

Amendment No. 451

Senate Amendment to Senate Bill No. 190	(BDR 54-3)
Proposed by: Senator Cannizzaro	
Amends: Summary: No Title: No Preamble: No Joint Sponsorship: No Digest: Yes	

Adoption of this amendment will MAINTAIN the unfunded mandate not requested by the affected local government to S.B. 190 (§ 10).
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ASSEMBLY ACTION		Initial and Date		SENATE ACTION		Initial and Date			
Adopted	<input type="checkbox"/>	Lost	<input type="checkbox"/>	_____	Adopted	<input type="checkbox"/>	Lost	<input type="checkbox"/>	_____
Concurred In	<input type="checkbox"/>	Not	<input type="checkbox"/>	_____	Concurred In	<input type="checkbox"/>	Not	<input type="checkbox"/>	_____
Receded	<input type="checkbox"/>	Not	<input type="checkbox"/>	_____	Receded	<input type="checkbox"/>	Not	<input type="checkbox"/>	_____

EXPLANATION: Matter in (1) *blue bold italics* is new language in the original bill; (2) variations of green bold underlining is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

SRF/EWR



Date: 4/14/2021

S.B. No. 190—Provides for the dispensing of self-administered hormonal contraceptives. (BDR 54-3)



SENATE BILL NO. 190—SENATORS CANNIZZARO, RATTI, LANGE, DONDERO LOOP, SCHEIBLE; BROOKS, DONATE, D. HARRIS AND OHRENSCHALL

MARCH 8, 2021

JOINT SPONSORS: ASSEMBLYMEN TORRES, NGUYEN, GORELOW, MARZOLA, FLORES; BILBRAY-AXELROD AND GONZÁLEZ

Referred to Committee on Commerce and Labor

SUMMARY—Provides for the dispensing of self-administered hormonal contraceptives. (BDR 54-3)

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

CONTAINS UNFUNDED MANDATE (§ 10) (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 contraceptives; requiring the Chief Medical Officer to issue a standing order authorizing a pharmacist to dispense self-administered hormonal contraceptives to any patient; authorizing a pharmacist to dispense self-administered hormonal contraceptives to any patient; requiring the State Plan for Medicaid and certain health insurance plans to provide certain benefits relating to self-administered hormonal contraceptives; and providing other matters properly relating thereto.

Legislative Counsel’s Digest:

1 Existing law requires a pharmacist to dispense up to a 12-month supply or an amount
2 equivalent to the balance of the plan year if the patient is covered by a health care plan,
3 whichever is less, of a contraceptive or its therapeutic equivalent pursuant to a valid
4 prescription or order if certain conditions are met. (NRS 639.28075) **Section 8** of this bill
5 requires: (1) the Chief Medical Officer or his or her designee to issue a standing order to allow
6 a pharmacist to dispense a self-administered hormonal contraceptive to any patient; and (2)
7 the State Board of Health, in consultation with the Chief Medical Officer, to prescribe by
8 regulation a protocol for dispensing a self-administered hormonal contraceptive. **Section 3** of
9 this bill authorizes a pharmacist to dispense a self-administered hormonal contraceptive under
10 the standing order and establishes the procedures the pharmacist must follow to dispense such
11 a contraceptive. **Section 3** requires such a pharmacist to: (1) provide a risk assessment
12 questionnaire prescribed by the State Board of Health pursuant to **section 8** ~~upon the request~~
13 ~~of~~ **to** the patient before the pharmacist dispenses the self-administered hormonal
14 contraceptive; (2) create a record concerning the dispensing of the self-administered hormonal
15 contraceptive; (3) provide the patient with a written record of the request and the self-
16 administered hormonal contraceptive dispensed and certain additional information; and (4)
17 comply with the regulations adopted pursuant to **section 8** and any guidelines recommended

18 by the manufacturer. **Sections 3 and 8** require the State Board of Pharmacy and the Division
 19 of Public and Behavioral Health of the Department of Health and Human Services to post on
 20 an Internet website a list of pharmacies that dispense self-administered hormonal
 21 contraceptives under the standing order.

22 Existing law defines the term “practice of pharmacy” for the purpose of determining
 23 which activities require a person to be registered and regulated by the State Board of
 24 Pharmacy as a pharmacist. (NRS 639.0124) **Section 5** of this bill provides that the practice of
 25 pharmacy includes the dispensing of self-administered hormonal contraceptives by a
 26 pharmacist in accordance with **section 3** and, thus, requires persons engaged in the dispensing
 27 of such contraceptives to be registered and regulated as pharmacists.

28 Existing law authorizes the State Board of Pharmacy to suspend or revoke any certificate
 29 to practice as a registered pharmacist if the holder of or applicant for such a certificate
 30 commits certain acts. (NRS 639.210) **Section 6** of this bill authorizes the Board to suspend or
 31 revoke any certificate to practice as a registered pharmacist if the holder or applicant has
 32 dispensed a self-administered hormonal contraceptive under the standing order issued
 33 pursuant to **section 8** without complying with the provisions of **section 3**.

34 Existing law requires public and private policies of insurance regulated under Nevada law
 35 to include coverage for certain contraceptive drugs and devices, including: (1) up to a 12-
 36 month supply of contraceptives; and (2) certain devices for contraception. (NRS 287.010,
 37 287.04335, 689A.0418, 689B.0378, 689C.1676, 695A.1865, 695B.1919, 695C.1696,
 38 695G.1715) Existing law also requires employers to provide certain benefits to employees,
 39 including the coverage required for health insurers, if the employer provides health benefits
 40 for its employees. (NRS 608.1555) **Sections 7 and 9-15** of this bill require that certain public
 41 and private policies of insurance and health care plans provide coverage for self-administered
 42 hormonal contraceptives dispensed by a pharmacist in accordance with **section 3**.

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

1 **Section 1.** Chapter 639 of NRS is hereby amended by adding thereto the
 2 provisions set forth as sections 2 and 3 of this act.

3 **Sec. 2.** *“Self-administered hormonal contraceptive” means a self-*
 4 *administered contraceptive that utilizes a hormone and is approved for use by the*
 5 *United States Food and Drug Administration to prevent pregnancy. The term*
 6 *includes, without limitation, an oral contraceptive, a vaginal contraceptive ring, a*
 7 *contraceptive patch and any other method of hormonal contraceptive identified*
 8 *by the standing order issued by the Chief Medical Officer or his or her designee*
 9 *pursuant to section 8 of this act.*

10 **Sec. 3. 1.** *A pharmacist may dispense a self-administered hormonal*
 11 *contraceptive under the standing order issued pursuant to section 8 of this act to*
 12 *a patient, regardless of whether the patient has obtained a prescription from a*
 13 *practitioner.*

14 **2.** *A pharmacist must provide the risk assessment questionnaire prescribed*
 15 *by the State Board of Health pursuant to section 8 of this act to a patient who*
 16 *requests ~~the questionnaire~~ a self-administered hormonal contraceptive before*
 17 *dispensing ~~at~~ the self-administered hormonal contraceptive to the patient. If*
 18 *~~such a questionnaire is provided~~ the patient completes the questionnaire and*
 19 *the results of the questionnaire indicate that it is unsafe to dispense the self-*
 20 *administered hormonal contraceptive to the patient, the pharmacist:*

21 *(a) Must not dispense the self-administered hormonal contraceptive; and*

22 *(b) Must refer the patient to the patient’s attending provider or another*
 23 *qualified provider of health care.*

24 **3.** *A pharmacist who dispenses a self-administered hormonal contraceptive*
 25 *under the standing order shall:*

1 (a) Create a record concerning the dispensing of the self-administered
2 hormonal contraceptive which includes, without limitation, the name of the
3 patient to whom the self-administered hormonal contraceptive was dispensed, the
4 type of self-administered hormonal contraceptive dispensed and any other
5 relevant information required by the protocol prescribed pursuant to section 8 of
6 this act. The pharmacist or his or her employer shall maintain the record for the
7 amount of time prescribed in that protocol.

8 (b) Inform the patient to whom the self-administered hormonal contraceptive
9 is dispensed concerning:

10 (1) Proper administration and storage of the self-administered hormonal
11 contraceptive;

12 (2) Potential side effects of the self-administered hormonal
13 contraceptive; and

14 (3) The need to use other methods of contraception, if appropriate.

15 (c) Provide to the patient to whom the self-administered hormonal
16 contraceptive is dispensed:

17 (1) The written record required by subsection 4; and

18 (2) Any written information required by the regulations adopted
19 pursuant to section 8 of this act.

