount the pharmacy benefit manager pays the pharmacy or pharmacist, as applicable, for those services.

Sec. 17. ***1. On or before April 1 of each year, a pharmacy benefit manager shall submit to the Commissioner:***

(a) A report which includes the information prescribed by subsection 2; and

(b) A statement signed under the penalty of perjury affirming the accuracy of the information in the report.

2. The report submitted pursuant to paragraph (a) of subsection 1 must include:

(a) Lists of:

(1) The 50 prescription drugs with the highest wholesale acquisition costs at the time the report is submitted;

(2) The 50 prescription drugs most frequently prescribed to covered persons in this State during the immediately preceding calendar year; and

(3) The 50 prescription drugs which produced the largest amount of revenue for the pharmacy benefit manager in this State during the immediately preceding calendar year.

(b) For each prescription for a drug included on a list compiled pursuant to paragraph (a) that was issued to a covered person within the immediately preceding year:

(1) The type of pharmacy that filled the prescription. The type of pharmacy may be an integrated pharmacy, chain pharmacy, specialty pharmacy, mail order pharmacy or other type of pharmacy.

(2) Information relating to pricing of and rebates for the drug, including, without limitation:

(I) The total amount that the pharmacy benefit manager paid to the pharmacy for filling the prescription;

(II) The net amount that the pharmacy benefit manager paid to the pharmacy for filling the prescription, after accounting for any fees or assessments imposed by the pharmacy benefit manager against the pharmacy;

(III) The amount of any rebate negotiated by the pharmacy benefit manager with the manufacturer for the purchase of the drug;

(IV) The amount of any rebate described in sub-subparagraph (III) that was passed on to either the applicable third party or the covered person; and

(V) The amount that the applicable third party paid the pharmacy benefit manager for the drug.

(c) Information prescribed by regulation of the Commissioner that allows the Commissioner to determine whether each claim for a prescription drug included on a list compiled pursuant to paragraph (a) required prior authorization. Such information must be in deidentified form.

(d) For each prescription drug appearing on a list compiled pursuant to paragraph (a), the aggregate amount for the immediately preceding year of the:

(1) Cost of the drug, based on the total units of the drug dispensed to covered persons in this State multiplied by the wholesale acquisition cost of the drug at the time each unit was dispensed;

(2) Amount of rebates negotiated for the purchase of the drug in this State;

(3) Amount of administrative fees received from a manufacturer or wholesaler for services provided in this State relating to the drug;

(4) Amount paid or reimbursed to affiliated pharmacies in this State for the drug; and

(5) Amount paid or reimbursed to nonaffiliated pharmacies in this State for the drug.

(e) A list of the third parties with which the pharmacy benefit manager has contracted, the scope of services provided to each third party and the number of persons covered in this State by each third party listed.

(f) The total amount of revenue derived from providing pharmacy benefit management services in this State in the immediately preceding year.

(g) The expenses incurred by providing pharmacy benefit management services in this State in the immediately preceding year.

(h) The identity of each group purchasing organization employed, contracted or otherwise utilized by or affiliated with the pharmacy benefit manager.

(i) A copy of each contract entered into with a group purchasing organization identified pursuant to paragraph (h).

(j) The aggregate financial benefit derived in the immediately preceding year from the use of the group purchasing organizations identified pursuant to paragraph (h).

(k) A list of the types and amounts of fees that the pharmacy benefit manager has collected during the immediately preceding year for performing pharmacy benefit management services in this State and a description of how those fees are calculated.

(l) A copy of all fee agreements entered into with third parties, pharmacies and pharmacy services administrative organizations doing business in this State.

(m) The amount of each premium, deductible, cost-sharing obligation or fee charged by the pharmacy benefit manager to covered persons in this State or other persons on behalf of such covered persons.

