2017 Legislative Session Bill Tracking	Potential Impact to PEBP	Bill Status	Effective Date
AB249 Requires the State Plan for Medicaid and all health insurance plans to provide certain benefits relating to contraception. (BDR 38-858) This bill proposes the following changes: • Requiring all public health insurance plans in this State to provide coverage for certain benefits relating to contraception without any copay, coinsurance or a higher deductible. • Requiring certain additional forms of contraceptive drugs, devices and services to be covered by a health insurance plan, including, without limitation, up to a 12-month supply of contraceptives or its therapeutic equivalent, insertion or removal of a contraceptive device, education and counseling relating to contraception, management of side effects relating to contraception and voluntary sterilization for men and women. • Prohibiting the use of a program of step therapy or prior authorization requirement relating to the contraceptive drugs, devices and services required by this bill. • Require a health insurance plan to provide coverage for certain therapeutic equivalent drugs and devices relating to contraception when a therapeutic equivalent covered by the plan is deemed to be medically inappropriate by a provider of health care. • Require that benefits provided by a health insurance plan relating to contraception which are provided to the insured must also be provided to the spouse or dependent of an insured.	If passed, PEBP's CDHP would be required to provide a 12-month supply of contraceptives (versus 30-90 days today), cover voluntary male sterilization at 100% (after deductible), and eliminate coinsurance requirements for multi-source contraceptives. PEBP's HMO plans will be required to eliminate copays for contraceptives and male sterilizations. Additionally, no plan can impose any other restrictions or delays on the access of an insured to any such benefits, including, without limitation, a program of step therapy or prior authorization.	3/6/17 – Will be heard by the Assembly Committee on Health & Human Services	January 1, 2018 (Upon Renewal for PEBP – July 1, 2018)
SB80 Makes various changes relating to the Public Employees' Benefits Program and the Deferred Compensation Program. (BDR 18-243) This bill proposes the following changes: • Creates the Employee Benefits Division of the Department of Administration. • Requiring the Director of the Department of Administration to appoint the Administrator of the Employee Benefits Division. • Converting the Board of the Public Employees' Benefits Program into an advisory board and removing the requirement that the Board award certain contracts and requires the Advisory Board to advise the Administrator concerning the administration of the Program. • Providing for the Administrator to assume certain powers, duties and functions of the Board and the Executive Officer of the Public Employees' Benefits Program. • Provides that the Administrator assumes: (1) the authority of the Executive Officer to appoint staff; and (2) the duties of the Executive Officer to submit certain reports and receive continuing education.	If passed, PEBP would transition to the Department of Administration, the PEBP Board would transition from governing to advisory, and the agency and the Executive Officer would be replaced with the Administrator, who would report directly to the Director of the Department of Administration. The Quality Control Officer would work at the pleasure of the Executive Officer with no additional Board oversight. PEBP would no longer have a Purchasing exemption to procurement processes in NRS 333.	2/20/17 – Notice of Eligibility for Exemption	January 1, 2018 (Upon Renewal for PEBP – July 1, 2018)

2017 Legislative Session Bill Tracking	Potential Impact to PEBP	Bill Status	Effective Date
SB139 Makes various changes to provisions relating to patient-centered medical homes. (BDR 40-679) This bill proposes the following changes: • Requiring the Advisory Council on the State Program for Wellness and the Prevention of Chronic Disease to establish an advisory group comprised of interested persons and government entities to study the delivery of health care through patient-centered medical homes. • Requiring the Commissioner of Insurance, in consultation with the advisory group established by the Advisory Council, the Director of the Dept. of Health and Human Services and other interested persons and governmental entities, to adopt regulations prescribing standards concerning certain payments to and incentives for patient-centered medical homes. • Incentives that are authorized by those regulations and by federal law are not considered unfair methods of competition or unfair or deceptive trade practices. • Requiring plans of health insurance that provide coverage for a service rendered by a patient-centered medical home, including plans of health insurance provided by state and local governmental entities to their employees and Medicaid managed care plans, to provide any such payments or incentives as applicable.	