

SENATE BILL NO. 280—SENATOR NGUYEN

MARCH 15, 2023

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions governing contraception. (BDR 40-40)

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

CONTAINS UNFUNDED MANDATE (§ 11) (NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

~

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

AN ACT relating to health care; requiring a hospital to provide for the insertion or injection of certain long-acting reversible contraception if requested by a patient giving birth at a hospital; limiting the amount a hospital or provider of health care may require an insurer to pay for long-acting reversible contraception under such circumstances; prohibiting an insurer from refusing to cover a contraceptive injection or the insertion of certain contraceptive devices at a hospital immediately after an insured gives birth; and providing other matters properly relating thereto.

Legislative Counsel’s Digest:

1 Existing law prescribes certain requirements governing the operation of
2 hospitals and other medical facilities. (NRS 449.029-449.2488) **Section 1** of this
3 bill requires a hospital, upon the request of a patient giving birth at the hospital, to
4 provide for the insertion or injection of long-acting reversible contraception unless:
5 (1) the contraception is contraindicated for the patient; (2) a physician, physician
6 assistant or advanced practice registered nurse determines that inserting or injecting
7 the contraception would create an unreasonable risk of harm to the patient; or (3)
8 the hospital is a religiously affiliated institution that objects to the insertion or
9 injection of such contraception on religious grounds. **Section 1** requires a
10 religiously affiliated hospital that objects to the insertion or injection of such
11 contraception on religious grounds to notify maternity patients of that objection.
12 **Section 1** also prohibits a hospital from requiring a provider of health care who
13 objects to the insertion or injection of such contraception on religious grounds to
14 participate in the insertion or injection of such contraception. **Section 1** requires



15 such a provider at a hospital to refer a patient who requests the insertion or injection
16 of such contraception to a provider who is willing to provide that service. **Section 1**
17 restricts the amount that a provider of health care or hospital is authorized to
18 require a third party insurer to pay for such contraception, the insertion or injection
19 of such contraception or testing associated with such contraception. **Sections 2-7**
20 **and 9** of this bill make conforming changes to provide for the administration and
21 enforcement of the requirements of **section 1** in the same manner as other
22 requirements imposed by existing law on medical facilities.

23 Existing law requires certain public and private insurers, including, without
24 limitation, Medicaid, to cover certain types of contraception, including certain
25 implantable rods and intrauterine contraceptive devices. (NRS 287.010, 287.04335,
26 422.27172, 689A.0418, 689B.0378, 689C.1676, 695A.1865, 695B.1919,
27 695C.1696, 695G.1715) **Sections 8 and 10-16** of this bill prohibit such an insurer
28 from refusing to cover the insertion of such a device or a contraceptive injection at
29 a hospital immediately after an insured gives birth.

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

1 **Section 1.** Chapter 449 of NRS is hereby amended by adding
2 thereto a new section to read as follows:

3 *1. Except as otherwise provided in subsection 2, if a patient*
4 *giving birth at a hospital requests the insertion or injection of*
5 *long-acting reversible contraception, the hospital shall provide for*
6 *the insertion or injection of the long-acting reversible*
7 *contraception immediately after the birth unless:*

8 *(a) The use of the long-acting reversible contraception is*
9 *contraindicated for the patient; or*

10 *(b) A physician, physician assistant or advanced practice*
11 *registered nurse determines that inserting or injecting the long-*
12 *acting reversible contraception would create an unreasonable risk*
13 *of harm to the patient.*

14 *2. A hospital that is affiliated with a religious organization is*
15 *not required to provide the service described in subsection 1 if the*
16 *hospital objects on religious grounds. Before scheduling a patient*
17 *for maternity care or, if such scheduling does not occur, upon*
18 *admitting a patient to the hospital for maternity care, the hospital*
19 *shall provide to the patient written notice that the hospital refuses*
20 *to provide the service required by subsection 1.*

21 *3. A hospital shall not require a provider of health care who*
22 *objects to the service described in subsection 1 on religious*
23 *grounds to participate in the provision of that service. If such a*
24 *provider of health care at a hospital, other than a hospital*
25 *described in subsection 2, receives a request for that service, the*
26 *provider shall refer the patient to a provider of health care who is*
27 *willing to provide the service.*



1 4. A hospital or provider of health care may not require a
2 *third party to pay more for:*

3 (a) *Long-acting reversible contraception inserted or injected*
4 *pursuant to subsection 1 than the lowest rate prescribed in a*
5 *contract between the third party and a hospital or a provider of the*
6 *same type as the provider of health care, as applicable, for the*
7 *same type of long-acting reversible contraception.*

8 (b) *The insertion or injection of long-acting reversible*
9 *contraception pursuant to subsection 1 than the lowest rate*
10 *prescribed in a contract between the third party and a hospital or a*
11 *provider of the same type as the provider of health care, as*
12 *applicable, for insertion or injection of the same type of long-*
13 *acting reversible contraception.*

14 (c) *Any testing associated with the insertion or injection of*
15 *long-acting reversible contraception pursuant to subsection 1 than*
16 *the lowest rate prescribed in a contract between the third party and*
17 *a hospital or a provider of health care of the same type as the*
18 *provider of health care, as applicable, for the same test.*

19 5. As used in this section:

20 (a) *“Long-acting reversible contraception” means a method of*
21 *contraception that requires administration less than once per*
22 *month, including, without limitation:*

23 (1) *An intrauterine device;*

24 (2) *A contraceptive implant; and*

25 (3) *An injectable contraceptive.*

26 (b) *“Third party” means:*

27 (1) *An insurer, as that term is defined in NRS 679B.540;*

28 (2) *A health benefit plan, as that term is defined in NRS*
29 *687B.470, for employees which provides coverage for prescription*
30 *drugs;*

31 (3) *A participating public agency, as that term is defined in*
32 *NRS 287.04052, and any other local governmental agency of the*
33 *State of Nevada which provides a system of health insurance for*
34 *the benefit of its officers and employees, and the dependents of*
35 *officers and employees, pursuant to chapter 287 of NRS; or*

36 (4) *Any other insurer or organization that provides health*
37 *coverage or benefits in accordance with state or federal law.*

38 **Sec. 2.** NRS 449.029 is hereby amended to read as follows:

39 449.029 As used in NRS 449.029 to 449.240, inclusive, *and*
40 *section 1 of this act*, unless the context otherwise requires, “medical
41 facility” has the meaning ascribed to it in NRS 449.0151 and
42 includes a program of hospice care described in NRS 449.196.