3. On or before July 1 of each even-numbered year, the Commissioner shall:

(a) Compile a report on the overall impact of pharmacy benefit managers on the cost of prescription drugs in this State based on the reports submitted to the Commissioner pursuant to subsection 1. The data in the report compiled pursuant to this subsection must be in aggregated form and must not reveal specific information concerning an individual purchaser or manufacturer of a drug, including, without limitation, information relating to a manufacturer's individual or aggregate discounted prices.

(b) Submit the report to the Director of the Legislative Counsel Bureau for transmittal to the Joint Interim Standing Committee on Health and Human Services and the Joint Interim Standing Committee on Commerce and Labor.

(c) Present the report at a meeting of the Joint Interim Standing Committee on Health and Human Services.

(d) Post the report on an Internet website operated by the Division.

4. Except as otherwise provided in subsection 3, any information submitted by a pharmacy benefit manager pursuant to this section is confidential and is not a public record.

5. Nothing in this section shall be construed to impose any recordkeeping obligation on a third party for which a pharmacy benefit manager manages a pharmacy benefits plan.

6. As used in this section:

(a) "Group purchasing organization" means a person employed, contracted or otherwise utilized by or affiliated with a pharmacy benefit manager to negotiate, obtain or procure rebates from manufacturers or wholesalers.

(b) "National Drug Code" means the numerical code assigned to a prescription drug by the United States Food and Drug Administration.

(c) "Wholesale acquisition cost" means the manufacturer's published list price for a prescription drug with a unique National Drug Code for sale to a wholesaler or any other purchaser or entity that purchases the prescription drug from the manufacturer, not including any rebates or other price concessions.

Sec. 18. NRS 683A.171 is hereby amended to read as follows:

683A.171 As used in NRS 683A.171 to 683A.179, inclusive, ***and sections 2 to 17, inclusive, of this act,*** unless the context otherwise requires, the words and terms defined in NRS 683A.172 to 683A.176, inclusive, ***and sections 2 to 13, inclusive, of this act*** have the meanings ascribed to them in those sections.

Sec. 19. NRS 683A.175 is hereby amended to read as follows:

683A.175 "Pharmacy benefits plan" means coverage of prescription drugs ***and pharmacist services*** provided by a third party.

Sec. 20. NRS 683A.177 is hereby amended to read as follows:

683A.177 1. Except as otherwise provided in ~~[subsection]~~ ***subsections*** 2 ~~[,]~~ ***and 3,*** the requirements of NRS 683A.171 to 683A.179, inclusive, ***and sections 2 to 17, inclusive, of this act*** and any regulations adopted by the Commissioner pursuant thereto do not apply to the coverage of prescription drugs under a plan that is subject to the Employee Retirement Income Security Act of 1974 or any information relating to such coverage.

2. Except as otherwise provided in this subsection, the provisions of NRS 683A.179, except for paragraph (d) of subsection 1 of NRS 683A.179, section 15 of this act, except for paragraph (a) of subsection 2 of section 15 of this act, and paragraphs (a) and (c) of subsection 1 of section 16 of this act apply to the coverage of prescription drugs under a plan that is subject to the Employee Retirement Income Security Act of 1974 or any information relating to such coverage. Except where required pursuant to subsection 3, a pharmacy benefit manager is not required to include in a report submitted pursuant to section 17 of this act any information:

(a) Derived from data relating to claims administered or coverage provided under such a plan; or

(b) Specifically relating to or that otherwise reveals the details of the administration of such a plan.

~~[2.]~~ ***3.*** A plan described in subsection 1 may, by contract, require a pharmacy benefit manager that manages the coverage of prescription drugs under the plan to comply with the requirements of NRS 683A.171 to 683A.179, inclusive, ***and sections 2 to 17, inclusive, of this act*** and any regulations adopted by the Commissioner pursuant thereto.