If passed, PEBP would have to build incentives into reimbursing patient-centered medical homes in Nevada, without knowing what those incentives will be until approved by an advisory group that may or may not include PEBP's input on those incentives. Depending on the costs, the impact can be minimal to massive. These required incentives will need to be passed on to participants in the form of rate increases. PEBP's HMO plans will also need to incur these incentives and will increase rates accordingly.	2/28/17 – Notice of Eligibility for Exemption	January 1, 2018 (Upon Renewal for PEBP – July 1, 2018)
SB233 Requires the State Plan for Medicaid and health insurance plans to provide certain benefits. (BDR 38-817) This bill proposes the following changes: • Requiring all public and private health insurance plans made available in this State to provide coverage for certain preventative services without any copay, coinsurance or a higher deductible. • Requiring certain additional forms of contraceptive drugs, devices, supplies and services to be covered by a health insurance plan, including up to a 12-month supply of contraceptives or a therapeutic equivalent, insertion or removal of a contraceptive device, education and counseling relating to contraception and voluntary sterilization for men and women. • Requiring all public and private health insurance plans in this State to provide coverage for hormone replacement therapy without any copay, coinsurance or higher deductible. • Requiring a pharmacist to dispense up to a 12-month supply of contraceptives or their therapeutic equivalent upon the request of a patient who has a valid prescription.	If passed, PEBP would be required to provide a 12-month supply of contraceptives (versus 30-90 days today), cover voluntary male sterilization at 100% (after deductible), and eliminate coinsurance requirements for multi-source contraceptives. PEBP's HMO plans will be required to eliminate copays for contraceptives and male sterilizations. Additionally, no plan can impose any other restrictions or delays on the access of an insured to any such benefits, including, without limitation, a program of step therapy or prior authorization. This bill also includes the requirement to provide hormone replacement therapy (which PEBP does today) but eliminating the step therapy and prior authorization which PEBP has in place currently through a pre-certification requirement.	3/6/17 – Will be heard by the Senate Committee on Health & Human Services	January 1, 2018 (Upon Renewal for PEBP – July 1, 2018)

2017 Legislative Session Bill Tracking	Potential Impact to PEBP	Bill Status	Effective Date
BDR 40-809 Revises provisions concerning prescription drugs. This bill draft request proposes the following changes: • Requiring the manufacturers of certain expensive prescription drugs or prescription drugs that have increased in price to submit to the Dept. of Health and Human Services a report providing justification for the price or price increase, as applicable. • Prohibiting any insurer that provides coverage of prescription drugs, including a state or local governmental entity that insures its employees, from requiring an insured to pay a total of more than $500 out-of-pocket in any plan year for prescription drugs that are covered as a pharmacy benefit. • Requiring an insurer, including a state or local governmental entity that insures its employees, that uses a formulary to publish before each open enrollment period a notice of all drugs that have been removed from the formulary or will be removed from the formulary during the current plan year or the next plan year.	If passed, PEBP's CDHP would be forced to discontinue the Health Savings Account (HSA) as the IRS does not allow HSA plans to exist with low deductibles ($500) nor carved out benefits for pharmacy on a high deductible health plan. This bill requires an annual $500 out-of-pocket maximum which forces the CDHP deductible to be either 1) $500 or less eliminating the CDHP as designed and reverting to a low deductible PPO, or 2) eliminate the HSA option, keep an HRA option, and carve out pharmacy benefits with a $500 deductible. The bill will result in massive cost increases to both the CDHP and HMO plans as cost controls (out-of-pocket maximums) would be greatly reduced. These costs are anticipated to be between $20 million to $35 million per year (pending plan design above) and rates on all plans would increase greatly.		January 1, 2018 (Upon Renewal for PEBP – July 1, 2018)