

ASSEMBLY BILL NO. 249—ASSEMBLYMEN FRIERSON, BILBRAY-AXELROD, SPRINKLE, BENITEZ-THOMPSON, YEAGER; ELLIOT ANDERSON, ARAUJO, BROOKS, BUSTAMANTE ADAMS, CARLTON, CARRILLO, COHEN, DALY, DIAZ, FLORES, FUMO, JAUREGUI, JOINER, MCCURDY II, MILLER, MONROE-MORENO, NEAL, OHRENSCHALL, SPIEGEL, SWANK, THOMPSON AND WATKINS

MARCH 1, 2017

JOINT SPONSORS: SENATORS FORD, RATTI AND CANCELA

Referred to Committee on Health and Human Services

SUMMARY—Requires the State Plan for Medicaid and all health insurance plans to provide certain benefits relating to contraception. (BDR 38-858)

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

CONTAINS UNFUNDED MANDATE (§§ 3, 4)  
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

AN ACT relating to health care; requiring the State Plan for Medicaid to provide certain benefits relating to contraception; revising provisions relating to dispensing of contraceptives; requiring all health insurance plans to provide certain benefits relating to contraception; and providing other matters properly relating thereto.

**Legislative Counsel's Digest:**

1 Existing law requires most health insurance plans which cover prescription  
2 drugs and outpatient care to also include coverage for contraceptive drugs and  
3 devices without an additional copay, coinsurance or a higher deductible than that  
4 which may be charged for other prescription drugs and outpatient care under the  
5 plan. (NRS 689A.0415, 689A.0417, 689B.0376, 689B.0377, 695B.1916,  
6 695B.1918, 695C.1694, 695C.1695) Certain plans, including small employer plans,  
7 benefit contracts provided by fraternal benefit societies, plans issued by a managed  
8 care organization and certain plans offered by governmental entities of this State



\* A B 2 4 9 R 2 \*

9 are not currently subject to these requirements. (Chapters 287, 689C, 695A and  
10 695G of NRS)

11 The federal Patient Protection and Affordable Care Act, Pub. L. 111-148, as  
12 amended, requires certain contraceptive drugs, devices and services to be covered  
13 by every health insurance plan without any copay, coinsurance or higher  
14 deductible. (42 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130) **Sections 3, 4 and 7-**  
15 **25** of this bill align Nevada law with federal law, requiring all public and private  
16 health insurance plans made available in this State to provide coverage for certain  
17 benefits relating to contraception without any copay, coinsurance or a higher  
18 deductible. **Sections 3, 4 and 7-25** require certain contraceptive drugs, devices and  
19 services which are approved by the Food and Drug Administration to be covered by  
20 a health insurance plan, including, without limitation, up to a 12-month supply of a  
21 drug for contraception or its therapeutic equivalent, insertion of a device for  
22 contraception, removal of such a device that was inserted while the insured was  
23 covered by the same policy of health insurance, education and counseling relating  
24 to contraception, management of side effects relating to contraception and  
25 voluntary sterilization for women. **Sections 3, 4 and 7-25** allow an insurer to  
26 require an insured to pay a higher deductible, copayment or coinsurance for a drug  
27 for contraception if the insured refuses to accept a therapeutic equivalent of the  
28 drug. In addition, a health insurance plan must include for each method of  
29 contraception which is approved by the Food and Drug Administration and for  
30 which the insurer is required to provide coverage at least one contraceptive drug or  
31 device for which no deductible, copayment or coinsurance may be charged to the  
32 insured. **Sections 3, 4 and 7-25** authorize an insurer to use medical management  
33 techniques to determine the frequency of treatment using the contraceptive drugs,  
34 devices and services required by this bill. **Sections 3, 4 and 7-25** prohibit an insurer  
35 from using medical management techniques to require an insured to use a method  
36 of contraception other than that prescribed by a provider of health care. **Sections 3,**  
37 **4 and 7-25** additionally require an insurer to provide a process by which an insured  
38 may request an exemption from a medical management technique required by an  
39 insurer. **Sections 3, 4 and 7-25** also require a health insurance plan to provide  
40 coverage for certain therapeutic equivalent drugs relating to contraception when a  
41 therapeutic equivalent covered by the plan is deemed to be medically inappropriate  
42 by a provider of health care. Additionally, **sections 7, 11, 14, 16, 17, 20 and 25**  
43 require that the benefits provided by a health insurance plan relating to  
44 contraception which are provided to the insured must also be provided to a covered  
45 dependent of an insured.

46 Existing law allows an insurer which is affiliated with a religious organization  
47 and which objects on religious grounds to providing coverage for contraceptive  
48 drugs and devices to exclude coverage in its policies, plans or contracts for such  
49 drugs and devices. (NRS 689A.0415, 689B.0376, 695B.1916, 695C.1694) **Sections**  
50 **7, 11, 14, 16, 17, 20 and 25** of this bill move the religious exemption coverage for  
51 the contraceptive drugs, devices and services required by this bill to the new  
52 provisions relating to coverage of contraception.

53 Existing law requires this State to develop a State Plan for Medicaid which  
54 includes, without limitation, a list of the medical services provided to Medicaid  
55 recipients. (42 U.S.C. § 1396a; NRS 422.063) Existing federal law authorizes a  
56 state to charge a copay, coinsurance or deductible for most Medicaid services, but  
57 prohibits any copay, coinsurance or deductible for certain contraceptive drugs,  
58 devices and services. (42 U.S.C. § 1396o-1) Existing federal law also authorizes a  
59 state to define the parameters of contraceptive coverage provided under Medicaid.  
60 (42 U.S.C. § 1396u-7) Existing Nevada law requires a number of specific medical  
61 services to be covered under Medicaid. (NRS 422.2717-422.27241) **Section 1** of  
62 this bill requires the State Plan for Medicaid to include certain benefits relating to  
63 contraception currently required to be covered by private health insurance plans



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64 pursuant to existing Nevada law and the Patient Protection and Affordable Care  
65 Act, Pub. L. 111-148, as amended, as well as certain additional benefits related to  
66 contraception required by **sections 3, 4 and 7-25** of this bill without any copay,  
67 coinsurance or deductible in most cases. The benefits relating to drugs for  
68 contraception which are provided by **section 1** of this bill are subject to step  
69 therapy and prior authorization requirements pursuant to existing law.

70 Existing law authorizes a pharmacist to dispense up to a 90-day supply of a  
71 drug pursuant to a valid prescription or order in certain circumstances. (NRS  
72 639.2396) **Section 4.5** of this bill requires a pharmacist to dispense up to a 12-  
73 month supply of drugs for contraception or a therapeutic equivalent thereof  
74 pursuant to a valid prescription or order if: (1) the patient has previously received a  
75 3-month supply of the same drug; (2) the patient has previously received a 9-month  
76 supply of the same drug or a supply of the same drug for the balance of the plan  
77 year in which the 3-month supply was prescribed or ordered, whichever is less; (3)  
78 the patient is insured by the same health insurance plan; and (4) a provider of health  
79 care has not specified in the prescription or order that a different supply of the drug  
80 is necessary.

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

1 **Section 1.** Chapter 422 of NRS is hereby amended by adding  
2 thereto a new section to read as follows:

3 *1. The Director shall include in the State Plan for Medicaid a*  
4 *requirement that the State pay the nonfederal share of*  
5 *expenditures for family planning services and supplies, including,*  
6 *without limitation:*

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

9 *(1) Lawfully prescribed or ordered;*

10 *(2) Approved by the Food and Drug Administration; and*

11 *(3) Dispensed in accordance with section 4.5 of this act;*

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

15 *(c) Insertion or removal of a device for contraception;*

16 *(d) Education and counseling relating to the initiation of the*  
17 *use of contraception and any necessary follow-up after initiating*  
18 *such use;*

19 *(e) Management of side effects relating to contraception; and*

20 *(f) Voluntary sterilization for women.*

21 *2. Except as otherwise provided in subsections 4 and 5, to*  
22 *obtain any benefit included in the Plan pursuant to subsection 1, a*  
23 *person enrolled in Medicaid must not be required to:*

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

25 *(b) Be subject to a longer waiting period or any other*  
26 *condition.*



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

6       **4. The Plan may require a person enrolled in Medicaid to pay**  
7 **a higher deductible, copayment or coinsurance for a drug for**  
8 **contraception if the person refuses to accept a therapeutic**  
9 **equivalent of the drug.**

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

17       **6. As used in this section, “therapeutic equivalent” means a**  
18 **drug which:**

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

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

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

27       **Sec. 2.** (Deleted by amendment.)

28       **Sec. 2.5.** NRS 422.401 is hereby amended to read as follows:

29       422.401 As used in NRS 422.401 to 422.406, inclusive, **and**  
30 **section 1 of this act**, unless the context otherwise requires, the  
31 words and terms defined in NRS 422.4015 and 422.402 have the  
32 meanings ascribed to them in those sections.

