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

MARCH 8, 2021

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

Referred to Committee on Commerce and Labor

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

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

CONTAINS UNFUNDED MANDATE (§ 10)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

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

Legislative Counsel’s Digest:

1 Existing law requires a pharmacist to dispense up to a 12-month supply or an
2 amount equivalent to the balance of the plan year if the patient is covered by a
3 health care plan, whichever is less, of a contraceptive or its therapeutic equivalent
4 pursuant to a valid prescription or order if certain conditions are met. (NRS
5 639.28075) **Section 8** of this bill requires: (1) the Chief Medical Officer or his or
6 her designee to issue a standing order to allow a pharmacist to dispense a self-
7 administered hormonal contraceptive to any patient; and (2) the State Board of
8 Health, in consultation with the Chief Medical Officer, to prescribe by regulation a
9 protocol for dispensing a self-administered hormonal contraceptive. **Section 3** of



10 this bill authorizes a pharmacist to dispense a self-administered hormonal
11 contraceptive under the standing order and establishes the procedures the
12 pharmacist must follow to dispense such a contraceptive. **Section 3** requires such a
13 pharmacist to: (1) provide a risk assessment questionnaire prescribed by the State
14 Board of Health pursuant to **section 8** upon the request of the patient before the
15 pharmacist dispenses the self-administered hormonal contraceptive; (2) create a
16 record concerning the dispensing of the self-administered hormonal contraceptive;
17 (3) provide the patient with a written record of the request and the self-administered
18 hormonal contraceptive dispensed and certain additional information; and (4)
19 comply with the regulations adopted pursuant to **section 8** and any guidelines
20 recommended by the manufacturer. **Sections 3 and 8** require the State Board of
21 Pharmacy and the Division of Public and Behavioral Health of the Department of
22 Health and Human Services to post on an Internet website a list of pharmacies that
23 dispense self-administered hormonal contraceptives under the standing order.

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

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

38 Existing law requires public and private policies of insurance regulated under
39 Nevada law to include coverage for certain contraceptive drugs and devices,
40 including: (1) up to a 12-month supply of contraceptives; and (2) certain devices for
41 contraception. (NRS 287.010, 287.04335, 689A.0418, 689B.0378, 689C.1676,
42 695A.1865, 695B.1919, 695C.1696, 695G.1715) Existing law also requires
43 employers to provide certain benefits to employees, including the coverage required
44 for health insurers, if the employer provides health benefits for its employees. (NRS
45 608.1555) **Sections 7 and 9-15** of this bill require that certain public and private
46 policies of insurance and health care plans provide coverage for self-administered
47 hormonal contraceptives dispensed by a pharmacist in accordance with **section 3**.

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

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

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



1 *Medical Officer or his or her designee pursuant to section 8 of this*
2 *act.*

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

7 *2. A pharmacist must provide the risk assessment*
8 *questionnaire prescribed by the State Board of Health pursuant to*
9 *section 8 of this act to a patient who requests the questionnaire*
10 *before dispensing a self-administered hormonal contraceptive to*
11 *the patient. If such a questionnaire is provided and the results of*
12 *the questionnaire indicate that it is unsafe to dispense the self-*
13 *administered hormonal contraceptive to the patient, the*
14 *pharmacist:*

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

17 *(b) Must refer the patient to the patient's attending provider or*
18 *another qualified provider of health care.*

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

21 *(a) Create a record concerning the dispensing of the self-*
22 *administered hormonal contraceptive which includes, without*
23 *limitation, the name of the patient to whom the self-administered*
24 *hormonal contraceptive was dispensed, the type of self-*
25 *administered hormonal contraceptive dispensed and any other*
26 *relevant information required by the protocol prescribed pursuant*
27 *to section 8 of this act. The pharmacist or his or her employer*
28 *shall maintain the record for the amount of time prescribed in that*
29 *protocol.*

30 *(b) Inform the patient to whom the self-administered hormonal*
31 *contraceptive is dispensed concerning:*

32 *(1) Proper administration and storage of the self-*
33 *administered hormonal contraceptive;*

34 *(2) Potential side effects of the self-administered hormonal*
35 *contraceptive; and*

36 *(3) The need to use other methods of contraception, if*
37 *appropriate.*

38 *(c) Provide to the patient to whom the self-administered*
39 *hormonal contraceptive is dispensed:*

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

41 *(2) Any written information required by the regulations*
42 *adopted pursuant to section 8 of this act.*

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



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

6 (a) A copy of the risk assessment questionnaire if completed
7 pursuant to subsection 2; and

8 (b) A written record of the self-administered hormonal
9 contraceptive requested and any self-administered hormonal
10 contraceptive dispensed.