20 (d) Comply with the regulations adopted pursuant to section 8 of this act and
21 any guidelines for dispensing the self-administered hormonal contraceptive
22 recommended by the manufacturer.

23 4. A pharmacist shall provide to any patient who requests a self-
24 administered hormonal contraceptive under the standing order a written record
25 of the request, regardless of whether the self-administered hormonal
26 contraceptive is dispensed. The record must include, without limitation:

27 (a) A copy of the risk assessment questionnaire if completed by the patient
28 pursuant to subsection 2; and

29 (b) A written record of the self-administered hormonal contraceptive
30 requested and any self-administered hormonal contraceptive dispensed.

31 5. Any pharmacy that wishes to dispense self-administered hormonal
32 contraceptives under the standing order must notify the Board of that fact. The
33 Board shall post on an Internet website maintained by the Board a list of the
34 names, addresses and contact information of pharmacies that have provided such
35 notice.

36 6. As used in this section:

37 (a) "Attending provider" means a provider of health care who provides or
38 has provided care to the patient.

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

40 Sec. 4. NRS 639.001 is hereby amended to read as follows:

41 639.001 As used in this chapter, unless the context otherwise requires, the
42 words and terms defined in NRS 639.0015 to 639.016, inclusive, **and section 2 of**
43 **this act** have the meanings ascribed to them in those sections.

44 Sec. 5. NRS 639.0124 is hereby amended to read as follows:

45 639.0124 1. "Practice of pharmacy" includes, but is not limited to, the:

46 ~~1~~ (a) Performance or supervision of activities associated with
47 manufacturing, compounding, labeling, dispensing and distributing of a drug,
48 including the receipt, handling and storage of prescriptions and other confidential
49 information relating to patients.

50 ~~2~~ (b) Interpretation and evaluation of prescriptions or orders for medicine.

51 ~~3~~ (c) Participation in drug evaluation and drug research.

52 ~~4~~ (d) Advising of the therapeutic value, reaction, drug interaction, hazard
53 and use of a drug.

~~5.~~ (e) Selection of the source, storage and distribution of a drug.
~~6.~~ (f) Maintenance of proper documentation of the source, storage and distribution of a drug.
~~7.~~ (g) Interpretation of clinical data contained in a person's record of medication.

~~8.~~ (h) Development of written guidelines and protocols in collaboration with a practitioner which are intended for a patient in a licensed medical facility or in a setting that is affiliated with a medical facility where the patient is receiving care and which authorize collaborative drug therapy management. The written guidelines and protocols must comply with NRS 639.2629.

~~9.~~ (i) Implementation and modification of drug therapy, administering drugs and ordering and performing tests in accordance with a collaborative practice agreement.

(j) Dispensing a self-administered hormonal contraceptive pursuant to section 3 of this act.

~~1.~~ 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 ~~1.~~ *and section 3 of this act.*

Sec. 6. NRS 639.210 is hereby amended to read as follows:

639.210 The Board may suspend or revoke any certificate, license, registration or permit issued pursuant to this chapter, and deny the application of any person for a certificate, license, registration or permit, if the holder or applicant:

1. Is not of good moral character;
2. Is guilty of habitual intemperance;
3. Becomes or is intoxicated or under the influence of liquor, any depressant drug or a controlled substance, unless taken pursuant to a lawfully issued prescription, while on duty in any establishment licensed by the Board;
4. Is guilty of unprofessional conduct or conduct contrary to the public interest;
5. Has a substance use disorder;
6. Has been convicted of a violation of any law or regulation of the Federal Government or of this or any other state related to controlled substances, dangerous drugs, drug samples, or the wholesale or retail distribution of drugs;
7. Has been convicted of:
 - (a) A felony relating to holding a certificate, license, registration or permit pursuant to this chapter;
 - (b) A felony pursuant to NRS 639.550 or 639.555; or
 - (c) Other crime involving moral turpitude, dishonesty or corruption;
8. Has been convicted of violating any of the provisions of NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440, inclusive;
9. Has willfully made to the Board or its authorized representative any false statement which is material to the administration or enforcement of any of the provisions of this chapter;
10. Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent;
11. Has violated any provision of the Federal Food, Drug and Cosmetic Act or any other federal law or regulation relating to prescription drugs;
12. Has violated, attempted to violate, assisted or abetted in the violation of or conspired to violate any of the provisions of this chapter or any law or regulation relating to drugs, the manufacture or distribution of drugs or the practice of pharmacy, or has knowingly permitted, allowed, condoned or failed to report a violation of any of the provisions of this chapter or any law or regulation relating to

1 drugs, the manufacture or distribution of drugs or the practice of pharmacy
2 committed by the holder of a certificate, license, registration or permit;

3 13. Has failed to renew a certificate, license or permit by failing to submit the
4 application for renewal or pay the renewal fee therefor;

5 14. Has had a certificate, license or permit suspended or revoked in another
6 state on grounds which would cause suspension or revocation of a certificate,
7 license or permit in this State;

8 15. Has, as a managing pharmacist, violated any provision of law or
9 regulation concerning recordkeeping or inventory in a store over which he or she
10 presides, or has knowingly allowed a violation of any provision of this chapter or
11 other state or federal laws or regulations relating to the practice of pharmacy by
12 personnel of the pharmacy under his or her supervision;

13 16. Has repeatedly been negligent, which may be evidenced by claims of
14 malpractice settled against him or her;

15 17. Has failed to maintain and make available to a state or federal officer any
16 records in accordance with the provisions of this chapter or chapter 453 or 454 of
17 NRS;

18 18. Has failed to file or maintain a bond or other security if required by NRS
19 639.515; ~~fee~~

20 19. *Has dispensed a self-administered hormonal contraceptive under the*
21 *standing order issued pursuant to section 8 of this act without complying with*
22 *section 3 of this act; or*

23 20. Has operated a medical facility, as defined in NRS 449.0151, at any time
24 during which:

25 (a) The license of the facility was suspended or revoked; or

26 (b) An act or omission occurred which resulted in the suspension or revocation
27 of the license pursuant to NRS 449.160.

28 **↳** This subsection applies to an owner or other principal responsible for the
29 operation of the facility.

30 **Sec. 7.** NRS 422.27172 is hereby amended to read as follows:

31 422.27172 1. The Director shall include in the State Plan for Medicaid a
32 requirement that the State pay the nonfederal share of expenditures incurred for:

33 (a) Up to a 12-month supply, per prescription, of any type of drug for
34 contraception or its therapeutic equivalent which is:

35 (1) Lawfully prescribed or ordered;

36 (2) Approved by the Food and Drug Administration; and

37 (3) Dispensed in accordance with NRS 639.28075;

38 (b) Any type of device for contraception which is lawfully prescribed or
39 ordered and which has been approved by the Food and Drug Administration;

40 (c) *Self-administered hormonal contraceptives dispensed by a pharmacist*
41 *pursuant to section 3 of this act;*

42 (d) Insertion or removal of a device for contraception;

43 ~~(d)~~ (e) Education and counseling relating to the initiation of the use of
44 contraceptives and any necessary follow-up after initiating such use;

45 ~~(e)~~ (f) Management of side effects relating to contraception; and

46 ~~(f)~~ (g) Voluntary sterilization for women.

47 2. Except as otherwise provided in subsections 4 and 5, to obtain any benefit
48 provided in the Plan pursuant to subsection 1, a person enrolled in Medicaid must
49 not be required to:

50 (a) Pay a higher deductible, any copayment or coinsurance; or

51 (b) Be subject to a longer waiting period or any other condition.

52 3. The Director shall ensure that the provisions of this section are carried out
53 in a manner which complies with the requirements established by the Drug Use

1 Review Board and set forth in the list of preferred prescription drugs established by
2 the Department pursuant to NRS 422.4025.

3 4. The Plan may require a person enrolled in Medicaid to pay a higher
4 deductible, copayment or coinsurance for a drug for contraception if the person
5 refuses to accept a therapeutic equivalent of the contraceptive drug.

6 5. For each method of contraception which is approved by the Food and Drug
7 Administration, the Plan must include at least one contraceptive drug or device for
8 which no deductible, copayment or coinsurance may be charged to the person
9 enrolled in Medicaid, but the Plan may charge a deductible, copayment or
10 coinsurance for any other contraceptive drug or device that provides the same
11 method of contraception.

12 6. As used in this section:

13 (a) "Drug Use Review Board" has the meaning ascribed to it in NRS 422.402.