43 **Sec. 3.** NRS 449.0301 is hereby amended to read as follows:

44 449.0301 The provisions of NRS 449.029 to 449.2428,
45 inclusive, *and section 1 of this act* do not apply to:



1 1. Any facility conducted by and for the adherents of any
2 church or religious denomination for the purpose of providing
3 facilities for the care and treatment of the sick who depend solely
4 upon spiritual means through prayer for healing in the practice of
5 the religion of the church or denomination, except that such a
6 facility shall comply with all regulations relative to sanitation and
7 safety applicable to other facilities of a similar category.

8 2. Foster homes as defined in NRS 424.014.

9 3. Any medical facility, facility for the dependent or facility
10 which is otherwise required by the regulations adopted by the Board
11 pursuant to NRS 449.0303 to be licensed that is operated and
12 maintained by the United States Government or an agency thereof.

13 **Sec. 4.** NRS 449.0302 is hereby amended to read as follows:

14 449.0302 1. The Board shall adopt:

15 (a) Licensing standards for each class of medical facility or
16 facility for the dependent covered by NRS 449.029 to 449.2428,
17 inclusive, *and section 1 of this act* and for programs of hospice
18 care.

19 (b) Regulations governing the licensing of such facilities and
20 programs.

21 (c) Regulations governing the procedure and standards for
22 granting an extension of the time for which a natural person may
23 provide certain care in his or her home without being considered a
24 residential facility for groups pursuant to NRS 449.017. The
25 regulations must require that such grants are effective only if made
26 in writing.

27 (d) Regulations establishing a procedure for the indemnification
28 by the Division, from the amount of any surety bond or other
29 obligation filed or deposited by a facility for refractive surgery
30 pursuant to NRS 449.068 or 449.069, of a patient of the facility who
31 has sustained any damages as a result of the bankruptcy of or any
32 breach of contract by the facility.

33 (e) Regulations that prescribe the specific types of
34 discrimination prohibited by NRS 449.101.

35 (f) Regulations requiring a hospital or independent center for
36 emergency medical care to provide training to each employee who
37 provides care to victims of sexual assault or attempted sexual assault
38 concerning appropriate care for such persons, including, without
39 limitation, training concerning the requirements of NRS 449.1885.

40 (g) Any other regulations as it deems necessary or convenient to
41 carry out the provisions of NRS 449.029 to 449.2428, inclusive **[]**,
42 *and section 1 of this act*.

43 2. The Board shall adopt separate regulations governing the
44 licensing and operation of:

45 (a) Facilities for the care of adults during the day; and



1 (b) Residential facilities for groups,
2 ➔ which provide care to persons with Alzheimer's disease or other
3 severe dementia, as described in paragraph (a) of subsection 2 of
4 NRS 449.1845.

5 3. The Board shall adopt separate regulations for:

6 (a) The licensure of rural hospitals which take into consideration
7 the unique problems of operating such a facility in a rural area.

8 (b) The licensure of facilities for refractive surgery which take
9 into consideration the unique factors of operating such a facility.

10 (c) The licensure of mobile units which take into consideration
11 the unique factors of operating a facility that is not in a fixed
12 location.

13 4. The Board shall require that the practices and policies of
14 each medical facility or facility for the dependent provide
15 adequately for the protection of the health, safety and physical,
16 moral and mental well-being of each person accommodated in the
17 facility.

18 5. In addition to the training requirements prescribed pursuant
19 to NRS 449.093, the Board shall establish minimum qualifications
20 for administrators and employees of residential facilities for groups.
21 In establishing the qualifications, the Board shall consider the
22 related standards set by nationally recognized organizations which
23 accredit such facilities.

24 6. The Board shall adopt separate regulations regarding the
25 assistance which may be given pursuant to NRS 453.375 and
26 454.213 to an ultimate user of controlled substances or dangerous
27 drugs by employees of residential facilities for groups. The
28 regulations must require at least the following conditions before
29 such assistance may be given:

30 (a) The ultimate user's physical and mental condition is stable
31 and is following a predictable course.

32 (b) The amount of the medication prescribed is at a maintenance
33 level and does not require a daily assessment.

34 (c) A written plan of care by a physician or registered nurse has
35 been established that:

36 (1) Addresses possession and assistance in the administration
37 of the medication; and

38 (2) Includes a plan, which has been prepared under the
39 supervision of a registered nurse or licensed pharmacist, for
40 emergency intervention if an adverse condition results.

41 (d) Except as otherwise authorized by the regulations adopted
42 pursuant to NRS 449.0304, the prescribed medication is not
43 administered by injection or intravenously.



1 (e) The employee has successfully completed training and
2 examination approved by the Division regarding the authorized
3 manner of assistance.

4 7. The Board shall adopt separate regulations governing the
5 licensing and operation of residential facilities for groups which
6 provide assisted living services. The Board shall not allow the
7 licensing of a facility as a residential facility for groups which
8 provides assisted living services and a residential facility for groups
9 shall not claim that it provides "assisted living services" unless:

10 (a) Before authorizing a person to move into the facility, the
11 facility makes a full written disclosure to the person regarding what
12 services of personalized care will be available to the person and the
13 amount that will be charged for those services throughout the
14 resident's stay at the facility.

15 (b) The residents of the facility reside in their own living units
16 which:

17 (1) Except as otherwise provided in subsection 8, contain
18 toilet facilities;

19 (2) Contain a sleeping area or bedroom; and

20 (3) Are shared with another occupant only upon consent of
21 both occupants.