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

16 6. As used in this section:

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

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

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

22 639.001 As used in this chapter, unless the context otherwise
23 requires, the words and terms defined in NRS 639.0015 to 639.016,
24 inclusive, *and section 2 of this act* have the meanings ascribed to
25 them in those sections.

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

27 639.0124 1. "Practice of pharmacy" includes, but is not
28 limited to, the:

29 ~~[1.]~~ (a) Performance or supervision of activities associated with
30 manufacturing, compounding, labeling, dispensing and distributing
31 of a drug, including the receipt, handling and storage of
32 prescriptions and other confidential information relating to patients.

33 ~~[2.]~~ (b) Interpretation and evaluation of prescriptions or orders
34 for medicine.

35 ~~[3.]~~ (c) Participation in drug evaluation and drug research.

36 ~~[4.]~~ (d) Advising of the therapeutic value, reaction, drug
37 interaction, hazard and use of a drug.

38 ~~[5.]~~ (e) Selection of the source, storage and distribution of a
39 drug.

40 ~~[6.]~~ (f) Maintenance of proper documentation of the source,
41 storage and distribution of a drug.

42 ~~[7.]~~ (g) Interpretation of clinical data contained in a person's
43 record of medication.

44 ~~[8.]~~ (h) Development of written guidelines and protocols in
45 collaboration with a practitioner which are intended for a patient in a



1 licensed medical facility or in a setting that is affiliated with a
2 medical facility where the patient is receiving care and which
3 authorize collaborative drug therapy management. The written
4 guidelines and protocols must comply with NRS 639.2629.

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

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

10 ~~1.~~ 2. The term does not include the changing of a prescription by
11 a pharmacist or practitioner without the consent of the prescribing
12 practitioner, except as otherwise provided in NRS 639.2583 ~~1.~~ and
13 *section 3 of this act.*

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

15 639.210 The Board may suspend or revoke any certificate,
16 license, registration or permit issued pursuant to this chapter, and
17 deny the application of any person for a certificate, license,
18 registration or permit, if the holder or applicant:

19 1. Is not of good moral character;

20 2. Is guilty of habitual intemperance;

21 3. Becomes or is intoxicated or under the influence of liquor,
22 any depressant drug or a controlled substance, unless taken pursuant
23 to a lawfully issued prescription, while on duty in any establishment
24 licensed by the Board;

25 4. Is guilty of unprofessional conduct or conduct contrary to
26 the public interest;

27 5. Has a substance use disorder;

28 6. Has been convicted of a violation of any law or regulation of
29 the Federal Government or of this or any other state related to
30 controlled substances, dangerous drugs, drug samples, or the
31 wholesale or retail distribution of drugs;

32 7. Has been convicted of:

33 (a) A felony relating to holding a certificate, license, registration
34 or permit pursuant to this chapter;

35 (b) A felony pursuant to NRS 639.550 or 639.555; or

36 (c) Other crime involving moral turpitude, dishonesty or
37 corruption;

38 8. Has been convicted of violating any of the provisions of
39 NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440,
40 inclusive;

41 9. Has willfully made to the Board or its authorized
42 representative any false statement which is material to the
43 administration or enforcement of any of the provisions of this
44 chapter;



1 10. Has obtained any certificate, certification, license or permit
2 by the filing of an application, or any record, affidavit or other
3 information in support thereof, which is false or fraudulent;

4 11. Has violated any provision of the Federal Food, Drug and
5 Cosmetic Act or any other federal law or regulation relating to
6 prescription drugs;

7 12. Has violated, attempted to violate, assisted or abetted in the
8 violation of or conspired to violate any of the provisions of this
9 chapter or any law or regulation relating to drugs, the manufacture
10 or distribution of drugs or the practice of pharmacy, or has
11 knowingly permitted, allowed, condoned or failed to report a
12 violation of any of the provisions of this chapter or any law or
13 regulation relating to drugs, the manufacture or distribution of drugs
14 or the practice of pharmacy committed by the holder of a certificate,
15 license, registration or permit;

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

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

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

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

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

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

35 19. *Has dispensed a self-administered hormonal*
36 *contraceptive under the standing order issued pursuant to section*
37 *8 of this act without complying with section 3 of this act; or*

38 20. Has operated a medical facility, as defined in NRS
39 449.0151, at any time during which:

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

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

43 ↪ This subsection applies to an owner or other principal responsible
44 for the operation of the facility.



1 **Sec. 7.** NRS 422.27172 is hereby amended to read as follows:
2 422.27172 1. The Director shall include in the State Plan for
3 Medicaid a requirement that the State pay the nonfederal share of
4 expenditures incurred for:

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

- 7 (1) Lawfully prescribed or ordered;
8 (2) Approved by the Food and Drug Administration; and
9 (3) Dispensed in accordance with NRS 639.28075;

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

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

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

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

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

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

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

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

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

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

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

36 5. For each method of contraception which is approved by the
37 Food and Drug Administration, the Plan must include at least one
38 contraceptive drug or device for which no deductible, copayment or
39 coinsurance may be charged to the person enrolled in Medicaid, but
40 the Plan may charge a deductible, copayment or coinsurance for any
41 other contraceptive drug or device that provides the same method of
42 contraception.