33       **Sec. 3.** NRS 287.010 is hereby amended to read as follows:

34       287.010 1. The governing body of any county, school  
35 district, municipal corporation, political subdivision, public  
36 corporation or other local governmental agency of the State of  
37 Nevada may:

38       (a) Adopt and carry into effect a system of group life, accident  
39 or health insurance, or any combination thereof, for the benefit of its  
40 officers and employees, and the dependents of officers and  
41 employees who elect to accept the insurance and who, where  
42 necessary, have authorized the governing body to make deductions  
43 from their compensation for the payment of premiums on the  
44 insurance.



1 (b) Purchase group policies of life, accident or health insurance,  
2 or any combination thereof, for the benefit of such officers and  
3 employees, and the dependents of such officers and employees, as  
4 have authorized the purchase, from insurance companies authorized  
5 to transact the business of such insurance in the State of Nevada,  
6 and, where necessary, deduct from the compensation of officers and  
7 employees the premiums upon insurance and pay the deductions  
8 upon the premiums.

9 (c) Provide group life, accident or health coverage through a  
10 self-insurance reserve fund and, where necessary, deduct  
11 contributions to the maintenance of the fund from the compensation  
12 of officers and employees and pay the deductions into the fund. The  
13 money accumulated for this purpose through deductions from the  
14 compensation of officers and employees and contributions of the  
15 governing body must be maintained as an internal service fund as  
16 defined by NRS 354.543. The money must be deposited in a state or  
17 national bank or credit union authorized to transact business in the  
18 State of Nevada. Any independent administrator of a fund created  
19 under this section is subject to the licensing requirements of chapter  
20 683A of NRS, and must be a resident of this State. Any contract  
21 with an independent administrator must be approved by the  
22 Commissioner of Insurance as to the reasonableness of  
23 administrative charges in relation to contributions collected and  
24 benefits provided. The provisions of NRS 687B.408, 689B.030 to  
25 689B.050, inclusive, *and section 11 of this act* and 689B.287 apply  
26 to coverage provided pursuant to this paragraph ~~H~~, *except that the*  
27 *provisions of section 11 of this act only apply to coverage for*  
28 *active officers and employees of the governing body or the*  
29 *dependents of such officers and employees.*

30 (d) Defray part or all of the cost of maintenance of a self-  
31 insurance fund or of the premiums upon insurance. The money for  
32 contributions must be budgeted for in accordance with the laws  
33 governing the county, school district, municipal corporation,  
34 political subdivision, public corporation or other local governmental  
35 agency of the State of Nevada.

36 2. If a school district offers group insurance to its officers and  
37 employees pursuant to this section, members of the board of trustees  
38 of the school district must not be excluded from participating in the  
39 group insurance. If the amount of the deductions from compensation  
40 required to pay for the group insurance exceeds the compensation to  
41 which a trustee is entitled, the difference must be paid by the trustee.

42 3. In any county in which a legal services organization exists,  
43 the governing body of the county, or of any school district,  
44 municipal corporation, political subdivision, public corporation or  
45 other local governmental agency of the State of Nevada in the



1 county, may enter into a contract with the legal services  
2 organization pursuant to which the officers and employees of the  
3 legal services organization, and the dependents of those officers and  
4 employees, are eligible for any life, accident or health insurance  
5 provided pursuant to this section to the officers and employees, and  
6 the dependents of the officers and employees, of the county, school  
7 district, municipal corporation, political subdivision, public  
8 corporation or other local governmental agency.

9 4. If a contract is entered into pursuant to subsection 3, the  
10 officers and employees of the legal services organization:

11 (a) Shall be deemed, solely for the purposes of this section, to be  
12 officers and employees of the county, school district, municipal  
13 corporation, political subdivision, public corporation or other local  
14 governmental agency with which the legal services organization has  
15 contracted; and

16 (b) Must be required by the contract to pay the premiums or  
17 contributions for all insurance which they elect to accept or of which  
18 they authorize the purchase.

19 5. A contract that is entered into pursuant to subsection 3:

20 (a) Must be submitted to the Commissioner of Insurance for  
21 approval not less than 30 days before the date on which the contract  
22 is to become effective.

23 (b) Does not become effective unless approved by the  
24 Commissioner.

25 (c) Shall be deemed to be approved if not disapproved by the  
26 Commissioner within 30 days after its submission.

27 6. As used in this section, "legal services organization" means  
28 an organization that operates a program for legal aid and receives  
29 money pursuant to NRS 19.031.

30 **Sec. 4.** NRS 287.04335 is hereby amended to read as follows:

31 287.04335 If the Board provides health insurance through a  
32 plan of self-insurance, it shall comply with the provisions of NRS  
33 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645,  
34 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177,  
35 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive,  
36 and 695G.405, *and section 25 of this act* in the same manner as an  
37 insurer that is licensed pursuant to title 57 of NRS is required to  
38 comply with those provisions.

39 **Sec. 4.5.** Chapter 639 of NRS is hereby amended by adding  
40 thereto a new section to read as follows:

41 *1. Except as otherwise provided in subsections 2 and 3,*  
42 *pursuant to a valid prescription or order for a drug to be used for*  
43 *contraception or its therapeutic equivalent which has been*  
44 *approved by the Food and Drug Administration a pharmacist*  
45 *shall:*



1 (a) *The first time dispensing the drug or therapeutic equivalent*  
2 *to the patient, dispense up to a 3-month supply of the drug or*  
3 *therapeutic equivalent.*

4 (b) *The second time dispensing the drug or therapeutic*  
5 *equivalent to the patient, dispense up to a 9-month supply of the*  
6 *drug or therapeutic equivalent, or any amount which covers the*  
7 *remainder of the plan year if the patient is covered by a health*  
8 *care plan, whichever is less.*

9 (c) *For a refill in a plan year following the initial dispensing of*  
10 *a drug or therapeutic equivalent pursuant to paragraphs (a) and*  
11 *(b), dispense up to a 12-month supply of the drug or therapeutic*  
12 *equivalent or any amount which covers the remainder of the plan*  
13 *year if the patient is covered by a health care plan, whichever is*  
14 *less.*

15 2. *The provisions of paragraphs (b) and (c) of subsection 1*  
16 *only apply if:*

17 (a) *The drug for contraception or the therapeutic equivalent of*  
18 *such drug is the same drug or therapeutic equivalent which was*  
19 *previously prescribed or ordered pursuant to paragraph (a) of*  
20 *subsection 1; and*

21 (b) *The patient is covered by the same health care plan.*

22 3. *If a prescription or order for a drug for contraception or its*  
23 *therapeutic equivalent limits the dispensing of the drug or*  
24 *therapeutic equivalent to a quantity which is less than the amount*  
25 *otherwise authorized to be dispensed pursuant to subsection 1, the*  
26 *pharmacist must dispense the drug or therapeutic equivalent in*  
27 *accordance with the quantity specified in the prescription or order.*

28 4. *As used in this section:*

29 (a) *“Health care plan” means a policy, contract, certificate or*  
30 *agreement offered or issued by an insurer, including without*  
31 *limitation, the State Plan for Medicaid, to provide, deliver, arrange*  
32 *for, pay for or reimburse any of the costs of health care services.*

33 (b) *“Plan year” means the year designated in the evidence of*  
34 *coverage of a health care plan in which a person is covered by*  
35 *such plan.*

36 (c) *“Therapeutic equivalent” means a drug which:*

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

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

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



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1 **Sec. 5.** NRS 639.2396 is hereby amended to read as follows:

2 639.2396 1. Except as otherwise provided by subsection 2, a  
3 prescription which bears specific authorization to refill, given by the  
4 prescribing practitioner at the time he or she issued the original  
5 prescription, or a prescription which bears authorization permitting  
6 the pharmacist to refill the prescription as needed by the patient,  
7 may be refilled for the number of times authorized or for the period  
8 authorized if it was refilled in accordance with the number of doses  
9 ordered and the directions for use.

10 2. ~~1A~~ *Except as otherwise provided in section 4.5 of this act,*  
11 *a pharmacist may, in his or her professional judgment and pursuant to*  
12 *a valid prescription that specifies an initial amount of less than a*  
13 *90-day supply of a drug other than a controlled substance followed*  
14 *by periodic refills of the initial amount of the drug, dispense not*  
15 *more than a 90-day supply of the drug if:*

16 (a) The patient has used an initial 30-day supply of the drug or  
17 the drug has previously been prescribed to the patient in a 90-day  
18 supply;

19 (b) The total number of dosage units that are dispensed pursuant  
20 to the prescription does not exceed the total number of dosage units,  
21 including refills, that are authorized on the prescription by the  
22 prescribing practitioner; and

23 (c) The prescribing practitioner has not specified on the  
24 prescription that dispensing the prescription in an initial amount of  
25 less than a 90-day supply followed by periodic refills of the initial  
26 amount of the drug is medically necessary.