Sec. 21. NRS 683A.179 is hereby amended to read as follows:

683A.179 1. A pharmacy benefit manager shall not:

(a) Prohibit a pharmacist or pharmacy from providing information to a covered person concerning:

(1) The amount of any copayment or coinsurance for a prescription drug; or

(2) The availability of a less expensive alternative or generic drug including, without limitation, information concerning clinical efficacy of such a drug;

(b) Penalize a pharmacist or pharmacy for providing the information described in paragraph (a) or selling a less expensive alternative or generic drug to a covered person;

(c) Prohibit a pharmacy from offering or providing delivery services directly to a covered person as an ancillary service of the pharmacy; ~~[or]~~

(d) If the pharmacy benefit manager manages a pharmacy benefits plan that provides coverage through a network plan, charge a copayment or coinsurance for a prescription drug in an amount that is greater than the total amount paid to a pharmacy that is in the network of providers under contract with the third party ~~[.]~~ ***;***

(e) Restrict, by contract or otherwise, the ability of a pharmacy to share or disclose the details of a contract between the pharmacy and the pharmacy benefit manager with a trade organization for pharmacies or the Commissioner;

(f) Reimburse a pharmacy for a prescription drug in an amount that is less than the pharmacy pays a wholesaler for the prescription drug, as reflected on the invoice provided by the wholesaler to the pharmacy;

(g) Directly or indirectly reduce or allow the reduction of any payment to a pharmacy under a pharmacy benefits plan managed by the pharmacy benefit manager under a reconciliation process to an effective rate of reimbursement;

(h) Directly or indirectly retroactively reduce or deny a claim after the claim has been adjudicated unless:

(1) The original claim is fraudulent;

(2) The original payment of the claim was incorrect because the pharmacy or pharmacist had already been paid for the pharmacist services to which the claim relates; or

(3) The pharmacy or pharmacist that submitted the claim did not properly render the pharmacist services to which the claim relates;

(i) Reverse and resubmit the claim of a pharmacy:

(1) Without notifying and attempting to reconcile the claim with the pharmacy; or

(2) More than 90 days after the claim was first affirmatively adjudicated;

(j) Charge a pharmacy or a pharmacist a fee to process a claim electronically;

(k) Refuse to pay a claim after terminating a contract with a pharmacy, except where the pharmacy benefit manager is investigating possible insurance fraud; or

(l) Retaliate against a pharmacy for reporting a potential or actual violation of this title or attempting to settle a dispute with a pharmacy benefit manager based on a potential or actual violation of this title.

2. The provisions of this section:

(a) Must not be construed to authorize a pharmacist to dispense a drug that has not been prescribed by a practitioner, as defined in NRS 639.0125, except to the extent authorized by a specific provision of law, including, without limitation, NRS 453C.120, 639.28078 and 639.28085.

(b) Do not apply to an institutional pharmacy, as defined in NRS 639.0085, or a pharmacist working in such a pharmacy as an employee or independent contractor.

3. ***Any provision of a contract that restricts the ability of a pharmacy to share information pursuant to paragraph (e) of subsection 1 is against public policy, void and unenforceable.***

4. A pharmacy may bring an action for statutory damages against a pharmacy benefit manager who retaliates against the pharmacy in violation of paragraph (l) of subsection 1. If the pharmacy prevails in such an action, the court shall award the pharmacy $5,000 for each violation, in addition to attorney's fees and costs.

5. As used in this section, ~~[~~"network plan" means a health benefit plan offered by a health carrier under which the financing and delivery of medical care is 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.~~]~~ ***"retaliate" includes, without limitation:***

(a) Terminating or refusing to renew a contract with a pharmacy.

(b) Making the renewal of a contract with a pharmacy contingent on the pharmacy acceding to terms and conditions not applicable to other pharmacies.

(c) Subjecting the pharmacy to increased audits.

(d) Failing to promptly pay or reimburse a pharmacy without substantial justification.

Sec. 22. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer that uses a pharmacy benefit manager to manage coverage of prescription drugs included in a policy of health insurance shall use any money received from the pharmacy benefit manager pursuant to section 15 of this act for the sole purpose of reducing premiums and offsetting or reducing cost-sharing obligations of insureds.