22 (c) The facility provides personalized care to the residents of the
23 facility and the general approach to operating the facility
24 incorporates these core principles:

25 (1) The facility is designed to create a residential
26 environment that actively supports and promotes each resident's
27 quality of life and right to privacy;

28 (2) The facility is committed to offering high-quality
29 supportive services that are developed by the facility in
30 collaboration with the resident to meet the resident's individual
31 needs;

32 (3) The facility provides a variety of creative and innovative
33 services that emphasize the particular needs of each individual
34 resident and the resident's personal choice of lifestyle;

35 (4) The operation of the facility and its interaction with its
36 residents supports, to the maximum extent possible, each resident's
37 need for autonomy and the right to make decisions regarding his or
38 her own life;

39 (5) The operation of the facility is designed to foster a social
40 climate that allows the resident to develop and maintain personal
41 relationships with fellow residents and with persons in the general
42 community;

43 (6) The facility is designed to minimize and is operated in a
44 manner which minimizes the need for its residents to move out of



1 the facility as their respective physical and mental conditions change
2 over time; and

3 (7) The facility is operated in such a manner as to foster a
4 culture that provides a high-quality environment for the residents,
5 their families, the staff, any volunteers and the community at large.

6 8. The Division may grant an exception from the requirement
7 of subparagraph (1) of paragraph (b) of subsection 7 to a facility
8 which is licensed as a residential facility for groups on or before
9 July 1, 2005, and which is authorized to have 10 or fewer beds and
10 was originally constructed as a single-family dwelling if the
11 Division finds that:

12 (a) Strict application of that requirement would result in
13 economic hardship to the facility requesting the exception; and

14 (b) The exception, if granted, would not:

15 (1) Cause substantial detriment to the health or welfare of
16 any resident of the facility;

17 (2) Result in more than two residents sharing a toilet facility;
18 or

19 (3) Otherwise impair substantially the purpose of that
20 requirement.

21 9. The Board shall, if it determines necessary, adopt
22 regulations and requirements to ensure that each residential facility
23 for groups and its staff are prepared to respond to an emergency,
24 including, without limitation:

25 (a) The adoption of plans to respond to a natural disaster and
26 other types of emergency situations, including, without limitation,
27 an emergency involving fire;

28 (b) The adoption of plans to provide for the evacuation of a
29 residential facility for groups in an emergency, including, without
30 limitation, plans to ensure that nonambulatory patients may be
31 evacuated;

32 (c) Educating the residents of residential facilities for groups
33 concerning the plans adopted pursuant to paragraphs (a) and (b); and

34 (d) Posting the plans or a summary of the plans adopted
35 pursuant to paragraphs (a) and (b) in a conspicuous place in each
36 residential facility for groups.

37 10. The regulations governing the licensing and operation of
38 facilities for transitional living for released offenders must provide
39 for the licensure of at least three different types of facilities,
40 including, without limitation:

41 (a) Facilities that only provide a housing and living
42 environment;

43 (b) Facilities that provide or arrange for the provision of
44 supportive services for residents of the facility to assist the residents



1 with reintegration into the community, in addition to providing a
2 housing and living environment; and

3 (c) Facilities that provide or arrange for the provision of
4 programs for alcohol and other substance use disorders, in addition
5 to providing a housing and living environment and providing or
6 arranging for the provision of other supportive services.

7 ↪ The regulations must provide that if a facility was originally
8 constructed as a single-family dwelling, the facility must not be
9 authorized for more than eight beds.

10 11. The Board shall adopt regulations applicable to providers
11 of community-based living arrangement services which:

12 (a) Except as otherwise provided in paragraph (b), require a
13 natural person responsible for the operation of a provider of
14 community-based living arrangement services and each employee of
15 a provider of community-based living arrangement services who
16 supervises or provides support to recipients of community-based
17 living arrangement services to complete training concerning the
18 provision of community-based living arrangement services to
19 persons with mental illness and continuing education concerning the
20 particular population served by the provider;

21 (b) Exempt a person licensed or certified pursuant to title 54 of
22 NRS from the requirements prescribed pursuant to paragraph (a) if
23 the Board determines that the person is required to receive training
24 and continuing education substantially equivalent to that prescribed
25 pursuant to that paragraph;

26 (c) Require a natural person responsible for the operation of a
27 provider of community-based living arrangement services to receive
28 training concerning the provisions of title 53 of NRS applicable to
29 the provision of community-based living arrangement services; and

30 (d) Require an applicant for a license to provide community-
31 based living arrangement services to post a surety bond in an
32 amount equal to the operating expenses of the applicant for 2
33 months, place that amount in escrow or take another action
34 prescribed by the Division to ensure that, if the applicant becomes
35 insolvent, recipients of community-based living arrangement
36 services from the applicant may continue to receive community-
37 based living arrangement services for 2 months at the expense of the
38 applicant.

39 12. The Board shall adopt separate regulations governing the
40 licensing and operation of freestanding birthing centers. Such
41 regulations must:

42 (a) Align with the standards established by the American
43 Association of Birth Centers, or its successor organization, the
44 accrediting body of the Commission for the Accreditation of Birth
45 Centers, or its successor organization, or another nationally



1 recognized organization for accrediting freestanding birthing
2 centers; and

3 (b) Allow the provision of supervised training to providers of
4 health care, as appropriate, at a freestanding birthing center.

5 13. As used in this section, "living unit" means an individual
6 private accommodation designated for a resident within the facility.

7 **Sec. 5.** NRS 449.160 is hereby amended to read as follows:

8 449.160 1. The Division may deny an application for a
9 license or may suspend or revoke any license issued under the
10 provisions of NRS 449.029 to 449.2428, inclusive, *and section 1 of*
11 *this act* upon any of the following grounds:

12 (a) Violation by the applicant or the licensee of any of the
13 provisions of NRS 439B.410 or 449.029 to 449.245, inclusive, *and*
14 *section 1 of this act* or of any other law of this State or of the
15 standards, rules and regulations adopted thereunder.

16 (b) Aiding, abetting or permitting the commission of any illegal
17 act.

18 (c) Conduct inimical to the public health, morals, welfare and
19 safety of the people of the State of Nevada in the maintenance and
20 operation of the premises for which a license is issued.

21 (d) Conduct or practice detrimental to the health or safety of the
22 occupants or employees of the facility.

23 (e) Failure of the applicant to obtain written approval from the
24 Director of the Department of Health and Human Services as
25 required by NRS 439A.100 or as provided in any regulation adopted
26 pursuant to NRS 449.001 to 449.430, inclusive, *and section 1 of*
27 *this act* and 449.435 to 449.531, inclusive, and chapter 449A of
28 NRS if such approval is required.