27 3. Nothing in this section shall be construed to alter the  
28 coverage provided under any contract or policy of health insurance,  
29 health plan or program or other agreement arrangement that  
30 provides health coverage.

31 **Sec. 6.** (Deleted by amendment.)

32 **Sec. 7.** Chapter 689A of NRS is hereby amended by adding  
33 thereto a new section to read as follows:

34 1. *Except as otherwise provided in subsection 7, an insurer*  
35 *that offers or issues a policy of health insurance shall include in*  
36 *the policy coverage for:*

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

39 (1) *Lawfully prescribed or ordered;*

40 (2) *Approved by the Food and Drug Administration;*

41 (3) *Listed in subsection 10; and*

42 (4) *Dispensed in accordance with section 4.5 of this act;*

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

44 (1) *Lawfully prescribed or ordered;*

45 (2) *Approved by the Food and Drug Administration; and*





- 1           (3) *Listed in subsection 10;*  
2           (c) *Insertion of a device for contraception or removal of such a*  
3 *device if the device was inserted while the insured was covered by*  
4 *the same policy of health insurance;*  
5           (d) *Education and counseling relating to the initiation of the*  
6 *use of contraception and any necessary follow-up after initiating*  
7 *such use;*  
8           (e) *Management of side effects relating to contraception; and*  
9           (f) *Voluntary sterilization for women.*  
10          2. *An insurer must ensure that the benefits required by*  
11 *subsection 1 are made available to an insured through a provider*  
12 *of health care who participates in the network plan of the insurer.*  
13          3. *If a covered therapeutic equivalent listed in subsection 1 is*  
14 *not available or a provider of health care deems a covered*  
15 *therapeutic equivalent to be medically inappropriate, an alternate*  
16 *therapeutic equivalent prescribed by a provider of health care*  
17 *must be covered by the insurer.*  
18          4. *Except as otherwise provided in subsections 8, 9 and 11, an*  
19 *insurer that offers or issues a policy of health insurance shall not:*  
20           (a) *Require an insured to pay a higher deductible, any*  
21 *copayment or coinsurance or require a longer waiting period or*  
22 *other condition for coverage to obtain any benefit included in the*  
23 *policy pursuant to subsection 1;*  
24           (b) *Refuse to issue a policy of health insurance or cancel a*  
25 *policy of health insurance solely because the person applying for*  
26 *or covered by the policy uses or may use any such benefit;*  
27           (c) *Offer or pay any type of material inducement or financial*  
28 *incentive to an insured to discourage the insured from obtaining*  
29 *any such benefit;*  
30           (d) *Penalize a provider of health care who provides any such*  
31 *benefit to an insured, including, without limitation, reducing the*  
32 *reimbursement of the provider of health care;*  
33           (e) *Offer or pay any type of material inducement, bonus or*  
34 *other financial incentive to a provider of health care to deny,*  
35 *reduce, withhold, limit or delay access to any such benefit to an*  
36 *insured; or*  
37           (f) *Impose any other restrictions or delays on the access of an*  
38 *insured any such benefit.*  
39          5. *Coverage pursuant to this section for the covered*  
40 *dependent of an insured must be the same as for the insured.*  
41          6. *Except as otherwise provided in subsection 7, a policy*  
42 *subject to the provisions of this chapter that is delivered, issued for*  
43 *delivery or renewed on or after January 1, 2018, has the legal*  
44 *effect of including the coverage required by subsection 1, and any*



1 *provision of the policy or the renewal which is in conflict with this*  
2 *section is void.*

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

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

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

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

25 *(a) Voluntary sterilization for women;*

26 *(b) Surgical sterilization implants for women;*

27 *(c) Implantable rods;*

28 *(d) Copper-based intrauterine devices;*

29 *(e) Progesterone-based intrauterine devices;*

30 *(f) Injections;*

31 *(g) Combined estrogen- and progestin-based drugs;*

32 *(h) Progestin-based drugs;*

33 *(i) Extended- or continuous-regimen drugs;*

34 *(j) Estrogen- and progestin-based patches;*

35 *(k) Vaginal contraceptive rings;*

36 *(l) Diaphragms with spermicide;*

37 *(m) Sponges with spermicide;*

38 *(n) Cervical caps with spermicide;*

39 *(o) Female condoms;*

40 *(p) Spermicide;*

41 *(q) Combined estrogen- and progestin-based drugs for*  
42 *emergency contraception or progestin-based drugs for emergency*  
43 *contraception; and*

44 *(r) Antiprogestin-based drugs for emergency contraception.*



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

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

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

17 *14. As used in this section:*

18 *(a) "Medical management technique" means a practice which*  
19 *is used to control the cost or utilization of health care services or*  
20 *prescription drug use. The term includes, without limitation, the*  
21 *use 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 policy of health insurance offered*  
24 *by an insurer under which the financing and delivery of medical*  
25 *care, including items and services paid for as medical care, are*  
26 *provided, in whole or in part, through a defined set of providers*  
27 *under contract with the insurer. The term does not include an*  
28 *arrangement for the financing of premiums.*

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

31 *(d) "Therapeutic equivalent" means a drug which:*

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

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

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

40 **Sec. 8.** NRS 689A.0415 is hereby amended to read as follows:

41 689A.0415 1. ~~Except as otherwise provided in subsection 5,~~  
42 ~~an~~ **An** insurer that offers or issues a policy of health insurance  
43 which provides coverage for prescription drugs or devices shall  
44 include in the policy coverage for ~~†~~

45 ~~—(a) Any type of drug or device for contraception; and~~



- 1 ~~—(b) Any~~ **any** type of hormone replacement therapy ~~f;~~  
2 ~~→~~ which is lawfully prescribed or ordered and which has been  
3 approved by the Food and Drug Administration.
- 4 2. An insurer that offers or issues a policy of health insurance  
5 that provides coverage for prescription drugs shall not:
- 6 (a) Require an insured to pay a higher deductible, copayment or  
7 coinsurance or require a longer waiting period or other condition for  
8 coverage for a prescription for ~~—a contraceptive or—~~ hormone  
9 replacement therapy than is required for other prescription drugs  
10 covered by the policy;
- 11 (b) Refuse to issue a policy of health insurance or cancel a  
12 policy of health insurance solely because the person applying for or  
13 covered by the policy uses or may use in the future ~~—any of the~~  
14 ~~services listed in subsection 1;~~ **hormone replacement therapy;**
- 15 (c) Offer or pay any type of material inducement or financial  
16 incentive to an insured to discourage the insured from accessing  
17 ~~—any of the services listed in subsection 1;~~ **hormone replacement**  
18 **therapy;**
- 19 (d) Penalize a provider of health care who provides ~~—any of the~~  
20 ~~services listed in subsection 1;~~ **hormone replacement therapy** to an  
21 insured, including, without limitation, reducing the reimbursement  
22 of the provider of health care; or
- 23 (e) Offer or pay any type of material inducement, bonus or other  
24 financial incentive to a provider of health care to deny, reduce,  
25 withhold, limit or delay ~~—any of the services listed in subsection 1;~~  
26 **hormone replacement therapy** to an insured.
- 27 3. ~~—Except as otherwise provided in subsection 5, a~~ **A** policy  
28 subject to the provisions of this chapter that is delivered, issued for  
29 delivery or renewed on or after October 1, 1999, has the legal effect  
30 of including the coverage required by subsection 1, and any  
31 provision of the policy or the renewal which is in conflict with this  
32 section is void.
- 33 4. The provisions of this section do not:
- 34 (a) Require an insurer to provide coverage for fertility drugs.  
35 (b) Prohibit an insurer from requiring an insured to pay a  
36 deductible, copayment or coinsurance for the coverage required by  
37 ~~—paragraphs (a) and (b) of—~~ subsection 1 that is the same as the  
38 insured is required to pay for other prescription drugs covered by the  
39 policy.
- 40 5. ~~—An insurer which offers or issues a policy of health~~  
41 ~~insurance and which is affiliated with a religious organization is not~~  
42 ~~required to provide the coverage required by paragraph (a) of~~  
43 ~~subsection 1 if the insurer objects on religious grounds. Such an~~  
44 ~~insurer shall, before the issuance of a policy of health insurance and~~  
45 ~~before the renewal of such a policy, provide to the prospective~~



1 ~~insured, written notice of the coverage that the insurer refuses to~~  
2 ~~provide pursuant to this subsection.~~

3 ~~—6.~~ As used in this section, “provider of health care” has the  
4 meaning ascribed to it in NRS 629.031.

5 **Sec. 9.** NRS 689A.0417 is hereby amended to read as follows:

6 689A.0417 1. ~~{Except as otherwise provided in subsection 5,~~  
7 ~~an}~~ **An** insurer that offers or issues a policy of health insurance  
8 which provides coverage for outpatient care shall include in the  
9 policy coverage for any health care service related to ~~{contraceptives~~  
10 ~~or}~~ hormone replacement therapy.