2. As used in this section:

(a) "Cost-sharing obligation" has the meaning ascribed to it in section 5 of this act.

(b) "Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.

Sec. 23. 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 22 of this act.***

Sec. 24. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer that uses a pharmacy benefit manager to manage coverage of prescription drugs included in a policy of group health insurance shall use any money received from the pharmacy benefit manager pursuant to section 15 of this act for the sole purpose of reducing premiums and offsetting or reducing cost-sharing obligations of insureds.

2. As used in this section:

(a) "Cost-sharing obligation" has the meaning ascribed to it in section 5 of this act.

(b) "Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.

Sec. 25. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A carrier that uses a pharmacy benefit manager to manage coverage of prescription drugs included in a health benefit plan shall use any money received from the pharmacy benefit manager pursuant to section 15 of this act for the sole purpose of reducing premiums and offsetting or reducing cost-sharing obligations of insureds.

2. As used in this section:

(a) "Cost-sharing obligation" has the meaning ascribed to it in section 5 of this act.

(b) "Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.

Sec. 26. 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 25 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. 27. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. A society that uses a pharmacy benefit manager to manage coverage of prescription drugs included in a benefit contract shall

use any money received from the pharmacy benefit manager pursuant to section 15 of this act for the sole purpose of reducing premiums and offsetting or reducing cost-sharing obligations of insureds.

2. As used in this section:

(a) "Cost-sharing obligation" has the meaning ascribed to it in section 5 of this act.

(b) "Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.

Sec. 28. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A hospital or medical services corporation that uses a pharmacy benefit manager to manage coverage of prescription drugs included in a policy of health insurance shall use any money received from the pharmacy benefit manager pursuant to section 15 of this act for the sole purpose of reducing premiums and offsetting or reducing cost-sharing obligations of insureds.

2. As used in this section:

(a) "Cost-sharing obligation" has the meaning ascribed to it in section 5 of this act.

(b) "Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.

Sec. 29. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health maintenance organization that uses a pharmacy benefit manager to manage coverage of prescription drugs included in a health care plan shall use any money received from the pharmacy benefit manager pursuant to section 15 of this act for the sole purpose of reducing premiums and offsetting or reducing cost-sharing obligations of enrollees.

2. As used in this section:

(a) "Cost-sharing obligation" has the meaning ascribed to it in section 5 of this act.

(b) "Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.

Sec. 30. 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 ***and section 29 of this act*** 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.16932 to 695C.1699, inclusive, 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333, 695C.17345, 695C.17347, 695C.1736 to 695C.1745, inclusive, 695C.1757 and 695C.204 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 NRS 695C.17095 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.

7. The provisions of NRS 695C.1735 do not apply to a health maintenance organization that provides health care services to:

(a) The officers and employees, and the dependents of officers and employees, of the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of this State; or

(b) 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. 31. 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 29 of this act or NRS*** 695C.204 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. 32. Chapter 695F of NRS is hereby amended by adding thereto a new section to read as follows:

1. A prepaid limited health service organization that uses a pharmacy benefit manager to manage coverage of prescription drugs included in a limited health service shall use any money received from the pharmacy benefit manager pursuant to section 15 of this act for the sole purpose of reducing premiums and offsetting or reducing cost-sharing obligations of enrollees.

2. As used in this section:

(a) "Cost-sharing obligation" has the meaning ascribed to it in section 5 of this act.

(b) "Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.

Sec. 33. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. A managed care organization that uses a pharmacy benefit manager to manage coverage of prescription drugs included in a health care plan shall use any money received from the pharmacy benefit manager pursuant to section 15 of this act for the sole purpose of reducing premiums and offsetting or reducing cost-sharing obligations of insureds.

2. As used in this section:

(a) "Cost-sharing obligation" has the meaning ascribed to it in section 5 of this act.

(b) "Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.