29 (f) Failure to comply with the provisions of NRS 441A.315 and
30 any regulations adopted pursuant thereto or NRS 449.2486.

31 (g) Violation of the provisions of NRS 458.112.

32 2. In addition to the provisions of subsection 1, the Division
33 may revoke a license to operate a facility for the dependent if, with
34 respect to that facility, the licensee that operates the facility, or an
35 agent or employee of the licensee:

36 (a) Is convicted of violating any of the provisions of
37 NRS 202.470;

38 (b) Is ordered to but fails to abate a nuisance pursuant to NRS
39 244.360, 244.3603 or 268.4124; or

40 (c) Is ordered by the appropriate governmental agency to correct
41 a violation of a building, safety or health code or regulation but fails
42 to correct the violation.

43 3. The Division shall maintain a log of any complaints that it
44 receives relating to activities for which the Division may revoke the
45 license to operate a facility for the dependent pursuant to



1 subsection 2. The Division shall provide to a facility for the care of
2 adults during the day:

3 (a) A summary of a complaint against the facility if the
4 investigation of the complaint by the Division either substantiates
5 the complaint or is inconclusive;

6 (b) A report of any investigation conducted with respect to the
7 complaint; and

8 (c) A report of any disciplinary action taken against the facility.

9 ➔ The facility shall make the information available to the public
10 pursuant to NRS 449.2486.

11 4. On or before February 1 of each odd-numbered year, the
12 Division shall submit to the Director of the Legislative Counsel
13 Bureau a written report setting forth, for the previous biennium:

14 (a) Any complaints included in the log maintained by the
15 Division pursuant to subsection 3; and

16 (b) Any disciplinary actions taken by the Division pursuant to
17 subsection 2.

18 **Sec. 6.** NRS 449.163 is hereby amended to read as follows:

19 449.163 1. In addition to the payment of the amount required
20 by NRS 449.0308, if a medical facility, facility for the dependent or
21 facility which is required by the regulations adopted by the Board
22 pursuant to NRS 449.0303 to be licensed violates any provision
23 related to its licensure, including any provision of NRS 439B.410 or
24 449.029 to 449.2428, inclusive, *and section 1 of this act* or any
25 condition, standard or regulation adopted by the Board, the
26 Division, in accordance with the regulations adopted pursuant to
27 NRS 449.165, may:

28 (a) Prohibit the facility from admitting any patient until it
29 determines that the facility has corrected the violation;

30 (b) Limit the occupancy of the facility to the number of beds
31 occupied when the violation occurred, until it determines that the
32 facility has corrected the violation;

33 (c) If the license of the facility limits the occupancy of the
34 facility and the facility has exceeded the approved occupancy,
35 require the facility, at its own expense, to move patients to another
36 facility that is licensed;

37 (d) Impose an administrative penalty of not more than \$5,000
38 per day for each violation, together with interest thereon at a rate not
39 to exceed 10 percent per annum; and

40 (e) Appoint temporary management to oversee the operation of
41 the facility and to ensure the health and safety of the patients of the
42 facility, until:

43 (1) It determines that the facility has corrected the violation
44 and has management which is capable of ensuring continued



1 compliance with the applicable statutes, conditions, standards and
2 regulations; or

3 (2) Improvements are made to correct the violation.

4 2. If the facility fails to pay any administrative penalty imposed
5 pursuant to paragraph (d) of subsection 1, the Division may:

6 (a) Suspend the license of the facility until the administrative
7 penalty is paid; and

8 (b) Collect court costs, reasonable attorney's fees and other
9 costs incurred to collect the administrative penalty.

10 3. The Division may require any facility that violates any
11 provision of NRS 439B.410 or 449.029 to 449.2428, inclusive, *and*
12 *section 1 of this act* or any condition, standard or regulation adopted
13 by the Board to make any improvements necessary to correct the
14 violation.

15 4. Any money collected as administrative penalties pursuant to
16 paragraph (d) of subsection 1 must be accounted for separately and
17 used to administer and carry out the provisions of NRS 449.001 to
18 449.430, inclusive, *and section 1 of this act*, 449.435 to 449.531,
19 inclusive, and chapter 449A of NRS to protect the health, safety,
20 well-being and property of the patients and residents of facilities in
21 accordance with applicable state and federal standards or for any
22 other purpose authorized by the Legislature.

23 **Sec. 7.** NRS 449.240 is hereby amended to read as follows:

24 449.240 The district attorney of the county in which the facility
25 is located shall, upon application by the Division, institute and
26 conduct the prosecution of any action for violation of any provisions
27 of NRS 449.029 to 449.245, inclusive ~~§~~, *and section 1 of this act.*

28 **Sec. 8.** NRS 422.27172 is hereby amended to read as follows:

29 422.27172 1. The Director shall include in the State Plan for
30 Medicaid a requirement that the State pay the nonfederal share of
31 expenditures incurred for:

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

34 (1) Lawfully prescribed or ordered;

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

36 (3) Dispensed in accordance with NRS 639.28075;

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

40 (c) Self-administered hormonal contraceptives dispensed by a
41 pharmacist pursuant to NRS 639.28078;

42 (d) Insertion or removal of a device for contraception ~~§~~,
43 *including, without limitation, the insertion of such a device at a*
44 *hospital immediately after a person gives birth;*



1 (e) *A contraceptive injection, including, without limitation,*
2 *such an injection immediately after a person gives birth;*

3 (f) Education and counseling relating to the initiation of the use
4 of contraceptives and any necessary follow-up after initiating such
5 use;

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

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

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

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

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

14 3. The Director shall ensure that the provisions of this section
15 are carried out in a manner which complies with the requirements
16 established by the Drug Use Review Board and set forth in the list
17 of preferred prescription drugs established by the Department
18 pursuant to NRS 422.4025.

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

23 5. For each method of contraception which is approved by the
24 Food and Drug Administration, the Plan must include at least one
25 contraceptive drug or device for which no deductible, copayment or
26 coinsurance may be charged to the person enrolled in Medicaid, but
27 the Plan may charge a deductible, copayment or coinsurance for any
28 other contraceptive drug or device that provides the same method of
29 contraception.