11 2. An insurer that offers or issues a policy of health insurance  
12 that provides coverage for outpatient care shall not:

13 (a) Require an insured to pay a higher deductible, copayment or  
14 coinsurance or require a longer waiting period or other condition for  
15 coverage for outpatient care related to ~~{contraceptives or}~~ hormone  
16 replacement therapy than is required for other outpatient care  
17 covered by the policy;

18 (b) Refuse to issue a policy of health insurance or cancel a  
19 policy of health insurance solely because the person applying for or  
20 covered by the policy uses or may use in the future ~~{any of the~~  
21 ~~services listed in subsection 1;}~~ **hormone replacement therapy;**

22 (c) Offer or pay any type of material inducement or financial  
23 incentive to an insured to discourage the insured from accessing  
24 ~~{any of the services listed in subsection 1;}~~ **hormone replacement**  
25 **therapy;**

26 (d) Penalize a provider of health care who provides ~~{any of the~~  
27 ~~services listed in subsection 1;}~~ **hormone replacement therapy** to an  
28 insured, including, without limitation, reducing the reimbursement  
29 of the provider of health care; or

30 (e) Offer or pay any type of material inducement, bonus or other  
31 financial incentive to a provider of health care to deny, reduce,  
32 withhold, limit or delay ~~{any of the services listed in subsection 1;}~~  
33 **hormone replacement therapy** to an insured.

34 3. ~~{Except as otherwise provided in subsection 5, a}~~ **A** policy  
35 subject to the provisions of this chapter that is delivered, issued for  
36 delivery or renewed on or after October 1, 1999, has the legal effect  
37 of including the coverage required by subsection 1, and any  
38 provision of the policy or the renewal which is in conflict with this  
39 section is void.

40 4. The provisions of this section do not prohibit an insurer from  
41 requiring an insured to pay a deductible, copayment or coinsurance  
42 for the coverage required by subsection 1 that is the same as the  
43 insured is required to pay for other outpatient care covered by the  
44 policy.



1       5. ~~{An insurer which offers or issues such a policy of health~~  
2 ~~insurance and which is affiliated with a religious organization is not~~  
3 ~~required to provide the coverage for health care service related to~~  
4 ~~contraceptives required by this section if the insurer objects on~~  
5 ~~religious grounds. Such an insurer shall, before the issuance of a~~  
6 ~~policy of health insurance and before the renewal of such a policy,~~  
7 ~~provide to the prospective insured written notice of the coverage~~  
8 ~~that the insurer refuses to provide pursuant to this subsection.~~

9       —6.† As used in this section, “provider of health care” has the  
10 meaning ascribed to it in NRS 629.031.

11       **Sec. 10.** NRS 689A.330 is hereby amended to read as follows:

12       689A.330 If any policy is issued by a domestic insurer for  
13 delivery to a person residing in another state, and if the insurance  
14 commissioner or corresponding public officer of that other state has  
15 informed the Commissioner that the policy is not subject to approval  
16 or disapproval by that officer, the Commissioner may by ruling  
17 require that the policy meet the standards set forth in NRS 689A.030  
18 to 689A.320, inclusive **††**, and **section 7 of this act.**

19       **Sec. 11.** Chapter 689B of NRS is hereby amended by adding  
20 thereto a new section to read as follows:

21       1. *Except as otherwise provided in subsection 7, an insurer*  
22 *that offers or issues a policy of group health insurance shall*  
23 *include in the policy coverage for:*

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

- 26       (1) *Lawfully prescribed or ordered;*  
27       (2) *Approved by the Food and Drug Administration;*  
28       (3) *Listed in subsection 11; and*  
29       (4) *Dispensed in accordance with section 4.5 of this act;*

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

- 31       (1) *Lawfully prescribed or ordered;*  
32       (2) *Approved by the Food and Drug Administration; and*  
33       (3) *Listed in subsection 11;*

34       (c) *Insertion of a device for contraception or removal of such a*  
35 *device if the device was inserted while the insured was covered by*  
36 *the same policy of group health insurance;*

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

40       (e) *Management of side effects relating to contraception; and*

41       (f) *Voluntary sterilization for women.*

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



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

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

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

13       (b) *Refuse to issue a policy of group health insurance or*  
14 *cancel a policy of group health insurance solely because the*  
15 *person applying for or covered by the policy uses or may use any*  
16 *such benefit;*

17       (c) *Offer or pay any type of material inducement or financial*  
18 *incentive to an insured to discourage the insured from obtaining*  
19 *any such benefit;*

20       (d) *Penalize a provider of health care who provides any such*  
21 *benefit to an insured, including, without limitation, reducing the*  
22 *reimbursement to the provider of health care;*

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

27       (f) *Impose any other restrictions or delays on the access of an*  
28 *insured to any such benefit.*

29       5. *Coverage pursuant to this section for the covered*  
30 *dependent of an insured must be the same as for the insured.*

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

37       7. *An insurer that offers or issues a policy of group health*  
38 *insurance and which is affiliated with a religious organization is*  
39 *not required to provide the coverage required by subsection 1 if*  
40 *the insurer objects on religious grounds. Such an insurer shall,*  
41 *before the issuance of a policy of group health insurance and*  
42 *before the renewal of such a policy, provide to the group*  
43 *policyholder or prospective insured, as applicable, written notice*  
44 *of the coverage that the insurer refuses to provide pursuant to this*  
45 *subsection.*





1       8. *If an insurer refuses, pursuant to subsection 7, to provide*  
2 *the coverage required by subsection 1, an employer may otherwise*  
3 *provide for the coverage for the employees of the employer.*

4       9. *An insurer may require an insured to pay a higher*  
5 *deductible, copayment or coinsurance for a drug for contraception*  
6 *if the insured refuses to accept a therapeutic equivalent of the*  
7 *drug.*

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

16       11. *The following 18 methods of contraception must be*  
17 *covered pursuant to this section:*

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

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





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

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

11       15. *As used in this section:*

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

17       (b) *“Network plan” means a policy of group health insurance*  
18 *offered by an insurer under which the financing and delivery of*  
19 *medical care, including items and services paid for as medical*  
20 *care, are provided, in whole or in part, through a defined set of*  
21 *providers under contract with the insurer. The term does not*  
22 *include an arrangement for the financing of premiums.*

23       (c) *“Provider of health care” has the meaning ascribed to it in*  
24 *NRS 629.031.*

25       (d) *“Therapeutic equivalent” means a drug which:*

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

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

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

34       **Sec. 12.** NRS 689B.0376 is hereby amended to read as  
35 follows:

36       689B.0376 1. ~~Except as otherwise provided in subsection 5,~~  
37 ~~an~~ *An insurer that offers or issues a policy of group health*  
38 *insurance which provides coverage for prescription drugs or devices*  
39 *shall include in the policy coverage for ~~†~~*

40 ~~—(a) Any type of drug or device for contraception; and~~

41 ~~—(b) Any~~ *any* type of hormone replacement therapy ~~†~~

42 ~~→†~~ *which is lawfully prescribed or ordered and which has been*  
43 *approved by the Food and Drug Administration.*

44       2. An insurer that offers or issues a policy of group health  
45 insurance that provides coverage for prescription drugs shall not:



1 (a) Require an insured to pay a higher deductible, copayment or  
2 coinsurance or require a longer waiting period or other condition for  
3 coverage for a prescription for ~~{a contraceptive or}~~ hormone  
4 replacement therapy than is required for other prescription drugs  
5 covered by the policy;

6 (b) Refuse to issue a policy of group health insurance or cancel a  
7 policy of group health insurance solely because the person applying  
8 for or covered by the policy uses or may use in the future ~~{any of the~~  
9 ~~services listed in subsection 1;}~~ *hormone replacement therapy*;

10 (c) Offer or pay any type of material inducement or financial  
11 incentive to an insured to discourage the insured from accessing  
12 ~~{any of the services listed in subsection 1;}~~ *hormone replacement*  
13 *therapy*;

14 (d) Penalize a provider of health care who provides ~~{any of the~~  
15 ~~services listed in subsection 1;}~~ *hormone replacement therapy* to an  
16 insured, including, without limitation, reducing the reimbursement  
17 of the provider of health care; or

18 (e) Offer or pay any type of material inducement, bonus or other  
19 financial incentive to a provider of health care to deny, reduce,  
20 withhold, limit or delay ~~{any of the services listed in subsection 1;}~~  
21 *hormone replacement therapy* to an insured.

22 3. ~~{Except as otherwise provided in subsection 5, a}~~ A policy  
23 subject to the provisions of this chapter that is delivered, issued for  
24 delivery or renewed on or after October 1, 1999, has the legal effect  
25 of including the coverage required by subsection 1, and any  
26 provision of the policy or the renewal which is in conflict with this  
27 section is void.