14 (b) "Therapeutic equivalent" means a drug which:

15 (1) Contains an identical amount of the same active ingredients in the same
16 dosage and method of administration as another drug;

17 (2) Is expected to have the same clinical effect when administered to a
18 patient pursuant to a prescription or order as another drug; and

19 (3) Meets any other criteria required by the Food and Drug Administration
20 for classification as a therapeutic equivalent.

21 **Sec. 8.** Chapter 439 of NRS is hereby amended by adding thereto a new
22 section to read as follows:

23 *1. The Chief Medical Officer or his or her designee shall issue a standing
24 order to allow a pharmacist to dispense a self-administered hormonal
25 contraceptive to any patient pursuant to section 3 of this act.*

26 *2. In consultation with the Chief Medical Officer, the State Board of Health
27 shall prescribe by regulation a protocol for dispensing a self-administered
28 hormonal contraceptive. The protocol must include, without limitation:*

29 *(a) Requirements governing the information that must be included in a
30 record concerning the dispensing of the self-administered hormonal
31 contraceptive in addition to the information required by section 3 of this act; and*

32 *(b) The amount of time that such a record must be maintained by the
33 dispensing pharmacist or his or her employer.*

34 *3. In consultation with the State Board of Pharmacy, the State Board of
35 Health shall adopt regulations that prescribe:*

36 *(a) A risk assessment questionnaire that ~~may~~ must be ~~administered upon~~
37 ~~request~~ provided to a patient who requests a self-administered hormonal
38 contraceptive pursuant to section 3 of this act.*

39 *(b) The information that must be provided in writing to a patient to whom a
40 self-administered hormonal contraceptive is dispensed pursuant to section 3 of
41 this act, which may include, without limitation, information concerning:*

42 *(1) The importance of obtaining recommended tests and screening from
43 the patient's attending provider or another qualified provider of health care who
44 specializes in women's health;*

45 *(2) The effectiveness of long-acting reversible contraceptives as an
46 alternative to self-administered hormonal contraceptives;*

47 *(3) When to seek emergency medical services as a result of administering
48 a self-administered hormonal contraceptive; and*

49 *(4) The risk of contracting a sexually transmitted infection and ways to
50 reduce that risk.*

51 *4. The Division shall provide on an Internet website maintained by the
52 Division an electronic link to the list of pharmacies maintained by the State
53 Board of Pharmacy pursuant to section 3 of this act.*

1 **5. As used in this section:**

2 **(a) "Attending provider" has the meaning ascribed to it in section 3 of this**
3 **act.**

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

5 **(c) "Self-administered hormonal contraceptive" has the meaning ascribed to**
6 **it in section 2 of this act.**

7 **Sec. 9.** NRS 689A.0418 is hereby amended to read as follows:

8 689A.0418 1. Except as otherwise provided in subsection 7, an insurer that
9 offers or issues a policy of health insurance shall include in the policy coverage for:

10 (a) Up to a 12-month supply, per prescription, of any type of drug for
11 contraception or its therapeutic equivalent which is:

- 12 (1) Lawfully prescribed or ordered;
13 (2) Approved by the Food and Drug Administration;
14 (3) Listed in subsection 10; and
15 (4) Dispensed in accordance with NRS 639.28075;

16 (b) Any type of device for contraception which is:

- 17 (1) Lawfully prescribed or ordered;
18 (2) Approved by the Food and Drug Administration; and
19 (3) Listed in subsection 10;

20 (c) **Self-administered hormonal contraceptives dispensed by a pharmacist**
21 **pursuant to section 3 of this act;**

22 (d) Insertion of a device for contraception or removal of such a device if the
23 device was inserted while the insured was covered by the same policy of health
24 insurance;

25 ~~(e)~~ (e) Education and counseling relating to the initiation of the use of
26 contraception and any necessary follow-up after initiating such use;

27 ~~(f)~~ (f) Management of side effects relating to contraception; and

28 ~~(g)~~ (g) Voluntary sterilization for women.

29 2. An insurer must ensure that the benefits required by subsection 1 are made
30 available to an insured through a provider of health care who participates in the
31 network plan of the insurer.

32 3. If a covered therapeutic equivalent listed in subsection 1 is not available or
33 a provider of health care deems a covered therapeutic equivalent to be medically
34 inappropriate, an alternate therapeutic equivalent prescribed by a provider of health
35 care must be covered by the insurer.

36 4. Except as otherwise provided in subsections 8, 9 and 11, an insurer that
37 offers or issues a policy of health insurance shall not:

38 (a) Require an insured to pay a higher deductible, any copayment or
39 coinsurance or require a longer waiting period or other condition for coverage to
40 obtain any benefit included in the policy pursuant to subsection 1;

41 (b) Refuse to issue a policy of health insurance or cancel a policy of health
42 insurance solely because the person applying for or covered by the policy uses or
43 may use any such benefit;

44 (c) Offer or pay any type of material inducement or financial incentive to an
45 insured to discourage the insured from obtaining any such benefit;

46 (d) Penalize a provider of health care who provides any such benefit to an
47 insured, including, without limitation, reducing the reimbursement of the provider
48 of health care;

49 (e) Offer or pay any type of material inducement, bonus or other financial
50 incentive to a provider of health care to deny, reduce, withhold, limit or delay
51 access to any such benefit to an insured; or

52 (f) Impose any other restrictions or delays on the access of an insured any such
53 benefit.

1 5. Coverage pursuant to this section for the covered dependent of an insured
2 must be the same as for the insured.

3 6. Except as otherwise provided in subsection 7, a policy subject to the
4 provisions of this chapter that is delivered, issued for delivery or renewed on or
5 after January 1, ~~2018~~ 2022, has the legal effect of including the coverage required
6 by subsection 1, and any provision of the policy or the renewal which is in conflict
7 with this section is void.

8 7. An insurer that offers or issues a policy of health insurance and which is
9 affiliated with a religious organization is not required to provide the coverage
10 required by subsection 1 if the insurer objects on religious grounds. Such an insurer
11 shall, before the issuance of a policy of health insurance and before the renewal of
12 such a policy, provide to the prospective insured written notice of the coverage that
13 the insurer refuses to provide pursuant to this subsection.

14 8. An insurer may require an insured to pay a higher deductible, copayment or
15 coinsurance for a drug for contraception if the insured refuses to accept a
16 therapeutic equivalent of the drug.

17 9. For each of the 18 methods of contraception listed in subsection 10 that
18 have been approved by the Food and Drug Administration, a policy of health
19 insurance must include at least one drug or device for contraception within each
20 method for which no deductible, copayment or coinsurance may be charged to the
21 insured, but the insurer may charge a deductible, copayment or coinsurance for any
22 other drug or device that provides the same method of contraception.

23 10. The following 18 methods of contraception must be covered pursuant to
24 this section:

- 25 (a) Voluntary sterilization for women;
- 26 (b) Surgical sterilization implants for women;
- 27 (c) Implantable rods;
- 28 (d) Copper-based intrauterine devices;
- 29 (e) Progesterone-based intrauterine devices;
- 30 (f) Injections;
- 31 (g) Combined estrogen- and progestin-based drugs;
- 32 (h) Progestin-based drugs;
- 33 (i) Extended- or continuous-regimen drugs;
- 34 (j) Estrogen- and progestin-based patches;
- 35 (k) Vaginal contraceptive rings;
- 36 (l) Diaphragms with spermicide;
- 37 (m) Sponges with spermicide;
- 38 (n) Cervical caps with spermicide;
- 39 (o) Female condoms;
- 40 (p) Spermicide;
- 41 (q) Combined estrogen- and progestin-based drugs for emergency
42 contraception or progestin-based drugs for emergency contraception; and
- 43 (r) Ulipristal acetate for emergency contraception.

44 11. Except as otherwise provided in this section and federal law, an insurer
45 may use medical management techniques, including, without limitation, any
46 available clinical evidence, to determine the frequency of or treatment relating to
47 any benefit required by this section or the type of provider of health care to use for
48 such treatment.

49 12. An insurer shall not use medical management techniques to require an
50 insured to use a method of contraception other than the method prescribed or
51 ordered by a provider of health care.

52 13. An insurer must provide an accessible, transparent and expedited process
53 which is not unduly burdensome by which an insured, or the authorized

1 representative of the insured, may request an exception relating to any medical
 2 management technique used by the insurer to obtain any benefit required by this
 3 section without a higher deductible, copayment or coinsurance.