30 6. As used in this section:

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

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

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

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

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

42 **Sec. 9.** NRS 654.190 is hereby amended to read as follows:

43 654.190 1. The Board may, after notice and an opportunity
44 for a hearing as required by law, impose an administrative fine of
45 not more than \$10,000 for each violation on, recover reasonable



1 investigative fees and costs incurred from, suspend, revoke, deny
2 the issuance or renewal of or place conditions on the license of, and
3 place on probation or impose any combination of the foregoing on
4 any licensee who:

5 (a) Is convicted of a felony relating to the practice of
6 administering a nursing facility or residential facility or of any
7 offense involving moral turpitude.

8 (b) Has obtained his or her license by the use of fraud or deceit.

9 (c) Violates any of the provisions of this chapter.

10 (d) Aids or abets any person in the violation of any of the
11 provisions of NRS 449.029 to 449.2428, inclusive, *and section 1 of*
12 *this act*, as those provisions pertain to a facility for skilled nursing,
13 facility for intermediate care or residential facility for groups.

14 (e) Violates any regulation of the Board prescribing additional
15 standards of conduct for licensees, including, without limitation, a
16 code of ethics.

17 (f) Engages in conduct that violates the trust of a patient or
18 resident or exploits the relationship between the licensee and the
19 patient or resident for the financial or other gain of the licensee.

20 2. If a licensee requests a hearing pursuant to subsection 1, the
21 Board shall give the licensee written notice of a hearing pursuant to
22 NRS 233B.121 and 241.034. A licensee may waive, in writing, his
23 or her right to attend the hearing.

24 3. The Board may compel the attendance of witnesses or the
25 production of documents or objects by subpoena. The Board may
26 adopt regulations that set forth a procedure pursuant to which the
27 Chair of the Board may issue subpoenas on behalf of the Board.
28 Any person who is subpoenaed pursuant to this subsection may
29 request the Board to modify the terms of the subpoena or grant
30 additional time for compliance.

31 4. An order that imposes discipline and the findings of fact and
32 conclusions of law supporting that order are public records.

33 5. The expiration of a license by operation of law or by order
34 or decision of the Board or a court, or the voluntary surrender of a
35 license, does not deprive the Board of jurisdiction to proceed with
36 any investigation of, or action or disciplinary proceeding against, the
37 licensee or to render a decision suspending or revoking the license.

38 **Sec. 10.** NRS 689A.0418 is hereby amended to read as
39 follows:

40 689A.0418 1. Except as otherwise provided in subsection 7,
41 an insurer that offers or issues a policy of health insurance shall
42 include in the policy coverage for:

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

45 (1) Lawfully prescribed or ordered;



- 1 (2) Approved by the Food and Drug Administration;
2 (3) Listed in subsection 10; and
3 (4) Dispensed in accordance with NRS 639.28075;
4 (b) Any type of device for contraception which is:
5 (1) Lawfully prescribed or ordered;
6 (2) Approved by the Food and Drug Administration; and
7 (3) Listed in subsection 10;
8 (c) Self-administered hormonal contraceptives dispensed by a
9 pharmacist pursuant to NRS 639.28078;
10 (d) Insertion of a device for contraception or removal of such a
11 device if the device was inserted while the insured was covered by
12 the same policy of health insurance;
13 (e) Education and counseling relating to the initiation of the use
14 of contraception and any necessary follow-up after initiating such
15 use;
16 (f) Management of side effects relating to contraception; and
17 (g) Voluntary sterilization for women.
18 2. An insurer must ensure that the benefits required by
19 subsection 1 are made available to an insured through a provider of
20 health care who participates in the network plan of the insurer.
21 3. If a covered therapeutic equivalent listed in subsection 1 is
22 not available or a provider of health care deems a covered
23 therapeutic equivalent to be medically inappropriate, an alternate
24 therapeutic equivalent prescribed by a provider of health care must
25 be covered by the insurer.
26 4. Except as otherwise provided in subsections 8, 9 and 11, an
27 insurer that offers or issues a policy of health insurance shall not:
28 (a) Require an insured to pay a higher deductible, any
29 copayment or coinsurance or require a longer waiting period or
30 other condition for coverage to obtain any benefit included in the
31 policy pursuant to subsection 1;
32 (b) Refuse to issue a policy of health insurance or cancel a
33 policy of health insurance solely because the person applying for or
34 covered by the policy uses or may use any such benefit;
35 (c) Offer or pay any type of material inducement or financial
36 incentive to an insured to discourage the insured from obtaining any
37 such benefit;
38 (d) Penalize a provider of health care who provides any such
39 benefit to an insured, including, without limitation, reducing the
40 reimbursement of the provider of health care;
41 (e) Offer or pay any type of material inducement, bonus or other
42 financial incentive to a provider of health care to deny, reduce,
43 withhold, limit or delay access to any such benefit to an insured; or
44 (f) Impose any other restrictions or delays on the access of an
45 insured any such benefit.



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

3 6. Except as otherwise provided in subsection 7, a policy
4 subject to the provisions of this chapter that is delivered, issued for
5 delivery or renewed on or after January 1, ~~2022,~~ 2024, has the
6 legal effect of including the coverage required by subsection 1, and
7 any provision of the policy or the renewal which is in conflict with
8 this section is void.

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

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

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

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

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



1 (q) Combined estrogen- and progestin-based drugs for
2 emergency contraception or progestin-based drugs for emergency
3 contraception; and

4 (r) Ulipristal acetate for emergency contraception.

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

11 12. An insurer shall not ~~use~~:

12 (a) Use medical management techniques to require an insured to
13 use a method of contraception other than the method prescribed or
14 ordered by a provider of health care ~~to~~; or

15 (b) *Refuse to cover a contraceptive injection or the insertion of*
16 *a device described in paragraph (c), (d) or (e) of subsection 10 at a*
17 *hospital immediately after an insured gives birth.*

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

24 14. As used in this section:

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

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

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

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

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

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



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

3 **Sec. 11.** NRS 689B.0378 is hereby amended to read as
4 follows:

5 689B.0378 1. Except as otherwise provided in subsection 7,
6 an insurer that offers or issues a policy of group health insurance
7 shall include in the policy coverage for:

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

10 (1) Lawfully prescribed or ordered;

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

12 (3) Listed in subsection 11; and

13 (4) Dispensed in accordance with NRS 639.28075;

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

15 (1) Lawfully prescribed or ordered;

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

17 (3) Listed in subsection 11;

18 (c) Self-administered hormonal contraceptives dispensed by a
19 pharmacist pursuant to NRS 639.28078;

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

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

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

27 (g) Voluntary sterilization for women.