28 4. The provisions of this section do not:

29 (a) Require an insurer to provide coverage for fertility drugs.

30 (b) Prohibit an insurer from requiring an insured to pay a  
31 deductible, copayment or coinsurance for the coverage required by  
32 ~~{paragraphs (a) and (b) of}~~ subsection 1 that is the same as the  
33 insured is required to pay for other prescription drugs covered by the  
34 policy.

35 5. ~~{An insurer which offers or issues a policy of group health~~  
36 ~~insurance and which is affiliated with a religious organization is not~~  
37 ~~required to provide the coverage required by paragraph (a) of~~  
38 ~~subsection 1 if the insurer objects on religious grounds. Such an~~  
39 ~~insurer shall, before the issuance of a policy of group health~~  
40 ~~insurance and before the renewal of such a policy, provide to the~~  
41 ~~group policyholder or prospective insured, as applicable, written~~  
42 ~~notice of the coverage that the insurer refuses to provide pursuant to~~  
43 ~~this subsection. The insurer shall provide notice to each insured, at~~  
44 ~~the time the insured receives his or her certificate of coverage or~~



1 ~~evidence of coverage, that the insurer refused to provide coverage~~  
2 ~~pursuant to this subsection.~~

3 ~~—6.— If an insurer refuses, pursuant to subsection 5, to provide the~~  
4 ~~coverage required by paragraph (a) of subsection 1, an employer~~  
5 ~~may otherwise provide for the coverage for the employees of the~~  
6 ~~employer.~~

7 ~~—7.—~~ As used in this section, “provider of health care” has the  
8 meaning ascribed to it in NRS 629.031.

9 **Sec. 13.** NRS 689B.0377 is hereby amended to read as  
10 follows:

11 689B.0377 1. ~~{Except as otherwise provided in subsection 5,~~  
12 ~~an} An insurer that offers or issues a policy of group health~~  
13 insurance which provides coverage for outpatient care shall include  
14 in the policy coverage for any health care service related to  
15 ~~{contraceptives or}~~ hormone replacement therapy.

16 2. An insurer that offers or issues a policy of group health  
17 insurance that provides coverage for outpatient care shall not:

18 (a) Require an insured to pay a higher deductible, copayment or  
19 coinsurance or require a longer waiting period or other condition for  
20 coverage for outpatient care related to ~~{contraceptives or}~~ hormone  
21 replacement therapy than is required for other outpatient care  
22 covered by the policy;

23 (b) Refuse to issue a policy of group health insurance or cancel a  
24 policy of group health insurance solely because the person applying  
25 for or covered by the policy uses or may use in the future ~~{any of the~~  
26 ~~services listed in subsection 1;}~~ *hormone replacement therapy;*

27 (c) Offer or pay any type of material inducement or financial  
28 incentive to an insured to discourage the insured from accessing  
29 ~~{any of the services listed in subsection 1;}~~ *hormone replacement*  
30 *therapy;*

31 (d) Penalize a provider of health care who provides ~~{any of the~~  
32 ~~services listed in subsection 1;}~~ *hormone replacement therapy* to an  
33 insured, including, without limitation, reducing the reimbursement  
34 of the provider of health care; or

35 (e) Offer or pay any type of material inducement, bonus or other  
36 financial incentive to a provider of health care to deny, reduce,  
37 withhold, limit or delay ~~{any of the services listed in subsection 1;}~~  
38 *hormone replacement therapy* to an insured.

39 3. ~~{Except as otherwise provided in subsection 5, a}~~ A policy  
40 subject to the provisions of this chapter that is delivered, issued for  
41 delivery or renewed on or after October 1, 1999, has the legal effect  
42 of including the coverage required by subsection 1, and any  
43 provision of the policy or the renewal which is in conflict with this  
44 section is void.



\* A B 2 4 9 R 2 \*

1 4. The provisions of this section do not prohibit an insurer from  
2 requiring an insured to pay a deductible, copayment or coinsurance  
3 for the coverage required by subsection 1 that is the same as the  
4 insured is required to pay for other outpatient care covered by the  
5 policy.

6 ~~5. [An insurer which offers or issues a policy of group health  
7 insurance and which is affiliated with a religious organization is not  
8 required to provide the coverage for health care service related to  
9 contraceptives required by this section if the insurer objects on  
10 religious grounds. Such an insurer shall, before the issuance of a  
11 policy of group health insurance and before the renewal of such a  
12 policy, provide to the group policyholder or prospective insured, as  
13 applicable, written notice of the coverage that the insurer refuses to  
14 provide pursuant to this subsection. The insurer shall provide notice  
15 to each insured, at the time the insured receives his or her certificate  
16 of coverage or evidence of coverage, that the insurer refused to  
17 provide coverage pursuant to this subsection.~~

18 ~~—6.— If an insurer refuses, pursuant to subsection 5, to provide the  
19 coverage required by paragraph (a) of subsection 1, an employer  
20 may otherwise provide for the coverage for the employees of the  
21 employer.~~

22 ~~—7.—~~ As used in this section, “provider of health care” has the  
23 meaning ascribed to it in NRS 629.031.

24 **Sec. 14.** Chapter 689C of NRS is hereby amended by adding  
25 thereto a new section to read as follows:

26 *1. Except as otherwise provided in subsection 7, a carrier that  
27 offers or issues a health benefit plan shall include in the plan  
28 coverage for:*

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

31 *(1) Lawfully prescribed or ordered;*

32 *(2) Approved by the Food and Drug Administration;*

33 *(3) Listed in subsection 10; and*

34 *(4) Dispensed in accordance with section 4.5 of this act;*

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

36 *(1) Lawfully prescribed or ordered;*

37 *(2) Approved by the Food and Drug Administration; and*

38 *(3) Listed in subsection 10;*

39 *(c) Insertion of a device for contraception or removal of such a  
40 device if the device was inserted while the insured was covered by  
41 the same health benefit plan;*

42 *(d) Education and counseling relating to the initiation of the  
43 use of contraception and any necessary follow-up after initiating  
44 such use;*

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



1       (f) *Voluntary sterilization for women.*

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

5       3. *If a covered therapeutic equivalent listed in subsection 1 is*  
6 *not available or a provider of health care deems a covered*  
7 *therapeutic equivalent to be medically inappropriate, an alternate*  
8 *therapeutic equivalent prescribed by a provider of health care*  
9 *must be covered by the carrier.*

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

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

16      (b) *Refuse to issue a health benefit plan or cancel a health*  
17 *benefit plan solely because the person applying for or covered by*  
18 *the plan uses or may use any such benefit;*

19      (c) *Offer or pay any type of material inducement or financial*  
20 *incentive to an insured to discourage the insured from obtaining*  
21 *any such benefit;*

22      (d) *Penalize a provider of health care who provides any such*  
23 *benefit to an insured, including, without limitation, reducing the*  
24 *reimbursement to the provider of health care;*

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

29      (f) *Impose any other restrictions or delays on the access of an*  
30 *insured to any such benefit.*

31      5. *Coverage pursuant to this section for the covered*  
32 *dependent of an insured must be the same as for the insured.*

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

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



1 8. A carrier may require an insured to pay a higher  
2 deductible, copayment or coinsurance for a drug for contraception  
3 if the insured refuses to accept a therapeutic equivalent of the  
4 drug.

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

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

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

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

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

44 13. A carrier must provide an accessible, transparent and  
45 expedited process which is not unduly burdensome by which an



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

5 *14. As used in this section:*

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

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

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

19 *(d) "Therapeutic equivalent" means a drug which:*

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

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

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

28 **Sec. 15.** NRS 689C.425 is hereby amended to read as follows:

29 689C.425 A voluntary purchasing group and any contract  
30 issued to such a group pursuant to NRS 689C.360 to 689C.600,  
31 inclusive, are subject to the provisions of NRS 689C.015 to  
32 689C.355, inclusive, *and section 14 of this act*, to the extent  
33 applicable and not in conflict with the express provisions of NRS  
34 687B.408 and 689C.360 to 689C.600, inclusive.