4 14. As used in this section:

5 (a) "Medical management technique" means a practice which is used to control
 6 the cost or utilization of health care services or prescription drug use. The term
 7 includes, without limitation, the use of step therapy, prior authorization or
 8 categorizing drugs and devices based on cost, type or method of administration.

9 (b) "Network plan" means a policy of health insurance offered by an insurer
 10 under which the financing and delivery of medical care, including items and
 11 services paid for as medical care, are provided, in whole or in part, through a
 12 defined set of providers under contract with the insurer. The term does not include
 13 an arrangement for the financing of premiums.

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

15 (d) "Therapeutic equivalent" means a drug which:

16 (1) Contains an identical amount of the same active ingredients in the same
 17 dosage and method of administration as another drug;

18 (2) Is expected to have the same clinical effect when administered to a
 19 patient pursuant to a prescription or order as another drug; and

20 (3) Meets any other criteria required by the Food and Drug Administration
 21 for classification as a therapeutic equivalent.

22 **Sec. 10.** NRS 689B.0378 is hereby amended to read as follows:

23 689B.0378 1. Except as otherwise provided in subsection 7, an insurer that
 24 offers or issues a policy of group health insurance shall include in the policy
 25 coverage for:

26 (a) Up to a 12-month supply, per prescription, of any type of drug for
 27 contraception or its therapeutic equivalent which is:

28 (1) Lawfully prescribed or ordered;

29 (2) Approved by the Food and Drug Administration;

30 (3) Listed in subsection 11; and

31 (4) Dispensed in accordance with NRS 639.28075;

32 (b) Any type of device for contraception which is:

33 (1) Lawfully prescribed or ordered;

34 (2) Approved by the Food and Drug Administration; and

35 (3) Listed in subsection 11;

36 (c) *Self-administered hormonal contraceptives dispensed by a pharmacist*
 37 *pursuant to section 3 of this act;*

38 (d) Insertion of a device for contraception or removal of such a device if the
 39 device was inserted while the insured was covered by the same policy of group
 40 health insurance;

41 ~~(e)~~ (e) Education and counseling relating to the initiation of the use of
 42 contraception and any necessary follow-up after initiating such use;

43 ~~(f)~~ (f) Management of side effects relating to contraception; and

44 ~~(g)~~ (g) Voluntary sterilization for women.

45 2. An insurer must ensure that the benefits required by subsection 1 are made
 46 available to an insured through a provider of health care who participates in the
 47 network plan of the insurer.

48 3. If a covered therapeutic equivalent listed in subsection 1 is not available or
 49 a provider of health care deems a covered therapeutic equivalent to be medically
 50 inappropriate, an alternate therapeutic equivalent prescribed by a provider of health
 51 care must be covered by the insurer.

52 4. Except as otherwise provided in subsections 9, 10 and 12, an insurer that
 53 offers or issues a policy of group health insurance shall not:

1 (a) Require an insured to pay a higher deductible, any copayment or
2 coinsurance or require a longer waiting period or other condition to obtain any
3 benefit included in the policy pursuant to subsection 1;

4 (b) Refuse to issue a policy of group health insurance or cancel a policy of
5 group health insurance solely because the person applying for or covered by the
6 policy uses or may use any such benefit;

7 (c) Offer or pay any type of material inducement or financial incentive to an
8 insured to discourage the insured from obtaining any such benefit;

9 (d) Penalize a provider of health care who provides any such benefit to an
10 insured, including, without limitation, reducing the reimbursement to the provider
11 of health care;

12 (e) Offer or pay any type of material inducement, bonus or other financial
13 incentive to a provider of health care to deny, reduce, withhold, limit or delay
14 access to any such benefit to an insured; or

15 (f) Impose any other restrictions or delays on the access of an insured to any
16 such benefit.

17 5. Coverage pursuant to this section for the covered dependent of an insured
18 must be the same as for the insured.

19 6. Except as otherwise provided in subsection 7, a policy subject to the
20 provisions of this chapter that is delivered, issued for delivery or renewed on or
21 after January 1, ~~2018,~~ 2022, has the legal effect of including the coverage required
22 by subsection 1, and any provision of the policy or the renewal which is in conflict
23 with this section is void.

24 7. An insurer that offers or issues a policy of group health insurance and
25 which is affiliated with a religious organization is not required to provide the
26 coverage required by subsection 1 if the insurer objects on religious grounds. Such
27 an insurer shall, before the issuance of a policy of group health insurance and
28 before the renewal of such a policy, provide to the group policyholder or
29 prospective insured, as applicable, written notice of the coverage that the insurer
30 refuses to provide pursuant to this subsection.

31 8. If an insurer refuses, pursuant to subsection 7, to provide the coverage
32 required by subsection 1, an employer may otherwise provide for the coverage for
33 the employees of the employer.

34 9. An insurer may require an insured to pay a higher deductible, copayment or
35 coinsurance for a drug for contraception if the insured refuses to accept a
36 therapeutic equivalent of the drug.

37 10. For each of the 18 methods of contraception listed in subsection 11 that
38 have been approved by the Food and Drug Administration, a policy of group health
39 insurance must include at least one drug or device for contraception within each
40 method for which no deductible, copayment or coinsurance may be charged to the
41 insured, but the insurer may charge a deductible, copayment or coinsurance for any
42 other drug or device that provides the same method of contraception.

43 11. The following 18 methods of contraception must be covered pursuant to
44 this section:

- 45 (a) Voluntary sterilization for women;
- 46 (b) Surgical sterilization implants for women;
- 47 (c) Implantable rods;
- 48 (d) Copper-based intrauterine devices;
- 49 (e) Progesterone-based intrauterine devices;
- 50 (f) Injections;
- 51 (g) Combined estrogen- and progestin-based drugs;
- 52 (h) Progestin-based drugs;
- 53 (i) Extended- or continuous-regimen drugs;

- 1 (j) Estrogen- and progestin-based patches;
- 2 (k) Vaginal contraceptive rings;
- 3 (l) Diaphragms with spermicide;
- 4 (m) Sponges with spermicide;
- 5 (n) Cervical caps with spermicide;
- 6 (o) Female condoms;
- 7 (p) Spermicide;
- 8 (q) Combined estrogen- and progestin-based drugs for emergency
- 9 contraception or progestin-based drugs for emergency contraception; and
- 10 (r) Ulipristal acetate for emergency contraception.

11 12. Except as otherwise provided in this section and federal law, an insurer
12 may use medical management techniques, including, without limitation, any
13 available clinical evidence, to determine the frequency of or treatment relating to
14 any benefit required by this section or the type of provider of health care to use for
15 such treatment.

16 13. An insurer shall not use medical management techniques to require an
17 insured to use a method of contraception other than the method prescribed or
18 ordered by a provider of health care.

19 14. An insurer must provide an accessible, transparent and expedited process
20 which is not unduly burdensome by which an insured, or the authorized
21 representative of the insured, may request an exception relating to any medical
22 management technique used by the insurer to obtain any benefit required by this
23 section without a higher deductible, copayment or coinsurance.

24 15. As used in this section:

25 (a) "Medical management technique" means a practice which is used to control
26 the cost or utilization of health care services or prescription drug use. The term
27 includes, without limitation, the use of step therapy, prior authorization or
28 categorizing drugs and devices based on cost, type or method of administration.

29 (b) "Network plan" means a policy of group health insurance offered by an
30 insurer under which the financing and delivery of medical care, including items and
31 services paid for as medical care, are provided, in whole or in part, through a
32 defined set of providers under contract with the insurer. The term does not include
33 an arrangement for the financing of premiums.

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

35 (d) "Therapeutic equivalent" means a drug which:

36 (1) Contains an identical amount of the same active ingredients in the same
37 dosage and method of administration as another drug;

38 (2) Is expected to have the same clinical effect when administered to a
39 patient pursuant to a prescription or order as another drug; and

40 (3) Meets any other criteria required by the Food and Drug Administration
41 for classification as a therapeutic equivalent.