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

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

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

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

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



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

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

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

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

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

14 6. Except as otherwise provided in subsection 7, a policy
15 subject to the provisions of this chapter that is delivered, issued for
16 delivery or renewed on or after January 1, ~~2022,~~ 2024, has the
17 legal effect of including the coverage required by subsection 1, and
18 any provision of the policy or the renewal which is in conflict with
19 this section is void.

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

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

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

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

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

44 (a) Voluntary sterilization for women;

45 (b) Surgical sterilization implants for women;



- 1 (c) Implantable rods;
- 2 (d) Copper-based intrauterine devices;
- 3 (e) Progesterone-based intrauterine devices;
- 4 (f) Injections;
- 5 (g) Combined estrogen- and progestin-based drugs;
- 6 (h) Progestin-based drugs;
- 7 (i) Extended- or continuous-regimen drugs;
- 8 (j) Estrogen- and progestin-based patches;
- 9 (k) Vaginal contraceptive rings;
- 10 (l) Diaphragms with spermicide;
- 11 (m) Sponges with spermicide;
- 12 (n) Cervical caps with spermicide;
- 13 (o) Female condoms;
- 14 (p) Spermicide;
- 15 (q) Combined estrogen- and progestin-based drugs for
- 16 emergency contraception or progestin-based drugs for emergency
- 17 contraception; and
- 18 (r) Ulipristal acetate for emergency contraception.

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

25 13. An insurer shall not ~~use~~ :

26 (a) *Use* medical management techniques to require an insured to
27 use a method of contraception other than the method prescribed or
28 ordered by a provider of health care ~~to~~; *or*

29 (b) *Refuse to cover a contraceptive injection or the insertion of*
30 *a device described in paragraph (c), (d) or (e) of subsection 11 at a*
31 *hospital immediately after an insured gives birth.*

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

38 15. As used in this section:

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

44 (b) "Network plan" means a policy of group health insurance
45 offered by an insurer under which the financing and delivery of



1 medical care, including items and services paid for as medical care,
2 are provided, in whole or in part, through a defined set of providers
3 under contract with the insurer. The term does not include an
4 arrangement for the financing of premiums.

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

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

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

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

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

16 **Sec. 12.** NRS 689C.1676 is hereby amended to read as
17 follows:

18 689C.1676 1. Except as otherwise provided in subsection 7, a
19 carrier that offers or issues a health benefit plan shall include in the
20 plan coverage for:

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

23 (1) Lawfully prescribed or ordered;

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

25 (3) Listed in subsection 10; and

26 (4) Dispensed in accordance with NRS 639.28075;

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

28 (1) Lawfully prescribed or ordered;

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

30 (3) Listed in subsection 10;

31 (c) Self-administered hormonal contraceptives dispensed by a
32 pharmacist pursuant to NRS 639.28078;

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

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

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

40 (g) Voluntary sterilization for women.

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

44 3. If a covered therapeutic equivalent listed in subsection 1 is
45 not available or a provider of health care deems a covered



1 therapeutic equivalent to be medically inappropriate, an alternate
2 therapeutic equivalent prescribed by a provider of health care must
3 be covered by the carrier.

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

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

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

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

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

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

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

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

26 6. Except as otherwise provided in subsection 7, a health
27 benefit plan subject to the provisions of this chapter that is
28 delivered, issued for delivery or renewed on or after January 1,
29 ~~2022,~~ 2024, has the legal effect of including the coverage required
30 by subsection 1, and any provision of the plan or the renewal which
31 is in conflict with this section is void.

32 7. A carrier that offers or issues a health benefit plan and which
33 is affiliated with a religious organization is not required to provide
34 the coverage required by subsection 1 if the carrier objects on
35 religious grounds. Such a carrier shall, before the issuance of a
36 health benefit plan and before the renewal of such a plan, provide to
37 the prospective insured written notice of the coverage that the
38 carrier refuses to provide pursuant to this subsection.

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

42 9. For each of the 18 methods of contraception listed in
43 subsection 10 that have been approved by the Food and Drug
44 Administration, a health benefit plan must include at least one drug
45 or device for contraception within each method for which no



1 deductible, copayment or coinsurance may be charged to the
2 insured, but the carrier may charge a deductible, copayment or
3 coinsurance for any other drug or device that provides the same
4 method of contraception.

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

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

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

33 12. A carrier shall not **use** :

34 (a) *Use* medical management techniques to require an insured to
35 use a method of contraception other than the method prescribed or
36 ordered by a provider of health care **[-]**; *or*

37 (b) *Refuse to cover a contraceptive injection or the insertion of*
38 *a device described in paragraph (c), (d) or (e) of subsection 10 at a*
39 *hospital immediately after an insured gives birth.*

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



1 14. As used in this section:

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

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

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

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

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

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

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

24 **Sec. 13.** NRS 695A.1865 is hereby amended to read as
25 follows:

26 695A.1865 1. Except as otherwise provided in subsection 7,
27 a society that offers or issues a benefit contract which provides
28 coverage for prescription drugs or devices shall include in the
29 contract coverage for:

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

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

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

- 37 (1) Lawfully prescribed or ordered;
38 (2) Approved by the Food and Drug Administration; and
39 (3) Listed in subsection 10;

40 (c) Self-administered hormonal contraceptives dispensed by a
41 pharmacist pursuant to NRS 639.28078;

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



1 (e) Education and counseling relating to the initiation of the use
2 of contraception and any necessary follow-up after initiating such
3 use;

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

5 (g) Voluntary sterilization for women.