35 **Sec. 16.** Chapter 695A of NRS is hereby amended by adding  
36 thereto a new section to read as follows:

37 *1. Except as otherwise provided in subsection 7, a society that*  
38 *offers or issues a benefit contract which provides coverage for*  
39 *prescription drugs or devices shall include in the contract*  
40 *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 10; and*





- 1           (4) *Dispensed in accordance with section 4.5 of this act;*  
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 10;*  
6           (c) *Insertion of a device for contraception or removal of such a*  
7 *device if the device was inserted while the insured was covered by*  
8 *the same benefit contract;*  
9           (d) *Education and counseling relating to the initiation of the*  
10 *use of contraception and any necessary follow-up after initiating*  
11 *such use;*  
12           (e) *Management of side effects relating to contraception; and*  
13           (f) *Voluntary sterilization for women.*  
14           2. *A society must ensure that the benefits required by*  
15 *subsection 1 are made available to an insured through a provider*  
16 *of health care who participates in the network plan of the society.*  
17           3. *If a covered therapeutic equivalent listed in subsection 1 is*  
18 *not available or a provider of health care deems a covered*  
19 *therapeutic equivalent to be medically inappropriate, an alternate*  
20 *therapeutic equivalent prescribed by a provider of health care*  
21 *must be covered by the society.*  
22           4. *Except as otherwise provided in subsections 8, 9 and 11, a*  
23 *society that offers or issues a benefit contract shall not:*  
24               (a) *Require an insured to pay a higher deductible, any*  
25 *copayment or coinsurance or require a longer waiting period or*  
26 *other condition for coverage for any benefit included in the benefit*  
27 *contract pursuant to subsection 1;*  
28               (b) *Refuse to issue a benefit contract or cancel a benefit*  
29 *contract solely because the person applying for or covered by the*  
30 *contract uses or may use any such benefit;*  
31               (c) *Offer or pay any type of material inducement or financial*  
32 *incentive to an insured to discourage the insured from obtaining*  
33 *any such benefit;*  
34               (d) *Penalize a provider of health care who provides any such*  
35 *benefit to an insured, including, without limitation, reducing the*  
36 *reimbursement to the provider of health care;*  
37               (e) *Offer or pay any type of material inducement, bonus or*  
38 *other financial incentive to a provider of health care to deny,*  
39 *reduce, withhold, limit or delay access to any such benefit to an*  
40 *insured; or*  
41               (f) *Impose any other restrictions or delays on the access of an*  
42 *insured to any such benefit.*  
43           5. *Coverage pursuant to this section for the covered*  
44 *dependent of an insured must be the same as for the insured.*





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

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

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

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

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

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



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

4 (r) Antiprogestin-based drugs for emergency contraception.

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

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

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

20 14. As used in this section:

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

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

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

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

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

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

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



1       **Sec. 17.** Chapter 695B of NRS is hereby amended by adding  
2 thereto a new section to read as follows:

3       1. *Except as otherwise provided in subsection 7, an insurer*  
4 *that offers or issues a contract for hospital or medical service shall*  
5 *include in the contract coverage for:*

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

8       (1) *Lawfully prescribed or ordered;*

9       (2) *Approved by the Food and Drug Administration;*

10       (3) *Listed in subsection 11; and*

11       (4) *Dispensed in accordance with section 4.5 of this act;*

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

13       (1) *Lawfully prescribed or ordered;*

14       (2) *Approved by the Food and Drug Administration; and*

15       (3) *Listed in subsection 11;*

16       (c) *Insertion of a device for contraception or removal of such a*  
17 *device if the device was inserted while the insured was covered by*  
18 *the same contract for hospital or medical service;*

19       (d) *Education and counseling relating to the initiation of the*  
20 *use of contraception and any necessary follow-up after initiating*  
21 *such use;*

22       (e) *Management of side effects relating to contraception; and*

23       (f) *Voluntary sterilization for women.*

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

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

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

36       (a) *Require an insured to pay a higher deductible, any*  
37 *copayment or coinsurance or require a longer waiting period or*  
38 *other condition to obtain any benefit included in the contract for*  
39 *hospital or medical service pursuant to subsection 1;*

40       (b) *Refuse to issue a contract for hospital or medical service or*  
41 *cancel a contract for hospital or medical service solely because the*  
42 *person applying for or covered by the contract uses or may use any*  
43 *such benefit;*



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1 (c) Offer or pay any type of material inducement or financial  
2 incentive to an insured to discourage the insured from obtaining  
3 any 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  
8 other financial incentive to a provider of health care to deny,  
9 reduce, withhold, limit or delay access to any such benefit to an  
10 insured; or

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

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

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

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

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

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

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

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



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

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

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

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

38 15. *As used in this section:*

39 (a) *“Medical management technique” means a practice which*  
40 *is used to control the cost or utilization of health care services or*  
41 *prescription drug use. The term includes, without limitation, the*  
42 *use 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 contract for hospital or medical*  
45 *service offered by an insurer under which the financing and*



1 *delivery of medical care, including items and services paid for as*  
2 *medical care, are provided, in whole or in part, through a defined*  
3 *set of providers under contract with the insurer. The term does not*  
4 *include an 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. 18.** NRS 695B.1916 is hereby amended to read as  
17 follows:

18 695B.1916 1. ~~Except as otherwise provided in subsection 5,~~  
19 ~~an~~ An insurer that offers or issues a contract for hospital or medical  
20 service which provides coverage for prescription drugs or devices  
21 shall include in the contract coverage for ~~f~~

22 ~~—(a) Any type of drug or device for contraception; and~~

23 ~~—(b) Any~~ any type of hormone replacement therapy ~~f~~;

24 ~~→~~ which is lawfully prescribed or ordered and which has been  
25 approved by the Food and Drug Administration.

26 2. An insurer that offers or issues a contract for hospital or  
27 medical service that provides coverage for prescription drugs shall  
28 not:

29 (a) Require an insured to pay a higher deductible, copayment or  
30 coinsurance or require a longer waiting period or other condition for  
31 coverage for a prescription for ~~a contraceptive or~~ hormone  
32 replacement therapy than is required for other prescription drugs  
33 covered by the contract;

34 (b) Refuse to issue a contract for hospital or medical service or  
35 cancel a contract for hospital or medical service solely because the  
36 person applying for or covered by the contract uses or may use in  
37 the future ~~any of the services listed in subsection 1;~~ hormone  
38 replacement therapy;

39 (c) Offer or pay any type of material inducement or financial  
40 incentive to an insured to discourage the insured from accessing  
41 ~~any of the services listed in subsection 1;~~ hormone replacement  
42 therapy;

43 (d) Penalize a provider of health care who provides ~~any of the~~  
44 ~~services listed in subsection 1~~ hormone replacement therapy to an



1 insured, including, without limitation, reducing the reimbursement  
2 of the provider of health care; or

3 (e) Offer or pay any type of material inducement, bonus or other  
4 financial incentive to a provider of health care to deny, reduce,  
5 withhold, limit or delay ~~any of the services listed in subsection 1~~  
6 **hormone replacement therapy** to an insured.

7 3. ~~Except as otherwise provided in subsection 5, a~~ **A** contract  
8 subject to the provisions of this chapter that is delivered, issued for  
9 delivery or renewed on or after October 1, 1999, has the legal effect  
10 of including the coverage required by subsection 1, and any  
11 provision of the contract or the renewal which is in conflict with this  
12 section is void.

13 4. The provisions of this section do not:

14 (a) Require an insurer to provide coverage for fertility drugs.

15 (b) Prohibit an insurer from requiring an insured to pay a  
16 deductible, copayment or coinsurance for the coverage required by  
17 ~~paragraphs (a) and (b) of~~ subsection 1 that is the same as the  
18 insured is required to pay for other prescription drugs covered by the  
19 contract.

20 5. ~~An insurer which offers or issues a contract for hospital or  
21 medical service and which is affiliated with a religious organization  
22 is not required to provide the coverage required by paragraph (a) of  
23 subsection 1 if the insurer objects on religious grounds. Such an  
24 insurer shall, before the issuance of a contract for hospital or  
25 medical service and before the renewal of such a contract, provide  
26 to the group policyholder or prospective insured, as applicable,  
27 written notice of the coverage that the insurer refuses to provide  
28 pursuant to this subsection. The insurer shall provide notice to each  
29 insured, at the time the insured receives his or her certificate of  
30 coverage or evidence of coverage, that the insurer refused to provide  
31 coverage pursuant to this subsection.~~

32 ~~6. If an insurer refuses, pursuant to subsection 5, to provide the  
33 coverage required by paragraph (a) of subsection 1, an employer  
34 may otherwise provide for the coverage for the employees of the  
35 employer.~~

36 ~~7.~~ As used in this section, "provider of health care" has the  
37 meaning ascribed to it in NRS 629.031.

38 **Sec. 19.** NRS 695B.1918 is hereby amended to read as  
39 follows:

40 695B.1918 1. ~~Except as otherwise provided in subsection 5,~~  
41 **an** **An** insurer that offers or issues a contract for hospital or medical  
42 service which provides coverage for outpatient care shall include in  
43 the contract coverage for any health care service related to  
44 ~~contraceptives or~~ hormone replacement therapy.