42 **Sec. 11.** NRS 689C.1676 is hereby amended to read as follows:

43 689C.1676 1. Except as otherwise provided in subsection 7, a carrier that
44 offers or issues a health benefit plan shall include in the plan coverage for:

45 (a) Up to a 12-month supply, per prescription, of any type of drug for
46 contraception or its therapeutic equivalent which is:

47 (1) Lawfully prescribed or ordered;

48 (2) Approved by the Food and Drug Administration;

49 (3) Listed in subsection 10; and

50 (4) Dispensed in accordance with NRS 639.28075;

51 (b) Any type of device for contraception which is:

52 (1) Lawfully prescribed or ordered;

53 (2) Approved by the Food and Drug Administration; and

1 (3) Listed in subsection 10;

2 (c) *Self-administered hormonal contraceptives dispensed by a pharmacist*
3 *pursuant to section 3 of this act;*

4 (d) Insertion of a device for contraception or removal of such a device if the
5 device was inserted while the insured was covered by the same health benefit plan;

6 ~~[(d)]~~ (e) Education and counseling relating to the initiation of the use of
7 contraception and any necessary follow-up after initiating such use;

8 ~~[(e)]~~ (f) Management of side effects relating to contraception; and

9 ~~[(f)]~~ (g) Voluntary sterilization for women.

10 2. A carrier must ensure that the benefits required by subsection 1 are made
11 available to an insured through a provider of health care who participates in the
12 network plan of the carrier.

13 3. If a covered therapeutic equivalent listed in subsection 1 is not available or
14 a provider of health care deems a covered therapeutic equivalent to be medically
15 inappropriate, an alternate therapeutic equivalent prescribed by a provider of health
16 care must be covered by the carrier.

17 4. Except as otherwise provided in subsections 8, 9 and 11, a carrier that
18 offers or issues a health benefit plan shall not:

19 (a) Require an insured to pay a higher deductible, any copayment or
20 coinsurance or require a longer waiting period or other condition to obtain any
21 benefit included in the health benefit plan pursuant to subsection 1;

22 (b) Refuse to issue a health benefit plan or cancel a health benefit plan solely
23 because the person applying for or covered by the plan uses or may use any such
24 benefit;

25 (c) Offer or pay any type of material inducement or financial incentive to an
26 insured to discourage the insured from obtaining any such benefit;

27 (d) Penalize a provider of health care who provides any such benefit to an
28 insured, including, without limitation, reducing the reimbursement to the provider
29 of health care;

30 (e) Offer or pay any type of material inducement, bonus or other financial
31 incentive to a provider of health care to deny, reduce, withhold, limit or delay
32 access to any such benefit to an insured; or

33 (f) Impose any other restrictions or delays on the access of an insured to any
34 such benefit.

35 5. Coverage pursuant to this section for the covered dependent of an insured
36 must be the same as for the insured.

37 6. Except as otherwise provided in subsection 7, a health benefit plan subject
38 to the provisions of this chapter that is delivered, issued for delivery or renewed on
39 or after January 1, ~~2018,~~ 2022, has the legal effect of including the coverage
40 required by subsection 1, and any provision of the plan or the renewal which is in
41 conflict with this section is void.

42 7. A carrier that offers or issues a health benefit plan and which is affiliated
43 with a religious organization is not required to provide the coverage required by
44 subsection 1 if the carrier objects on religious grounds. Such a carrier shall, before
45 the issuance of a health benefit plan and before the renewal of such a plan, provide
46 to the prospective insured written notice of the coverage that the carrier refuses to
47 provide pursuant to this subsection.

48 8. A carrier may require an insured to pay a higher deductible, copayment or
49 coinsurance for a drug for contraception if the insured refuses to accept a
50 therapeutic equivalent of the drug.

51 9. For each of the 18 methods of contraception listed in subsection 10 that
52 have been approved by the Food and Drug Administration, a health benefit plan
53 must include at least one drug or device for contraception within each method for

1 which no deductible, copayment or coinsurance may be charged to the insured, but
2 the carrier may charge a deductible, copayment or coinsurance for any other drug or
3 device that provides the same method of contraception.

4 10. The following 18 methods of contraception must be covered pursuant to
5 this section:

- 6 (a) Voluntary sterilization for women;
- 7 (b) Surgical sterilization implants for women;
- 8 (c) Implantable rods;
- 9 (d) Copper-based intrauterine devices;
- 10 (e) Progesterone-based intrauterine devices;
- 11 (f) Injections;
- 12 (g) Combined estrogen- and progestin-based drugs;
- 13 (h) Progestin-based drugs;
- 14 (i) Extended- or continuous-regimen drugs;
- 15 (j) Estrogen- and progestin-based patches;
- 16 (k) Vaginal contraceptive rings;
- 17 (l) Diaphragms with spermicide;
- 18 (m) Sponges with spermicide;
- 19 (n) Cervical caps with spermicide;
- 20 (o) Female condoms;
- 21 (p) Spermicide;
- 22 (q) Combined estrogen- and progestin-based drugs for emergency
23 contraception or progestin-based drugs for emergency contraception; and
24 (r) Ulipristal acetate for emergency contraception.

25 11. Except as otherwise provided in this section and federal law, a carrier may
26 use medical management techniques, including, without limitation, any available
27 clinical evidence, to determine the frequency of or treatment relating to any benefit
28 required by this section or the type of provider of health care to use for such
29 treatment.

30 12. A carrier shall not use medical management techniques to require an
31 insured to use a method of contraception other than the method prescribed or
32 ordered by a provider of health care.

33 13. A carrier must provide an accessible, transparent and expedited process
34 which is not unduly burdensome by which an insured, or the authorized
35 representative of the insured, may request an exception relating to any medical
36 management technique used by the carrier to obtain any benefit required by this
37 section without a higher deductible, copayment or coinsurance.

38 14. As used in this section:

39 (a) "Medical management technique" means a practice which is used to control
40 the cost or utilization of health care services or prescription drug use. The term
41 includes, without limitation, the use of step therapy, prior authorization or
42 categorizing drugs and devices based on cost, type or method of administration.

43 (b) "Network plan" means a health benefit plan offered by a carrier under
44 which the financing and delivery of medical care, including items and services paid
45 for as medical care, are provided, in whole or in part, through a defined set of
46 providers under contract with the carrier. The term does not include an arrangement
47 for the financing of premiums.

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

49 (d) "Therapeutic equivalent" means a drug which:

50 (1) Contains an identical amount of the same active ingredients in the same
51 dosage and method of administration as another drug;

52 (2) Is expected to have the same clinical effect when administered to a
53 patient pursuant to a prescription or order as another drug; and

1 (3) Meets any other criteria required by the Food and Drug Administration
2 for classification as a therapeutic equivalent.

3 **Sec. 12.** NRS 695A.1865 is hereby amended to read as follows:

4 695A.1865 1. Except as otherwise provided in subsection 7, a society that
5 offers or issues a benefit contract which provides coverage for prescription drugs or
6 devices shall include in the contract coverage for:

7 (a) Up to a 12-month supply, per prescription, of any type of drug for
8 contraception or its therapeutic equivalent which is:

- 9 (1) Lawfully prescribed or ordered;
10 (2) Approved by the Food and Drug Administration;
11 (3) Listed in subsection 10; and
12 (4) Dispensed in accordance with NRS 639.28075;

13 (b) Any type of device for contraception which is:

- 14 (1) Lawfully prescribed or ordered;
15 (2) Approved by the Food and Drug Administration; and
16 (3) Listed in subsection 10;

17 (c) *Self-administered hormonal contraceptives dispensed by a pharmacist*
18 *pursuant to section 3 of this act;*

19 (d) Insertion of a device for contraception or removal of such a device if the
20 device was inserted while the insured was covered by the same benefit contract;

21 ~~[(e)]~~ (e) Education and counseling relating to the initiation of the use of
22 contraception and any necessary follow-up after initiating such use;

23 ~~[(e)]~~ (f) Management of side effects relating to contraception; and

24 ~~[(e)]~~ (g) Voluntary sterilization for women.

25 2. A society must ensure that the benefits required by subsection 1 are made
26 available to an insured through a provider of health care who participates in the
27 network plan of the society.

28 3. If a covered therapeutic equivalent listed in subsection 1 is not available or
29 a provider of health care deems a covered therapeutic equivalent to be medically
30 inappropriate, an alternate therapeutic equivalent prescribed by a provider of health
31 care must be covered by the society.

32 4. Except as otherwise provided in subsections 8, 9 and 11, a society that
33 offers or issues a benefit contract shall not:

34 (a) Require an insured to pay a higher deductible, any copayment or
35 coinsurance or require a longer waiting period or other condition for coverage for
36 any benefit included in the benefit contract pursuant to subsection 1;

37 (b) Refuse to issue a benefit contract or cancel a benefit contract solely because
38 the person applying for or covered by the contract uses or may use any such
39 benefit;

40 (c) Offer or pay any type of material inducement or financial incentive to an
41 insured to discourage the insured from obtaining any such benefit;

42 (d) Penalize a provider of health care who provides any such benefit to an
43 insured, including, without limitation, reducing the reimbursement to the provider
44 of health care;

45 (e) Offer or pay any type of material inducement, bonus or other financial
46 incentive to a provider of health care to deny, reduce, withhold, limit or delay
47 access to any such benefit to an insured; or

48 (f) Impose any other restrictions or delays on the access of an insured to any
49 such benefit.