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

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

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

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

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

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

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

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

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

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

36 6. Except as otherwise provided in subsection 7, a benefit
37 contract subject to the provisions of this chapter that is delivered,
38 issued for delivery or renewed on or after January 1, ~~2022,~~ 2024,
39 has the legal effect of including the coverage required by subsection
40 1, and any provision of the contract or the renewal which is in
41 conflict with this section is void.

42 7. A society that offers or issues a benefit contract and which is
43 affiliated with a religious organization is not required to provide the
44 coverage required by subsection 1 if the society objects on religious
45 grounds. Such a society shall, before the issuance of a benefit



1 contract and before the renewal of such a contract, provide to the
2 prospective insured written notice of the coverage that the society
3 refuses to provide pursuant to this subsection.

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

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

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

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

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

43 12. A society shall not ~~use~~:



1 (a) *Use* medical management techniques to require an insured to
2 use a method of contraception other than the method prescribed or
3 ordered by a provider of health care ~~§~~; *or*

4 (b) *Refuse to cover a contraceptive injection or the insertion of*
5 *a device described in paragraph (c), (d) or (e) of subsection 10 at a*
6 *hospital immediately after an insured gives birth.*

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

13 14. As used in this section:

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

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

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

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

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

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

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

36 **Sec. 14.** NRS 695B.1919 is hereby amended to read as
37 follows:

38 695B.1919 1. Except as otherwise provided in subsection 7,
39 an insurer that offers or issues a contract for hospital or medical
40 service shall include in the contract coverage for:

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

43 (1) Lawfully prescribed or ordered;

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

45 (3) Listed in subsection 11; and



- 1 (4) Dispensed in accordance with NRS 639.28075;
- 2 (b) Any type of device for contraception which is:
- 3 (1) Lawfully prescribed or ordered;
- 4 (2) Approved by the Food and Drug Administration; and
- 5 (3) Listed in subsection 11;
- 6 (c) Self-administered hormonal contraceptives dispensed by a
- 7 pharmacist pursuant to NRS 639.28078;
- 8 (d) Insertion of a device for contraception or removal of such a
- 9 device if the device was inserted while the insured was covered by
- 10 the same contract for hospital or medical service;
- 11 (e) Education and counseling relating to the initiation of the use
- 12 of contraception and any necessary follow-up after initiating such
- 13 use;
- 14 (f) Management of side effects relating to contraception; and
- 15 (g) Voluntary sterilization for women.
- 16 2. An insurer that offers or issues a contract for hospital or
- 17 medical services must ensure that the benefits required by
- 18 subsection 1 are made available to an insured through a provider of
- 19 health care who participates in the network plan of the insurer.
- 20 3. If a covered therapeutic equivalent listed in subsection 1 is
- 21 not available or a provider of health care deems a covered
- 22 therapeutic equivalent to be medically inappropriate, an alternate
- 23 therapeutic equivalent prescribed by a provider of health care must
- 24 be covered by the insurer.
- 25 4. Except as otherwise provided in subsections 9, 10 and 12, an
- 26 insurer that offers or issues a contract for hospital or medical service
- 27 shall not:
- 28 (a) Require an insured to pay a higher deductible, any
- 29 copayment or coinsurance or require a longer waiting period or
- 30 other condition to obtain any benefit included in the contract for
- 31 hospital or medical service pursuant to subsection 1;
- 32 (b) Refuse to issue a contract for hospital or medical service or
- 33 cancel a contract for hospital or medical service solely because the
- 34 person applying for or covered by the contract uses or may use any
- 35 such benefit;
- 36 (c) Offer or pay any type of material inducement or financial
- 37 incentive to an insured to discourage the insured from obtaining any
- 38 such benefit;
- 39 (d) Penalize a provider of health care who provides any such
- 40 benefit to an insured, including, without limitation, reducing the
- 41 reimbursement to the provider of health care;
- 42 (e) Offer or pay any type of material inducement, bonus or other
- 43 financial incentive to a provider of health care to deny, reduce,
- 44 withhold, limit or delay access to any such benefit to an insured; or



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

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

5 6. Except as otherwise provided in subsection 7, a contract for
6 hospital or medical service subject to the provisions of this chapter
7 that is delivered, issued for delivery or renewed on or after
8 January 1, ~~2022,~~ 2024, has the legal effect of including the
9 coverage required by subsection 1, and any provision of the contract
10 or the renewal which is in conflict with this section is void.

11 7. An insurer that offers or issues a contract for hospital or
12 medical service and which is affiliated with a religious organization
13 is not required to provide the coverage required by subsection 1 if
14 the insurer objects on religious grounds. Such an insurer shall,
15 before the issuance of a contract for hospital or medical service and
16 before the renewal of such a contract, provide to the prospective
17 insured written notice of the coverage that the insurer refuses to
18 provide pursuant to this subsection.

19 8. If an insurer refuses, pursuant to subsection 7, to provide the
20 coverage required by subsection 1, an employer may otherwise
21 provide for the coverage for the employees of the employer.

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

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

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

- 35 (a) Voluntary sterilization for women;
- 36 (b) Surgical sterilization implants for women;
- 37 (c) Implantable rods;
- 38 (d) Copper-based intrauterine devices;
- 39 (e) Progesterone-based intrauterine devices;
- 40 (f) Injections;
- 41 (g) Combined estrogen- and progestin-based drugs;
- 42 (h) Progestin-based drugs;
- 43 (i) Extended- or continuous-regimen drugs;
- 44 (j) Estrogen- and progestin-based patches;
- 45 (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
- 7 emergency contraception or progestin-based drugs for emergency
- 8 contraception; and
- 9 (r) Ulipristal acetate for emergency contraception.

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

17 13. An insurer shall not ~~use~~:

18 (a) Use medical management techniques to require an insured to
19 use a method of contraception other than the method prescribed or
20 ordered by a provider of health care ~~to~~; or

21 (b) *Refuse to cover a contraceptive injection or the insertion of*
22 *a device described in paragraph (c), (d) or (e) of subsection 11 at a*
23 *hospital immediately after an insured gives birth.*

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

30 15. As used in this section:

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

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

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

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



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

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

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

9 **Sec. 15.** NRS 695C.1696 is hereby amended to read as
10 follows:

11 695C.1696 1. Except as otherwise provided in subsection 7, a
12 health maintenance organization that offers or issues a health care
13 plan shall include in the plan coverage for:

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

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

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

- 21 (1) Lawfully prescribed or ordered;
- 22 (2) Approved by the Food and Drug Administration; and
- 23 (3) Listed in subsection 11;

24 (c) Self-administered hormonal contraceptives dispensed by a
25 pharmacist pursuant to NRS 639.28078;

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

29 (e) Education and counseling relating to the initiation of the use
30 of contraception and any necessary follow-up after initiating such
31 use;

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

33 (g) Voluntary sterilization for women.

