REVISED PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R074-14

August 3, 2015

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

AUTHORITY: §1, NRS 679B.130, 687B.120 and 689A.710; §2, NRS 679B.130 and 687B.120; §3, NRS 679B.130.

A REGULATION relating to health benefit plans; prohibiting certain persons that offer certain health benefit plans which provide coverage for prescription drugs and use a drug formulary approved by the Commissioner of Insurance from making changes to the formulary except under certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law provides that any health insurance policy or contract, health care plan or certificate of coverage delivered or issued for delivery in this State must be filed with and approved as to form by the Commissioner of Insurance. (NRS 687B.120) For various forms of health insurance that provide coverage for prescription drugs, existing law requires that the insured or enrollee be notified by the insurer about whether the coverage is subject to a "formulary" or a list of covered drugs. If a formulary is used, the required notice must include specified information about the formulary and additional information must be made available to insureds, enrollees and providers of health care. (NRS 689A.405, 689B.0283, 689C.281, 689C.455, 695A.255, 695B.176, 695C.1703, 695F.153, 695G.163)

Section 1 of this regulation prohibits an individual carrier that offers a health benefit plan from removing a drug from its approved formulary unless the United States Food and Drug Administration: (1) does not approve the drug; (2) questions the clinical safety of the drug; or (3) approves the drug for use without a prescription. If the individual carrier's approved formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier, **section 1** also prohibits the individual carrier from moving a brand name drug to a tier with a larger deductible, copayment or coinsurance, unless the individual carrier adds a generic alternative to the brand name drug at: (1) the tier from which the brand name drug is being moved; or (2) a tier that has a smaller deductible, copayment or coinsurance than the tier from which the brand name drug is being moved. **Section 2** of this regulation adopts the same provisions for individual coverage that is provided by a health maintenance organization. Other forms of health insurance are unaffected by this regulation.

Section 1. Chapter 689A of NAC is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in this section, an individual carrier that offers a health benefit plan which provides coverage for prescription drugs and uses a formulary that has been approved by the Commissioner pursuant to NRS 687B.120 shall not:

(a) Remove a prescription drug from the formulary; or

(b) If the formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier, move a drug to a tier with a larger deductible, copayment or coinsurance,

➥ during the plan year for which the formulary was approved by the Commissioner.

2. An individual carrier described in subsection 1 may:

(a) Remove a prescription drug from a formulary at any time if:

(1) The drug is not approved by the United States Food and Drug Administration;

(2) The United States Food and Drug Administration issues a notice, guidance, warning, announcement or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) The prescription drug is approved by the United States Food and Drug Administration for use without a prescription.

(b) If the individual carrier's formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier, move a brand name prescription drug to a tier with a larger deductible, copayment or coinsurance if the individual carrier adds to the formulary a generic prescription drug that is

approved by the United States Food and Drug Administration for use as an alternative to the brand name prescription drug at:

(1) The benefit tier from which the brand name prescription drug is being moved; or

(2) A benefit tier that has a smaller deductible, copayment or coinsurance than the benefit tier from which the brand name prescription drug is being moved.

3. This section does not prohibit an individual carrier from adding a prescription drug to a formulary at any time.

4. This section does not apply to a grandfathered plan.

5. As used in this section:

(a) "Health benefit plan" has the meaning ascribed to it in NRS 687B.470.

(b) "Individual carrier" has the meaning ascribed to it in NRS 689A.550.

Sec. 2. Chapter 695C of NAC is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in this section, a health maintenance organization that offers a health benefit plan in the individual market which provides coverage for prescription drugs and uses a formulary that has been approved by the Commissioner pursuant to NRS 687B.120 shall not:

(a) Remove a prescription drug from the formulary; or

(b) If the formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier, move a drug to a tier with a larger deductible, copayment or coinsurance,

➥ during the plan year for which the formulary was approved by the Commissioner.

2. A health maintenance organization described in subsection 1 may:

(a) Remove a prescription drug from a formulary at any time if:

(1) The drug is not approved by the United States Food and Drug Administration;

(2) The United States Food and Drug Administration issues a notice, guidance, warning, announcement or any other statement about the drug which calls into question the clinical safety of the drug; or

(3) The prescription drug is approved by the United States Food and Drug Administration for use without a prescription.

(b) If the health maintenance organization's formulary includes two or more tiers of benefits providing for different deductibles, copayments or coinsurance applicable to the prescription drugs in each tier, move a brand name prescription drug to a tier with a larger deductible, copayment or coinsurance if the health maintenance organization adds to the formulary a generic prescription drug that is approved by the United States Food and Drug Administration for use as an alternative to the brand name prescription drug at:

(1) The benefit tier from which the brand name prescription drug is being moved; or

(2) A benefit tier that has a smaller deductible, copayment or coinsurance than the benefit tier from which the brand name prescription drug is being moved.

3. This section does not prohibit a health maintenance organization from adding a prescription drug to a formulary at any time.

4. This section does not apply to a grandfathered plan.

5. As used in this section, "health benefit plan" has the meaning ascribed to it in NRS 687B.470.

Sec. 3. This regulation becomes effective on January 1, 2016.