50 5. Coverage pursuant to this section for the covered dependent of an insured
51 must be the same as for the insured.

52 6. Except as otherwise provided in subsection 7, a benefit contract subject to
53 the provisions of this chapter that is delivered, issued for delivery or renewed on or

1 after January 1, ~~2018~~ 2022, has the legal effect of including the coverage required
2 by subsection 1, and any provision of the contract or the renewal which is in
3 conflict with this section is void.

4 7. A society that offers or issues a benefit contract and which is affiliated with
5 a religious organization is not required to provide the coverage required by
6 subsection 1 if the society objects on religious grounds. Such a society shall, before
7 the issuance of a benefit contract and before the renewal of such a contract, provide
8 to the prospective insured written notice of the coverage that the society refuses to
9 provide pursuant to this subsection.

10 8. A society may require an insured to pay a higher deductible, copayment or
11 coinsurance for a drug for contraception if the insured refuses to accept a
12 therapeutic equivalent of the drug.

13 9. For each of the 18 methods of contraception listed in subsection 10 that
14 have been approved by the Food and Drug Administration, a benefit contract must
15 include at least one drug or device for contraception within each method for which
16 no deductible, copayment or coinsurance may be charged to the insured, but the
17 society may charge a deductible, copayment or coinsurance for any other drug or
18 device that provides the same method of contraception.

19 10. The following 18 methods of contraception must be covered pursuant to
20 this section:

- 21 (a) Voluntary sterilization for women;
- 22 (b) Surgical sterilization implants for women;
- 23 (c) Implantable rods;
- 24 (d) Copper-based intrauterine devices;
- 25 (e) Progesterone-based intrauterine devices;
- 26 (f) Injections;
- 27 (g) Combined estrogen- and progestin-based drugs;
- 28 (h) Progestin-based drugs;
- 29 (i) Extended- or continuous-regimen drugs;
- 30 (j) Estrogen- and progestin-based patches;
- 31 (k) Vaginal contraceptive rings;
- 32 (l) Diaphragms with spermicide;
- 33 (m) Sponges with spermicide;
- 34 (n) Cervical caps with spermicide;
- 35 (o) Female condoms;
- 36 (p) Spermicide;
- 37 (q) Combined estrogen- and progestin-based drugs for emergency
38 contraception or progestin-based drugs for emergency contraception; and
39 (r) Ulipristal acetate for emergency contraception.

40 11. Except as otherwise provided in this section and federal law, a society
41 may use medical management techniques, including, without limitation, any
42 available clinical evidence, to determine the frequency of or treatment relating to
43 any benefit required by this section or the type of provider of health care to use for
44 such treatment.

45 12. A society shall not use medical management techniques to require an
46 insured to use a method of contraception other than the method prescribed or
47 ordered by a provider of health care.

48 13. A society must provide an accessible, transparent and expedited process
49 which is not unduly burdensome by which an insured, or the authorized
50 representative of the insured, may request an exception relating to any medical
51 management technique used by the society to obtain any benefit required by this
52 section without a higher deductible, copayment or coinsurance.

53 14. As used in this section:

1 (a) "Medical management technique" means a practice which is used to control
2 the cost or utilization of health care services or prescription drug use. The term
3 includes, without limitation, the use of step therapy, prior authorization or
4 categorizing drugs and devices based on cost, type or method of administration.

5 (b) "Network plan" means a benefit contract offered by a society under which
6 the financing and delivery of medical care, including items and services paid for as
7 medical care, are provided, in whole or in part, through a defined set of providers
8 under contract with the society. The term does not include an arrangement for the
9 financing of premiums.

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

11 (d) "Therapeutic equivalent" means a drug which:

12 (1) Contains an identical amount of the same active ingredients in the same
13 dosage and method of administration as another drug;

14 (2) Is expected to have the same clinical effect when administered to a
15 patient pursuant to a prescription or order as another drug; and

16 (3) Meets any other criteria required by the Food and Drug Administration
17 for classification as a therapeutic equivalent.

18 **Sec. 13.** NRS 695B.1919 is hereby amended to read as follows:

19 695B.1919 1. Except as otherwise provided in subsection 7, an insurer that
20 offers or issues a contract for hospital or medical service shall include in the
21 contract coverage for:

22 (a) Up to a 12-month supply, per prescription, of any type of drug for
23 contraception or its therapeutic equivalent which is:

24 (1) Lawfully prescribed or ordered;

25 (2) Approved by the Food and Drug Administration;

26 (3) Listed in subsection 11; and

27 (4) Dispensed in accordance with NRS 639.28075;

28 (b) Any type of device for contraception which is:

29 (1) Lawfully prescribed or ordered;

30 (2) Approved by the Food and Drug Administration; and

31 (3) Listed in subsection 11;

32 (c) *Self-administered hormonal contraceptives dispensed by a pharmacist*
33 *pursuant to section 3 of this act;*

34 (d) Insertion of a device for contraception or removal of such a device if the
35 device was inserted while the insured was covered by the same contract for hospital
36 or medical service;

37 ~~(e)~~ (e) Education and counseling relating to the initiation of the use of
38 contraception and any necessary follow-up after initiating such use;

39 ~~(f)~~ (f) Management of side effects relating to contraception; and

40 ~~(g)~~ (g) Voluntary sterilization for women.

41 2. An insurer that offers or issues a contract for hospital or medical services
42 must ensure that the benefits required by subsection 1 are made available to an
43 insured through a provider of health care who participates in the network plan of
44 the insurer.

45 3. If a covered therapeutic equivalent listed in subsection 1 is not available or
46 a provider of health care deems a covered therapeutic equivalent to be medically
47 inappropriate, an alternate therapeutic equivalent prescribed by a provider of health
48 care must be covered by the insurer.

49 4. Except as otherwise provided in subsections 9, 10 and 12, an insurer that
50 offers or issues a contract for hospital or medical service shall not:

51 (a) Require an insured to pay a higher deductible, any copayment or
52 coinsurance or require a longer waiting period or other condition to obtain any

1 benefit included in the contract for hospital or medical service pursuant to
2 subsection 1;

3 (b) Refuse to issue a contract for hospital or medical service or cancel a
4 contract for hospital or medical service solely because the person applying for or
5 covered by the contract uses or may use any such benefit;

6 (c) Offer or pay any type of material inducement or financial incentive to an
7 insured to discourage the insured from obtaining any such benefit;

8 (d) Penalize a provider of health care who provides any such benefit to an
9 insured, including, without limitation, reducing the reimbursement to the provider
10 of health care;

11 (e) Offer or pay any type of material inducement, bonus or other financial
12 incentive to a provider of health care to deny, reduce, withhold, limit or delay
13 access to any such benefit to an insured; or

14 (f) Impose any other restrictions or delays on the access of an insured to any
15 such benefit.

16 5. Coverage pursuant to this section for the covered dependent of an insured
17 must be the same as for the insured.

18 6. Except as otherwise provided in subsection 7, a contract for hospital or
19 medical service subject to the provisions of this chapter that is delivered, issued for
20 delivery or renewed on or after January 1, ~~2018,~~ 2022, has the legal effect of
21 including the coverage required by subsection 1, and any provision of the contract
22 or the renewal which is in conflict with this section is void.

23 7. An insurer that offers or issues a contract for hospital or medical service
24 and which is affiliated with a religious organization is not required to provide the
25 coverage required by subsection 1 if the insurer objects on religious grounds. Such
26 an insurer shall, before the issuance of a contract for hospital or medical service and
27 before the renewal of such a contract, provide to the prospective insured written
28 notice of the coverage that the insurer refuses to provide pursuant to this subsection.

29 8. If an insurer refuses, pursuant to subsection 7, to provide the coverage
30 required by subsection 1, an employer may otherwise provide for the coverage for
31 the employees of the employer.

32 9. An insurer may require an insured to pay a higher deductible, copayment or
33 coinsurance for a drug for contraception if the insured refuses to accept a
34 therapeutic equivalent of the drug.

35 10. For each of the 18 methods of contraception listed in subsection 11 that
36 have been approved by the Food and Drug Administration, a contract for hospital or
37 medical service must include at least one drug or device for contraception within
38 each method for which no deductible, copayment or coinsurance may be charged to
39 the insured, but the insurer may charge a deductible, copayment or coinsurance for
40 any other drug or device that provides the same method of contraception.