Sec. 34. 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.1639, 695G.164, 695G.1645, 695G.167 and 695G.200 to 695G.230, inclusive, ***and section 33 of this act*** 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.

4. The provisions of NRS 695C.1735 and 695G.1639 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. 35. NRS 239.010 is hereby amended to read as follows:

239.010 1. Except as otherwise provided in this section and NRS 1.4683, 1.4687, 1A.110, 3.2203, 41.0397, 41.071, 49.095, 49.293, 62D.420, 62D.440, 62E.516, 62E.620, 62H.025, 62H.030, 62H.170, 62H.220, 62H.320, 75A.100, 75A.150, 76.160, 78.152, 80.113, 81.850, 82.183, 86.246, 86.54615, 87.515, 87.5413, 87A.200, 87A.580, 87A.640, 88.3355, 88.5927, 88.6067, 88A.345, 88A.7345, 89.045, 89.251, 90.730, 91.160, 116.757, 116A.270, 116B.880, 118B.026, 119.260, 119.265, 119.267, 119.280, 119A.280, 119A.653, 119A.677, 119B.370, 119B.382, 120A.640, 120A.690, 125.130, 125B.140, 126.141, 126.161, 126.163, 126.730, 127.007, 127.057, 127.130, 127.140, 127.2817, 128.090, 130.312, 130.712, 136.050, 159.044, 159A.044, 164.041, 172.075, 172.245, 176.01334, 176.01385, 176.015, 176.0625, 176.09129, 176.156, 176A.630, 178.39801, 178.4715, 178.5691, 178.5717, 179.495, 179A.070, 179A.165, 179D.160, 180.600, 200.3771, 200.3772, 200.5095, 200.604, 202.3662, 205.4651, 209.392, 209.3923,

209.3925, 209.419, 209.429, 209.521, 211A.140, 213.010, 213.040, 213.095, 213.131, 217.105, 217.110, 217.464, 217.475, 218A.350, 218E.625, 218F.150, 218G.130, 218G.240, 218G.350, 218G.615, 224.240, 226.462, 226.796, 228.270, 228.450, 228.495, 228.570, 231.069, 231.1285, 231.1473, 232.1369, 233.190, 237.300, 239.0105, 239.0113, 239.014, 239B.026, 239B.030, 239B.040, 239B.050, 239C.140, 239C.210, 239C.230, 239C.250, 239C.270, 239C.420, 240.007, 241.020, 241.030, 241.039, 242.105, 244.264, 244.335, 247.540, 247.545, 247.550, 247.560, 250.087, 250.130, 250.140, 250.145, 250.150, 268.095, 268.0978, 268.490, 268.910, 269.174, 271A.105, 281.195, 281.805, 281A.350, 281A.680, 281A.685, 281A.750, 281A.755, 281A.780, 284.4068, 284.4086, 286.110, 286.118, 287.0438, 289.025, 289.080, 289.387, 289.830, 293.4855, 293.5002, 293.503, 293.504, 293.558, 293.5757, 293.870, 293.906, 293.908, 293.909, 293.910, 293B.135, 293D.510, 331.110, 332.061, 332.351, 333.333, 333.335, 338.070, 338.1379, 338.1593, 338.1725, 338.1727, 348.420, 349.597, 349.775, 353.205, 353A.049, 353A.085, 353A.100, 353C.240, 353D.250, 360.240, 360.247, 360.255, 360.755, 361.044, 361.2242, 361.610, 365.138, 366.160, 368A.180, 370.257, 370.327, 372A.080, 378.290, 378.300, 379.0075, 379.008, 379.1495, 385A.830, 385B.100, 387.626, 387.631, 388.1455, 388.259, 388.501, 388.503, 388.513, 388.750, 388A.247, 388A.249, 391.033, 391.035, 391.0365, 391.120, 391.925, 392.029, 392.147, 392.264, 392.271, 392.315, 392.317, 392.325, 392.327, 392.335, 392.850, 393.045, 394.167, 394.16975, 394.1698, 394.447, 394.460, 394.465, 396.1415, 396.1425, 396.143, 396.159, 396.3295, 396.405, 396.525, 396.535, 396.9685, 398A.115, 408.3885, 408.3886, 408.3888, 408.5484, 412.153, 414.280, 416.070, 422.2749, 422.305, 422A.342, 422A.350, 425.400, 427A.1236, 427A.872, 427A.940, 432.028, 432.205, 432B.175, 432B.280, 432B.290, 432B.4018, 432B.407, 432B.430, 432B.560, 432B.5902, 432C.140, 432C.150, 433.534, 433A.360, 439.4941, 439.4988, 439.5282, 439.840, 439.914, 439A.116, 439A.124, 439B.420, 439B.754, 439B.760, 439B.845, 440.170, 441A.195, 441A.220, 441A.230, 442.330, 442.395, 442.735, 442.774, 445A.665, 445B.570, 445B.7773, 449.209, 449.245, 449.4315, 449A.112, 450.140, 450B.188, 450B.805, 453.164, 453.720, 458.055, 458.280, 459.050, 459.3866, 459.555, 459.7056, 459.846, 463.120, 463.15993, 463.240, 463.3403, 463.3407, 463.790, 467.1005, 480.535, 480.545, 480.935, 480.940, 481.063, 481.091, 481.093, 482.170, 482.368, 482.5536, 483.340, 483.363, 483.575, 483.659, 483.800, 484A.469, 484B.830, 484B.833, 484E.070, 485.316, 501.344, 503.452, 522.040, 534A.031, 561.285, 571.160, 584.655, 587.877, 598.0964, 598.098, 598A.110, 598A.420, 599B.090, 603.070, 603A.210, 604A.303, 604A.710,