1 2. An insurer that offers or issues a contract for hospital or  
2 medical service that provides coverage for outpatient care shall not:

3 (a) Require an insured to pay a higher deductible, copayment or  
4 coinsurance or require a longer waiting period or other condition for  
5 coverage for outpatient care related to ~~contraceptives or~~ hormone  
6 replacement therapy than is required for other outpatient care  
7 covered by the contract;

8 (b) Refuse to issue a contract for hospital or medical service or  
9 cancel a contract for hospital or medical service solely because the  
10 person applying for or covered by the contract uses or may use in  
11 the future ~~any of the services listed in subsection 1;~~ *hormone  
12 replacement therapy;*

13 (c) Offer or pay any type of material inducement or financial  
14 incentive to an insured to discourage the insured from accessing  
15 ~~any of the services listed in subsection 1;~~ *hormone replacement  
16 therapy;*

17 (d) Penalize a provider of health care who provides ~~any of the  
18 services listed in subsection 1~~ *hormone replacement therapy* to an  
19 insured, including, without limitation, reducing the reimbursement  
20 of the provider of health care; or

21 (e) Offer or pay any type of material inducement, bonus or other  
22 financial incentive to a provider of health care to deny, reduce,  
23 withhold, limit or delay ~~any of the services listed in subsection 1~~ *hormone replacement therapy* to an insured.

24 3. ~~Except as otherwise provided in subsection 5, a~~ A contract  
25 subject to the provisions of this chapter that is delivered, issued for  
26 delivery or renewed on or after October 1, 1999, has the legal effect  
27 of including the coverage required by subsection 1, and any  
28 provision of the contract or the renewal which is in conflict with this  
29 section is void.  
30

31 4. The provisions of this section do not prohibit an insurer from  
32 requiring an insured to pay a deductible, copayment or coinsurance  
33 for the coverage required by subsection 1 that is the same as the  
34 insured is required to pay for other outpatient care covered by the  
35 contract.

36 5. ~~An insurer which offers or issues a contract for hospital or  
37 medical service and which is affiliated with a religious organization  
38 is not required to provide the coverage for health care service related  
39 to contraceptives required by this section if the insurer objects on  
40 religious grounds. Such an insurer shall, before the issuance of a  
41 contract for hospital or medical service and before the renewal of  
42 such a contract, provide to the group policyholder or prospective  
43 insured, as applicable, written notice of the coverage that the insurer  
44 refuses to provide pursuant to this subsection. The insurer shall  
45 provide notice to each insured, at the time the insured receives his or~~



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~~her certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.~~

~~6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~7.1~~ As used in this section, “provider of health care” has the meaning ascribed to it in NRS 629.031.

**Sec. 20.** Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

*1. Except as otherwise provided in subsection 7, a health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:*

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

*(1) Lawfully prescribed or ordered;*

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

*(3) Listed in subsection 11; and*

*(4) Dispensed in accordance with section 4.5 of this act;*

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

*(1) Lawfully prescribed or ordered;*

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

*(3) Listed in subsection 11;*

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

*(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use;*

*(e) Management of side effects relating to contraception; and*

*(f) Voluntary sterilization for women.*

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

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

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

*(a) Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or*



1 *other condition to obtain any benefit included in the health care*  
2 *plan pursuant to subsection 1;*

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

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

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

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

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

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

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

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

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



1 or 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) Antiprogestin-based drugs 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  
31 available clinical evidence, to determine the frequency of or  
32 treatment relating to any benefit required by this section or the  
33 type of provider of health care to use for such treatment.

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

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

45 15. As used in this section:



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

6 (b) *“Network plan” means a health care plan offered by a*  
7 *health maintenance organization under which the financing and*  
8 *delivery of medical care, including items and services paid for as*  
9 *medical care, are provided, in whole or in part, through a defined*  
10 *set of providers under contract with the health maintenance*  
11 *organization. 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. 21.** NRS 695C.050 is hereby amended to read as follows:

25 695C.050 1. Except as otherwise provided in this chapter or  
26 in specific provisions of this title, the provisions of this title are not  
27 applicable to any health maintenance organization granted a  
28 certificate of authority under this chapter. This provision does not  
29 apply to an insurer licensed and regulated pursuant to this title  
30 except with respect to its activities as a health maintenance  
31 organization authorized and regulated pursuant to this chapter.

32 2. Solicitation of enrollees by a health maintenance  
33 organization granted a certificate of authority, or its representatives,  
34 must not be construed to violate any provision of law relating to  
35 solicitation or advertising by practitioners of a healing art.

36 3. Any health maintenance organization authorized under this  
37 chapter shall not be deemed to be practicing medicine and is exempt  
38 from the provisions of chapter 630 of NRS.

39 4. The provisions of NRS 695C.110, 695C.125, 695C.1691,  
40 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to  
41 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734,  
42 695C.1735 to 695C.1755, inclusive, 695C.176 to 695C.200,  
43 inclusive, and 695C.265 do not apply to a health maintenance  
44 organization that provides health care services through managed  
45 care to recipients of Medicaid under the State Plan for Medicaid or



1 insurance pursuant to the Children's Health Insurance Program  
2 pursuant to a contract with the Division of Health Care Financing  
3 and Policy of the Department of Health and Human Services. This  
4 subsection does not exempt a health maintenance organization from  
5 any provision of this chapter for services provided pursuant to any  
6 other contract.

7 5. The provisions of NRS 695C.1694, 695C.1695, 695C.1708,  
8 695C.1731, 695C.17345 , ~~and~~ 695C.1757 *and section 20 of this*  
9 *act* apply to a health maintenance organization that provides health  
10 care services through managed care to recipients of Medicaid under  
11 the State Plan for Medicaid.

12 **Sec. 22.** NRS 695C.1694 is hereby amended to read as  
13 follows:

14 695C.1694 1. ~~Except as otherwise provided in subsection 5,~~  
15 ~~a~~ A health maintenance organization which offers or issues a health  
16 care plan that provides coverage for prescription drugs or devices  
17 shall include in the plan coverage for ~~†~~:

18 ~~—(a) Any type of drug or device for contraception; and~~  
19 ~~—(b) Any~~ *any* type of hormone replacement therapy ~~†~~;  
20 ~~→~~ which is lawfully prescribed or ordered and which has been  
21 approved by the Food and Drug Administration.

22 2. A health maintenance organization that offers or issues a  
23 health care plan that provides coverage for prescription drugs shall  
24 not:

25 (a) Require an enrollee to pay a higher deductible, copayment or  
26 coinsurance or require a longer waiting period or other condition for  
27 coverage for ~~† a prescription for a contraceptive or~~ hormone  
28 replacement therapy than is required for other prescription drugs  
29 covered by the plan;

30 (b) Refuse to issue a health care plan or cancel a health care plan  
31 solely because the person applying for or covered by the plan uses  
32 or may use in the future ~~† any of the services listed in subsection 1;~~  
33 *hormone replacement therapy;*

34 (c) Offer or pay any type of material inducement or financial  
35 incentive to an enrollee to discourage the enrollee from accessing  
36 ~~† any of the services listed in subsection 1;~~ *hormone replacement*  
37 *therapy;*

38 (d) Penalize a provider of health care who provides ~~† any of the~~  
39 ~~services listed in subsection 1~~ *hormone replacement therapy* to an  
40 enrollee, including, without limitation, reducing the reimbursement  
41 of the provider of health care; or

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 ~~† any of the services listed in subsection 1;~~  
45 *hormone replacement therapy* to an enrollee.



1 3. ~~{Except as otherwise provided in subsection 5, evidence}~~  
2 **Evidence** of coverage subject to the provisions of this chapter that is  
3 delivered, issued for delivery or renewed on or after October 1,  
4 1999, has the legal effect of including the coverage required by  
5 subsection 1, and any provision of the evidence of coverage or the  
6 renewal which is in conflict with this section is void.

7 4. The provisions of this section do not:

8 (a) Require a health maintenance organization to provide  
9 coverage for fertility drugs.

10 (b) Prohibit a health maintenance organization from requiring an  
11 enrollee to pay a deductible, copayment or coinsurance for the  
12 coverage required by ~~{paragraphs (a) and (b) of}~~ subsection 1 that is  
13 the same as the enrollee is required to pay for other prescription  
14 drugs covered by the plan.

15 5. ~~{A health maintenance organization which offers or issues a  
16 health care plan and which is affiliated with a religious organization  
17 is not required to provide the coverage required by paragraph (a) of  
18 subsection 1 if the health maintenance organization objects on  
19 religious grounds. The health maintenance organization shall, before  
20 the issuance of a health care plan and before renewal of enrollment  
21 in such a plan, provide to the group policyholder or prospective  
22 enrollee, as applicable, written notice of the coverage that the health  
23 maintenance organization refuses to provide pursuant to this  
24 subsection. The health maintenance organization shall provide  
25 notice to each enrollee, at the time the enrollee receives his or her  
26 evidence of coverage, that the health maintenance organization  
27 refused to provide coverage pursuant to this subsection.~~

28 ~~—6. If a health maintenance organization refuses, pursuant to  
29 subsection 5, to provide the coverage required by paragraph (a) of  
30 subsection 1, an employer may otherwise provide for the coverage  
31 for the employees of the employer.~~

32 ~~—7.†~~ As used in this section, “provider of health care” has the  
33 meaning ascribed to it in NRS 629.031.