41 11. The following 18 methods of contraception must be covered pursuant to
42 this section:

- 43 (a) Voluntary sterilization for women;
- 44 (b) Surgical sterilization implants for women;
- 45 (c) Implantable rods;
- 46 (d) Copper-based intrauterine devices;
- 47 (e) Progesterone-based intrauterine devices;
- 48 (f) Injections;
- 49 (g) Combined estrogen- and progestin-based drugs;
- 50 (h) Progestin-based drugs;
- 51 (i) Extended- or continuous-regimen drugs;
- 52 (j) Estrogen- and progestin-based patches;
- 53 (k) Vaginal contraceptive rings;

1 (l) Diaphragms with spermicide;
2 (m) Sponges with spermicide;
3 (n) Cervical caps with spermicide;
4 (o) Female condoms;
5 (p) Spermicide;
6 (q) Combined estrogen- and progestin-based drugs for emergency
7 contraception or progestin-based drugs for emergency contraception; and
8 (r) Ulipristal acetate for emergency contraception.

9 12. Except as otherwise provided in this section and federal law, an insurer
10 that offers or issues a contract for hospital or medical services may use medical
11 management techniques, including, without limitation, any available clinical
12 evidence, to determine the frequency of or treatment relating to any benefit required
13 by this section or the type of provider of health care to use for such treatment.

14 13. An insurer shall not use medical management techniques to require an
15 insured to use a method of contraception other than the method prescribed or
16 ordered by a provider of health care.

17 14. An insurer must provide an accessible, transparent and expedited process
18 which is not unduly burdensome by which an insured, or the authorized
19 representative of the insured, may request an exception relating to any medical
20 management technique used by the insurer to obtain any benefit required by this
21 section without a higher deductible, copayment or coinsurance.

22 15. As used in this section:

23 (a) "Medical management technique" means a practice which is used to control
24 the cost or utilization of health care services or prescription drug use. The term
25 includes, without limitation, the use of step therapy, prior authorization or
26 categorizing drugs and devices based on cost, type or method of administration.

27 (b) "Network plan" means a contract for hospital or medical service offered by
28 an insurer under which the financing and delivery of medical care, including items
29 and services paid for as medical care, are provided, in whole or in part, through a
30 defined set of providers under contract with the insurer. The term does not include
31 an arrangement for the financing of premiums.

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

33 (d) "Therapeutic equivalent" means a drug which:

34 (1) Contains an identical amount of the same active ingredients in the same
35 dosage and method of administration as another drug;

36 (2) Is expected to have the same clinical effect when administered to a
37 patient pursuant to a prescription or order as another drug; and

38 (3) Meets any other criteria required by the Food and Drug Administration
39 for classification as a therapeutic equivalent.

40 **Sec. 14.** NRS 695C.1696 is hereby amended to read as follows:

41 695C.1696 1. Except as otherwise provided in subsection 7, a health
42 maintenance organization that offers or issues a health care plan shall include in the
43 plan coverage for:

44 (a) Up to a 12-month supply, per prescription, of any type of drug for
45 contraception or its therapeutic equivalent which is:

46 (1) Lawfully prescribed or ordered;

47 (2) Approved by the Food and Drug Administration;

48 (3) Listed in subsection 11; and

49 (4) Dispensed in accordance with NRS 639.28075;

50 (b) Any type of device for contraception which is:

51 (1) Lawfully prescribed or ordered;

52 (2) Approved by the Food and Drug Administration; and

53 (3) Listed in subsection 11;

1 (c) *Self-administered hormonal contraceptives dispensed by a pharmacist*
2 *pursuant to section 3 of this act;*

3 (d) Insertion of a device for contraception or removal of such a device if the
4 device was inserted while the enrollee was covered by the same health care plan;

5 ~~(e)~~ (e) Education and counseling relating to the initiation of the use of
6 contraception and any necessary follow-up after initiating such use;

7 ~~(f)~~ (f) Management of side effects relating to contraception; and

8 ~~(g)~~ (g) Voluntary sterilization for women.

9 2. A health maintenance organization must ensure that the benefits required
10 by subsection 1 are made available to an enrollee through a provider of health care
11 who participates in the network plan of the health maintenance organization.

12 3. If a covered therapeutic equivalent listed in subsection 1 is not available or
13 a provider of health care deems a covered therapeutic equivalent to be medically
14 inappropriate, an alternate therapeutic equivalent prescribed by a provider of health
15 care must be covered by the health maintenance organization.

16 4. Except as otherwise provided in subsections 9, 10 and 12, a health
17 maintenance organization that offers or issues a health care plan shall not:

18 (a) Require an enrollee to pay a higher deductible, any copayment or
19 coinsurance or require a longer waiting period or other condition to obtain any
20 benefit included in the health care plan pursuant to subsection 1;

21 (b) Refuse to issue a health care plan or cancel a health care plan solely
22 because the person applying for or covered by the plan uses or may use any such
23 benefit;

24 (c) Offer or pay any type of material inducement or financial incentive to an
25 enrollee to discourage the enrollee from obtaining any such benefit;

26 (d) Penalize a provider of health care who provides any such benefit to an
27 enrollee, including, without limitation, reducing the reimbursement of the provider
28 of health care;

29 (e) Offer or pay any type of material inducement, bonus or other financial
30 incentive to a provider of health care to deny, reduce, withhold, limit or delay
31 access to any such benefit to an enrollee; or

32 (f) Impose any other restrictions or delays on the access of an enrollee to any
33 such benefit.

34 5. Coverage pursuant to this section for the covered dependent of an enrollee
35 must be the same as for the enrollee.

36 6. Except as otherwise provided in subsection 7, a health care plan subject to
37 the provisions of this chapter that is delivered, issued for delivery or renewed on or
38 after January 1, ~~2018,~~ 2022, has the legal effect of including the coverage required
39 by subsection 1, and any provision of the plan or the renewal which is in conflict
40 with this section is void.

41 7. A health maintenance organization that offers or issues a health care plan
42 and which is affiliated with a religious organization is not required to provide the
43 coverage required by subsection 1 if the health maintenance organization objects on
44 religious grounds. Such an organization shall, before the issuance of a health care
45 plan and before the renewal of such a plan, provide to the prospective enrollee
46 written notice of the coverage that the health maintenance organization refuses to
47 provide pursuant to this subsection.

48 8. If a health maintenance organization refuses, pursuant to subsection 7, to
49 provide the coverage required by subsection 1, an employer may otherwise provide
50 for the coverage for the employees of the employer.

51 9. A health maintenance organization may require an enrollee to pay a higher
52 deductible, copayment or coinsurance for a drug for contraception if the enrollee
53 refuses to accept a therapeutic equivalent of the drug.

1 10. For each of the 18 methods of contraception listed in subsection 11 that
2 have been approved by the Food and Drug Administration, a health care plan must
3 include at least one drug or device for contraception within each method for which
4 no deductible, copayment or coinsurance may be charged to the enrollee, but the
5 health maintenance organization may charge a deductible, copayment or
6 coinsurance for any other drug or device that provides the same method of
7 contraception.

8 11. The following 18 methods of contraception must be covered pursuant to
9 this section:

- 10 (a) Voluntary sterilization for women;
11 (b) Surgical sterilization implants for women;
12 (c) Implantable rods;
13 (d) Copper-based intrauterine devices;
14 (e) Progesterone-based intrauterine devices;
15 (f) Injections;
16 (g) Combined estrogen- and progestin-based drugs;
17 (h) Progestin-based drugs;
18 (i) Extended- or continuous-regimen drugs;
19 (j) Estrogen- and progestin-based patches;
20 (k) Vaginal contraceptive rings;
21 (l) Diaphragms with spermicide;
22 (m) Sponges with spermicide;
23 (n) Cervical caps with spermicide;
24 (o) Female condoms;
25 (p) Spermicide;
26 (q) Combined estrogen- and progestin-based drugs for emergency
27 contraception or progestin-based drugs for emergency contraception; and
28 (r) Ulipristal acetate for emergency contraception.

29 12. Except as otherwise provided in this section and federal law, a health
30 maintenance organization may use medical management techniques, including,
31 without limitation, any available clinical evidence, to determine the frequency of or
32 treatment relating to any benefit required by this section or the type of provider of
33 health care to use for such treatment.