604D.500, 604D.600, 612.265, 616B.012, 616B.015, 616B.315, 616B.350, 618.341, 618.425, 622.238, 622.310, 623.131, 623A.137, 624.110, 624.265, 624.327, 625.425, 625A.185, 628.418, 628B.230, 628B.760, 629.043, 629.047, 629.069, 630.133, 630.2671, 630.2672, 630.2673, 630.2687, 630.30665, 630.336, 630A.327, 630A.555, 631.332, 631.368, 632.121, 632.125, 632.3415, 632.3423, 632.405, 633.283, 633.301, 633.427, 633.4715, 633.4716, 633.4717, 633.524, 634.055, 634.1303, 634.214, 634A.169, 634A.185, 634B.730, 635.111, 635.158, 636.262, 636.342, 637.085, 637.145, 637B.192, 637B.288, 638.087, 638.089, 639.183, 639.2485, 639.570, 640.075, 640.152, 640A.185, 640A.220, 640B.405, 640B.730, 640C.580, 640C.600, 640C.620, 640C.745, 640C.760, 640D.135, 640D.190, 640E.225, 640E.340, 641.090, 641.221, 641.2215, 641A.191, 641A.217, 641A.262, 641B.170, 641B.281, 641B.282, 641C.455, 641C.760, 641D.260, 641D.320, 642.524, 643.189, 644A.870, 645.180, 645.625, 645A.050, 645A.082, 645B.060, 645B.092, 645C.220, 645C.225, 645D.130, 645D.135, 645G.510, 645H.320, 645H.330, 647.0945, 647.0947, 648.033, 648.197, 649.065, 649.067, 652.126, 652.228, 653.900, 654.110, 656.105, 657A.510, 661.115, 665.130, 665.133, 669.275, 669.285, 669A.310, 670B.680, 671.365, 671.415, 673.450, 673.480, 675.380, 676A.340, 676A.370, 677.243, 678A.470, 678C.710, 678C.800, 679B.122, 679B.124, 679B.152, 679B.159, 679B.190, 679B.285, 679B.690, 680A.270, 681A.440, 681B.260, 681B.410, 681B.540, 683A.0873, 685A.077, 686A.289, 686B.170, 686C.306, 687A.060, 687A.115, 687B.404, 687C.010, 688C.230, 688C.480, 688C.490, 689A.696, 692A.117, 692C.190, 692C.3507, 692C.3536, 692C.3538, 692C.354, 692C.420, 693A.480, 693A.615, 696B.550, 696C.120, 703.196, 704B.325, 706.1725, 706A.230, 710.159, 711.600, ***and section 17 of this act,*** sections 35, 38 and 41 of chapter 478, Statutes of Nevada 2011 and section 2 of chapter 391, Statutes of Nevada 2013 and unless otherwise declared by law to be confidential, all public books and public records of a governmental entity must be open at all times during office hours to inspection by any person, and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. Any such copies, abstracts or memoranda may be used to supply the general public with copies, abstracts or memoranda of the records or may be used in any other way to the advantage of the governmental entity or of the general public. This section does not supersede or in any manner affect the federal laws governing copyrights or enlarge, diminish or affect in any other manner the rights of a person in any written book or record which is copyrighted pursuant to federal law.