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

38 3. If a covered therapeutic equivalent listed in subsection 1 is
39 not available or a provider of health care deems a covered
40 therapeutic equivalent to be medically inappropriate, an alternate
41 therapeutic equivalent prescribed by a provider of health care must
42 be covered by the health maintenance organization.

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



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

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

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

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

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

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

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

21 6. Except as otherwise provided in subsection 7, a health care
22 plan subject to the provisions of this chapter that is delivered, issued
23 for delivery or renewed on or after January 1, ~~2022,~~ 2024, has the
24 legal effect of including the coverage required by subsection 1, and
25 any provision of the plan or the renewal which is in conflict with
26 this section is void.

27 7. A health maintenance organization that offers or issues a
28 health care plan and which is affiliated with a religious organization
29 is not required to provide the coverage required by subsection 1 if
30 the health maintenance organization objects on religious grounds.
31 Such an organization shall, before the issuance of a health care plan
32 and before the renewal of such a plan, provide to the prospective
33 enrollee written notice of the coverage that the health maintenance
34 organization refuses to provide pursuant to this subsection.

35 8. If a health maintenance organization refuses, pursuant to
36 subsection 7, to provide the coverage required by subsection 1, an
37 employer may otherwise provide for the coverage for the employees
38 of the employer.

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

43 10. For each of the 18 methods of contraception listed in
44 subsection 11 that have been approved by the Food and Drug
45 Administration, a health care plan must include at least one drug or



1 device for contraception within each method for which no
2 deductible, copayment or coinsurance may be charged to the
3 enrollee, but the health maintenance organization may charge a
4 deductible, copayment or coinsurance for any other drug or device
5 that provides the same method of contraception.

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

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

28 12. Except as otherwise provided in this section and federal
29 law, a health maintenance organization may use medical
30 management techniques, including, without limitation, any available
31 clinical evidence, to determine the frequency of or treatment relating
32 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~~:

35 (a) *Use* medical management techniques to require an enrollee
36 to use a method of contraception other than the method prescribed
37 or ordered by a provider of health care ~~H~~; *or*

38 (b) *Refuse to cover a contraceptive injection or the insertion of*
39 *a device described in paragraph (c), (d) or (e) of subsection 11 at a*
40 *hospital immediately after an enrollee gives birth.*

41 14. A health maintenance organization must provide an
42 accessible, transparent and expedited process which is not unduly
43 burdensome by which an enrollee, or the authorized representative
44 of the enrollee, may request an exception relating to any medical
45 management technique used by the health maintenance organization



1 to obtain any benefit required by this section without a higher
2 deductible, copayment or coinsurance.

3 15. As used in this section:

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

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

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

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

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

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

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

26 **Sec. 16.** NRS 695G.1715 is hereby amended to read as
27 follows:

28 695G.1715 1. Except as otherwise provided in subsection 7,
29 a managed care organization that offers or issues a health care plan
30 shall include in the plan coverage for:

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

33 (1) Lawfully prescribed or ordered;

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

35 (3) Listed in subsection 10; and

36 (4) Dispensed in accordance with NRS 639.28075;

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

38 (1) Lawfully prescribed or ordered;

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

40 (3) Listed in subsection 10;

41 (c) Self-administered hormonal contraceptives dispensed by a
42 pharmacist pursuant to NRS 639.28078;

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



1 (e) Education and counseling relating to the initiation of the use
2 of contraception and any necessary follow-up after initiating such
3 use;

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

5 (g) Voluntary sterilization for women.

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

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

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

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

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

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

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

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

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

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

38 6. Except as otherwise provided in subsection 7, a health care
39 plan subject to the provisions of this chapter that is delivered, issued
40 for delivery or renewed on or after January 1, ~~2022,~~ 2024, has the
41 legal effect of including the coverage required by subsection 1, and
42 any provision of the plan or the renewal which is in conflict with
43 this section is void.

44 7. A managed care organization that offers or issues a health
45 care plan and which is affiliated with a religious organization is not



1 required to provide the coverage required by subsection 1 if the
2 managed care organization objects on religious grounds. Such an
3 organization shall, before the issuance of a health care plan and
4 before the renewal of such a plan, provide to the prospective insured
5 written notice of the coverage that the managed care organization
6 refuses to provide pursuant to this subsection.

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

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

19 10. The following 18 methods of contraception must be
20 covered pursuant to 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
38 emergency contraception or progestin-based drugs for emergency
39 contraception; and
- 40 (r) Ulipristal acetate for emergency contraception.

41 11. Except as otherwise provided in this section and federal
42 law, a managed care organization may use medical management
43 techniques, including, without limitation, any available clinical
44 evidence, to determine the frequency of or treatment relating to any



1 benefit required by this section or the type of provider of health care
2 to use for such treatment.

3 12. A managed care organization shall not ~~use~~:

4 (a) Use medical management techniques to require an insured to
5 use a method of contraception other than the method prescribed or
6 ordered by a provider of health care ~~to~~; or

7 (b) *Refuse to cover a contraceptive injection or the insertion of*
8 *a device described in paragraph (c), (d) or (e) of subsection 10 at a*
9 *hospital immediately after an insured gives birth.*

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

17 14. As used in this section:

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

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

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

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

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

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

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

41 **Sec. 17.** The provisions of NRS 354.599 do not apply to any
42 additional expenses of a local government that are related to the
43 provisions of this act.

44 **Sec. 18.** 1. This section becomes effective upon passage and
45 approval.



1 2. Sections 1 to 7, inclusive, and 9 of this act become effective
2 on October 1, 2023.

3 3. Sections 8 and 10 to 17, inclusive, of this act become
4 effective:

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

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