34 13. A health maintenance organization shall not use medical management
35 techniques to require an enrollee to use a method of contraception other than the
36 method prescribed or ordered by a provider of health care.

37 14. A health maintenance organization must provide an accessible,
38 transparent and expedited process which is not unduly burdensome by which an
39 enrollee, or the authorized representative of the enrollee, may request an exception
40 relating to any medical management technique used by the health maintenance
41 organization to obtain any benefit required by this section without a higher
42 deductible, copayment or coinsurance.

43 15. As used in this section:

44 (a) "Medical management technique" means a practice which is used to control
45 the cost or utilization of health care services or prescription drug use. The term
46 includes, without limitation, the use of step therapy, prior authorization or
47 categorizing drugs and devices based on cost, type or method of administration.

48 (b) "Network plan" means a health care plan offered by a health maintenance
49 organization under which the financing and delivery of medical care, including
50 items and services paid for as medical care, are provided, in whole or in part,
51 through a defined set of providers under contract with the health maintenance
52 organization. The term does not include an arrangement for the financing of
53 premiums.

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

2 (d) "Therapeutic equivalent" means a drug which:

3 (1) Contains an identical amount of the same active ingredients in the same
4 dosage and method of administration as another drug;

5 (2) Is expected to have the same clinical effect when administered to a
6 patient pursuant to a prescription or order as another drug; and

7 (3) Meets any other criteria required by the Food and Drug Administration
8 for classification as a therapeutic equivalent.

9 **Sec. 15.** NRS 695G.1715 is hereby amended to read as follows:

10 695G.1715 1. Except as otherwise provided in subsection 7, a managed care
11 organization that offers or issues a health care plan shall include in the plan
12 coverage for:

13 (a) Up to a 12-month supply, per prescription, of any type of drug for
14 contraception or its therapeutic equivalent which is:

15 (1) Lawfully prescribed or ordered;

16 (2) Approved by the Food and Drug Administration;

17 (3) Listed in subsection 10; and

18 (4) Dispensed in accordance with NRS 639.28075;

19 (b) Any type of device for contraception which is:

20 (1) Lawfully prescribed or ordered;

21 (2) Approved by the Food and Drug Administration; and

22 (3) Listed in subsection 10;

23 (c) *Self-administered hormonal contraceptives dispensed by a pharmacist*
24 *pursuant to section 3 of this act;*

25 (d) Insertion of a device for contraception or removal of such a device if the
26 device was inserted while the insured was covered by the same health care plan;

27 ~~(e)~~ (e) Education and counseling relating to the initiation of the use of
28 contraception and any necessary follow-up after initiating such use;

29 ~~(e)~~ (f) Management of side effects relating to contraception; and

30 ~~(f)~~ (g) Voluntary sterilization for women.

31 2. A managed care organization must ensure that the benefits required by
32 subsection 1 are made available to an insured through a provider of health care who
33 participates in the network plan of the managed care organization.

34 3. If a covered therapeutic equivalent listed in subsection 1 is not available or
35 a provider of health care deems a covered therapeutic equivalent to be medically
36 inappropriate, an alternate therapeutic equivalent prescribed by a provider of health
37 care must be covered by the managed care organization.

38 4. Except as otherwise provided in subsections 8, 9 and 11, a managed care
39 organization that offers or issues a health care plan shall not:

40 (a) Require an insured to pay a higher deductible, any copayment or
41 coinsurance or require a longer waiting period or other condition to obtain any
42 benefit included in the health care plan pursuant to subsection 1;

43 (b) Refuse to issue a health care plan or cancel a health care plan solely
44 because the person applying for or covered by the plan uses or may use any such
45 benefits;

46 (c) Offer or pay any type of material inducement or financial incentive to an
47 insured to discourage the insured from obtaining any such benefits;

48 (d) Penalize a provider of health care who provides any such benefits to an
49 insured, including, without limitation, reducing the reimbursement of the provider
50 of health care;

51 (e) Offer or pay any type of material inducement, bonus or other financial
52 incentive to a provider of health care to deny, reduce, withhold, limit or delay
53 access to any such benefits to an insured; or

1 (f) Impose any other restrictions or delays on the access of an insured to any
2 such benefits.

3 5. Coverage pursuant to this section for the covered dependent of an insured
4 must be the same as for the insured.

5 6. Except as otherwise provided in subsection 7, a health care plan subject to
6 the provisions of this chapter that is delivered, issued for delivery or renewed on or
7 after January 1, ~~2018,~~ 2022, has the legal effect of including the coverage required
8 by subsection 1, and any provision of the plan or the renewal which is in conflict
9 with this section is void.

10 7. A managed care organization that offers or issues a health care plan and
11 which is affiliated with a religious organization is not required to provide the
12 coverage required by subsection 1 if the managed care organization objects on
13 religious grounds. Such an organization shall, before the issuance of a health care
14 plan and before the renewal of such a plan, provide to the prospective insured
15 written notice of the coverage that the managed care organization refuses to provide
16 pursuant to this subsection.

17 8. A managed care organization may require an insured to pay a higher
18 deductible, copayment or coinsurance for a drug for contraception if the insured
19 refuses to accept a therapeutic equivalent of the drug.

20 9. For each of the 18 methods of contraception listed in subsection 10 that
21 have been approved by the Food and Drug Administration, a health care plan must
22 include at least one drug or device for contraception within each method for which
23 no deductible, copayment or coinsurance may be charged to the insured, but the
24 managed care organization may charge a deductible, copayment or coinsurance for
25 any other drug or device that provides the same method of contraception.

26 10. The following 18 methods of contraception must be covered pursuant to
27 this section:

- 28 (a) Voluntary sterilization for women;
- 29 (b) Surgical sterilization implants for women;
- 30 (c) Implantable rods;
- 31 (d) Copper-based intrauterine devices;
- 32 (e) Progesterone-based intrauterine devices;
- 33 (f) Injections;
- 34 (g) Combined estrogen- and progestin-based drugs;
- 35 (h) Progestin-based drugs;
- 36 (i) Extended- or continuous-regimen drugs;
- 37 (j) Estrogen- and progestin-based patches;
- 38 (k) Vaginal contraceptive rings;
- 39 (l) Diaphragms with spermicide;
- 40 (m) Sponges with spermicide;
- 41 (n) Cervical caps with spermicide;
- 42 (o) Female condoms;
- 43 (p) Spermicide;
- 44 (q) Combined estrogen- and progestin-based drugs for emergency
45 contraception or progestin-based drugs for emergency contraception; and
- 46 (r) Ulipristal acetate for emergency contraception.

47 11. Except as otherwise provided in this section and federal law, a managed
48 care organization may use medical management techniques, including, without
49 limitation, any available clinical evidence, to determine the frequency of or
50 treatment relating to any benefit required by this section or the type of provider of
51 health care to use for such treatment.

1 12. A managed care organization shall not use medical management
2 techniques to require an insured to use a method of contraception other than the
3 method prescribed or ordered by a provider of health care.

4 13. A managed care organization must provide an accessible, transparent and
5 expedited process which is not unduly burdensome by which an insured, or the
6 authorized representative of the insured, may request an exception relating to any
7 medical management technique used by the managed care organization to obtain
8 any benefit required by this section without a higher deductible, copayment or
9 coinsurance.

10 14. As used in this section:

11 (a) "Medical management technique" means a practice which is used to control
12 the cost or utilization of health care services or prescription drug use. The term
13 includes, without limitation, the use of step therapy, prior authorization or
14 categorizing drugs and devices based on cost, type or method of administration.

15 (b) "Network plan" means a health care plan offered by a managed care
16 organization under which the financing and delivery of medical care, including
17 items and services paid for as medical care, are provided, in whole or in part,
18 through a defined set of providers under contract with the managed care
19 organization. The term does not include an arrangement for the financing of
20 premiums.

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

22 (d) "Therapeutic equivalent" means a drug which:

23 (1) Contains an identical amount of the same active ingredients in the same
24 dosage and method of administration as another drug;

25 (2) Is expected to have the same clinical effect when administered to a
26 patient pursuant to a prescription or order as another drug; and

27 (3) Meets any other criteria required by the Food and Drug Administration
28 for classification as a therapeutic equivalent.

29 **Sec. 16.** The provisions of NRS 354.599 do not apply to any additional
30 expenses of a local government that are related to the provisions of this act.

31 **Sec. 17.** 1. This section becomes effective upon passage and approval.

32 2. Sections 1 to 16, inclusive, of this act become effective:

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

36 (b) On January 1, 2022, for all other purposes.