2. A governmental entity may not reject a book or record which is copyrighted solely because it is copyrighted.

3. A governmental entity that has legal custody or control of a public book or record shall not deny a request made pursuant to subsection 1 to inspect or copy or receive a copy of a public book or record on the basis that the requested public book or record contains information that is confidential if the governmental entity can redact, delete, conceal or separate, including, without limitation, electronically, the confidential information from the information included in the public book or record that is not otherwise confidential.

4. If requested, a governmental entity shall provide a copy of a public record in an electronic format by means of an electronic medium. Nothing in this subsection requires a governmental entity to provide a copy of a public record in an electronic format or by means of an electronic medium if:

(a) The public record:

(1) Was not created or prepared in an electronic format; and

(2) Is not available in an electronic format; or

(b) Providing the public record in an electronic format or by means of an electronic medium would:

(1) Give access to proprietary software; or

(2) Require the production of information that is confidential and that cannot be redacted, deleted, concealed or separated from information that is not otherwise confidential.

5. An officer, employee or agent of a governmental entity who has legal custody or control of a public record:

(a) Shall not refuse to provide a copy of that public record in the medium that is requested because the officer, employee or agent has already prepared or would prefer to provide the copy in a different medium.

(b) Except as otherwise provided in NRS 239.030, shall, upon request, prepare the copy of the public record and shall not require the person who has requested the copy to prepare the copy himself or herself.

Sec. 36. 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 439.581 to 439.597, inclusive, 686A.135, 687B.352, 687B.408, 687B.692, 687B.723, 687B.725, 687B.805, 689B.030 to 689B.0317, inclusive, paragraphs (b) and (c) of subsection 1 of NRS 689B.0319, subsections 2, 4, 6 and 7 of NRS 689B.0319, 689B.033 to 689B.0369, inclusive, 689B.0375 to 689B.050, inclusive, 689B.0675, 689B.265, 689B.287 and 689B.500 ***and section 24 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. 37. 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 439.581 to 439.597, inclusive, 686A.135, 687B.352, 687B.409, 687B.692, 687B.723, 687B.725, 687B.805, 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.1712, inclusive, 695G.1714 to 695G.174, inclusive, 695G.176, 695G.177, 695G.200 to 695G.230,

inclusive, 695G.241 to 695G.310, inclusive, 695G.405 and 695G.415, ***and section 33 of this act,*** in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 38. The amendatory provisions of this act do not apply to any contract or other agreement entered into before January 1, 2026, but apply to the renewal of any such contract or other agreement.

Sec. 39. The provisions of subsection 1 of NRS 218D.380 do not apply to any provision of this act which adds or revises a requirement to submit a report to the Legislature.

Sec. 40. 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. 41. 1. This section becomes effective upon passage and approval.

2. Sections 1 to 40, 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, 2026, for all other purposes.

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