34 **Sec. 23.** NRS 695C.1695 is hereby amended to read as  
35 follows:

36 695C.1695 1. ~~{Except as otherwise provided in subsection 5,  
37 a†~~ A health maintenance organization that offers or issues a health  
38 care plan which provides coverage for outpatient care shall include  
39 in the plan coverage for any health care service related to  
40 ~~{contraceptives or}~~ hormone replacement therapy.

41 2. A health maintenance organization that offers or issues a  
42 health care plan that provides coverage for outpatient care shall not:

43 (a) Require an enrollee to pay a higher deductible, copayment or  
44 coinsurance or require a longer waiting period or other condition for  
45 coverage for outpatient care related to ~~{contraceptives or}~~ hormone



1 replacement therapy than is required for other outpatient care  
2 covered by the plan;

3 (b) Refuse to issue a health care plan or cancel a health care plan  
4 solely because the person applying for or covered by the plan uses  
5 or may use in the future ~~any of the services listed in subsection 1;~~  
6 **hormone replacement therapy;**

7 (c) Offer or pay any type of material inducement or financial  
8 incentive to an enrollee to discourage the enrollee from accessing  
9 ~~any of the services listed in subsection 1;~~ **hormone replacement**  
10 **therapy;**

11 (d) Penalize a provider of health care who provides ~~any of the~~  
12 ~~services listed in subsection 1;~~ **hormone replacement therapy** to an  
13 enrollee, including, without limitation, reducing the reimbursement  
14 of the provider of health care; or

15 (e) Offer or pay any type of material inducement, bonus or other  
16 financial incentive to a provider of health care to deny, reduce,  
17 withhold, limit or delay ~~any of the services listed in subsection 1;~~  
18 **hormone replacement therapy** to an enrollee.

19 3. ~~Except as otherwise provided in subsection 5, evidence~~  
20 **Evidence** of coverage subject to the provisions of this chapter that is  
21 delivered, issued for delivery or renewed on or after October 1,  
22 1999, has the legal effect of including the coverage required by  
23 subsection 1, and any provision of the evidence of coverage or the  
24 renewal which is in conflict with this section is void.

25 4. The provisions of this section do not prohibit a health  
26 maintenance organization from requiring an enrollee to pay a  
27 deductible, copayment or coinsurance for the coverage required by  
28 subsection 1 that is the same as the enrollee is required to pay for  
29 other outpatient care covered by the plan.

30 5. ~~A health maintenance organization which offers or issues a~~  
31 ~~health care plan and which is affiliated with a religious organization~~  
32 ~~is not required to provide the coverage for health care service related~~  
33 ~~to contraceptives required by this section if the health maintenance~~  
34 ~~organization objects on religious grounds. The health maintenance~~  
35 ~~organization shall, before the issuance of a health care plan and~~  
36 ~~before renewal of enrollment in such a plan, provide to the group~~  
37 ~~policyholder or prospective enrollee, as applicable, written notice of~~  
38 ~~the coverage that the health maintenance organization refuses to~~  
39 ~~provide pursuant to this subsection. The health maintenance~~  
40 ~~organization shall provide notice to each enrollee, at the time the~~  
41 ~~enrollee receives his or her evidence of coverage, that the health~~  
42 ~~maintenance organization refused to provide coverage pursuant to~~  
43 ~~this subsection.~~

44 ~~6. If a health maintenance organization refuses, pursuant to~~  
45 ~~subsection 5, to provide the coverage required by paragraph (a) of~~





1 ~~subsection 1, an employer may otherwise provide for the coverage~~  
2 ~~for the employees of the employer.~~

3 ~~7.1~~ As used in this section, “provider of health care” has the  
4 meaning ascribed to it in NRS 629.031.

5 **Sec. 24.** NRS 695C.330 is hereby amended to read as follows:

6 695C.330 1. The Commissioner may suspend or revoke any  
7 certificate of authority issued to a health maintenance organization  
8 pursuant to the provisions of this chapter if the Commissioner finds  
9 that any of the following conditions exist:

10 (a) The health maintenance organization is operating  
11 significantly in contravention of its basic organizational document,  
12 its health care plan or in a manner contrary to that described in and  
13 reasonably inferred from any other information submitted pursuant  
14 to NRS 695C.060, 695C.070 and 695C.140, unless any amendments  
15 to those submissions have been filed with and approved by the  
16 Commissioner;

17 (b) The health maintenance organization issues evidence of  
18 coverage or uses a schedule of charges for health care services  
19 which do not comply with the requirements of NRS 695C.1691 to  
20 695C.200, inclusive, *and section 20 of this act* or 695C.207;

21 (c) The health care plan does not furnish comprehensive health  
22 care services as provided for in NRS 695C.060;

23 (d) The Commissioner certifies that the health maintenance  
24 organization:

25 (1) Does not meet the requirements of subsection 1 of NRS  
26 695C.080; or

27 (2) Is unable to fulfill its obligations to furnish health care  
28 services as required under its health care plan;

29 (e) The health maintenance organization is no longer financially  
30 responsible and may reasonably be expected to be unable to meet its  
31 obligations to enrollees or prospective enrollees;

32 (f) The health maintenance organization has failed to put into  
33 effect a mechanism affording the enrollees an opportunity to  
34 participate in matters relating to the content of programs pursuant to  
35 NRS 695C.110;

36 (g) The health maintenance organization has failed to put into  
37 effect the system required by NRS 695C.260 for:

38 (1) Resolving complaints in a manner reasonably to dispose  
39 of valid complaints; and

40 (2) Conducting external reviews of adverse determinations  
41 that comply with the provisions of NRS 695G.241 to 695G.310,  
42 inclusive;

43 (h) The health maintenance organization or any person on its  
44 behalf has advertised or merchandised its services in an untrue,  
45 misrepresentative, misleading, deceptive or unfair manner;



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1 (i) The continued operation of the health maintenance  
2 organization would be hazardous to its enrollees;

3 (j) The health maintenance organization fails to provide the  
4 coverage required by NRS 695C.1691; or

5 (k) The health maintenance organization has otherwise failed to  
6 comply substantially with the provisions of this chapter.

7 2. A certificate of authority must be suspended or revoked only  
8 after compliance with the requirements of NRS 695C.340.

9 3. If the certificate of authority of a health maintenance  
10 organization is suspended, the health maintenance organization shall  
11 not, during the period of that suspension, enroll any additional  
12 groups or new individual contracts, unless those groups or persons  
13 were contracted for before the date of suspension.

14 4. If the certificate of authority of a health maintenance  
15 organization is revoked, the organization shall proceed, immediately  
16 following the effective date of the order of revocation, to wind up its  
17 affairs and shall conduct no further business except as may be  
18 essential to the orderly conclusion of the affairs of the organization.  
19 It shall engage in no further advertising or solicitation of any kind.  
20 The Commissioner may, by written order, permit such further  
21 operation of the organization as the Commissioner may find to be in  
22 the best interest of enrollees to the end that enrollees are afforded  
23 the greatest practical opportunity to obtain continuing coverage for  
24 health care.

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

27 *1. Except as otherwise provided in subsection 7, a managed  
28 care organization that offers or issues a health care plan shall  
29 include in the plan 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 section 4.5 of this act;*

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) Insertion of a device for contraception or removal of such a  
41 device if the device was inserted while the insured was covered by  
42 the same health care plan;*

43 *(d) Education and counseling relating to the initiation of the  
44 use of contraception and any necessary follow-up after initiating  
45 such use;*



- 1 (e) *Management of side effects relating to contraception; and*
- 2 (f) *Voluntary sterilization for women.*

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

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

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

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

19 (b) *Refuse to issue a health care plan or cancel a health care*  
20 *plan solely because the person applying for or covered by the plan*  
21 *uses or may use any such benefits;*

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

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

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

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

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

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

42 7. *A managed care organization that offers or issues a health*  
43 *care plan and which is affiliated with a religious organization is*  
44 *not required to provide the coverage required by subsection 1 if*  
45 *the managed care organization objects on religious grounds. Such*



1 *an organization shall, before the issuance of a health care plan*  
2 *and before the renewal of such a plan, provide to the prospective*  
3 *insured written notice of the coverage that the managed care*  
4 *organization refuses to provide pursuant to this subsection.*

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

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

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

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

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



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

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

12       14. *As used in this section:*

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

18       (b) *“Network plan” means a health care plan offered by a*  
19 *managed care organization under which the financing and*  
20 *delivery of medical care, including items and services paid for as*  
21 *medical care, are provided, in whole or in part, through a defined*  
22 *set of providers under contract with the managed care*  
23 *organization. The term does not include an arrangement for the*  
24 *financing 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. 26.** The provisions of NRS 354.599 do not apply to any  
37 additional expenses of a local government that are related to the  
38 provisions of this act.

39       **Sec. 27.** This act becomes effective on January 1, 2018.