43 6. As used in this section:

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

5 *5. As used in this section:*

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

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

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

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

13 689A.0418 1. Except as otherwise provided in subsection 7,
14 an insurer that offers or issues a policy of health insurance shall
15 include in the policy coverage for:

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

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

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

- 23 (1) Lawfully prescribed or ordered;
24 (2) Approved by the Food and Drug Administration; and
25 (3) Listed in subsection 10;

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

29 7. An insurer that offers or issues a policy of health insurance
30 and which is affiliated with a religious organization is not required
31 to provide the coverage required by subsection 1 if the insurer
32 objects on religious grounds. Such an insurer shall, before the
33 issuance of a policy of health insurance and before the renewal of
34 such a policy, provide to the prospective insured written notice of
35 the coverage that the insurer refuses to provide pursuant to this
36 subsection.

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

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



1 coinsurance for any other drug or device that provides the same
2 method of contraception.

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

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

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

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

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

40 14. As used in this section:

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



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

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

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

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

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

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

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

20 689B.0378 1. Except as otherwise provided in subsection 7,
21 an insurer that offers or issues a policy of group health insurance
22 shall include in the policy coverage for:

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

25 (1) Lawfully prescribed or ordered;

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

27 (3) Listed in subsection 11; and

28 (4) Dispensed in accordance with NRS 639.28075;

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

30 (1) Lawfully prescribed or ordered;

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

32 (3) Listed in subsection 11;

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

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

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

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

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



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

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

9 4. Except as otherwise provided in subsections 9, 10 and 12, an
10 insurer that offers or issues a policy of group health insurance shall
11 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 policy pursuant
15 to subsection 1;

16 (b) Refuse to issue a policy of group health insurance or cancel a
17 policy of group health insurance solely because the person applying
18 for or covered by the policy 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 any
21 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 other
26 financial incentive to a provider of health care to deny, reduce,
27 withhold, limit or delay access to any such benefit to an insured; or

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

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

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

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



1 8. If an insurer refuses, pursuant to subsection 7, to provide the
2 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 if
6 the insured refuses to accept a therapeutic equivalent of the drug.

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

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

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

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

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



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

7 15. As used in this section:

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

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

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

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

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

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

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

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

32 689C.1676 1. Except as otherwise provided in subsection 7, a
33 carrier that offers or issues a health benefit plan shall include in the
34 plan coverage for:

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

37 (1) Lawfully prescribed or ordered;

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

39 (3) Listed in subsection 10; and

40 (4) Dispensed in accordance with NRS 639.28075;

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

42 (1) Lawfully prescribed or ordered;

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

44 (3) Listed in subsection 10;



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

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

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

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

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

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

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

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

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

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

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

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

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 access to any such benefit to an insured; or

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

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

42 6. Except as otherwise provided in subsection 7, a health
43 benefit plan subject to the provisions of this chapter that is
44 delivered, issued for delivery or renewed on or after January 1,
45 ~~[2018,]~~ 2022, has the legal effect of including the coverage required



1 by subsection 1, and any provision of the plan or the renewal which
2 is in conflict with this section is void.

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

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

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

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

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

43 11. Except as otherwise provided in this section and federal
44 law, a carrier may use medical management techniques, including,
45 without limitation, any available clinical evidence, to determine the



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

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

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

13 14. As used in this section:

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

19 (b) "Network plan" means a health benefit plan offered by a
20 carrier under which the financing and delivery of medical care,
21 including items and services paid for as medical care, are provided,
22 in whole or in part, through a defined set of providers under contract
23 with the carrier. 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. 12.** NRS 695A.1865 is hereby amended to read as
37 follows:

38 695A.1865 1. Except as otherwise provided in subsection 7,
39 a society that offers or issues a benefit contract which provides
40 coverage for prescription drugs or devices shall include in the
41 contract coverage for:

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

44 (1) Lawfully prescribed or ordered;

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



- 1 (3) Listed in subsection 10; and
- 2 (4) Dispensed in accordance with NRS 639.28075;
- 3 (b) Any type of device for contraception which is:
 - 4 (1) Lawfully prescribed or ordered;
 - 5 (2) Approved by the Food and Drug Administration; and
 - 6 (3) Listed in subsection 10;
- 7 (c) *Self-administered hormonal contraceptives dispensed by a*
- 8 *pharmacist pursuant to section 3 of this act;*

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

12 ~~(d)~~ (e) Education and counseling relating to the initiation of
13 the use of contraception and any necessary follow-up after initiating
14 such use;

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

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

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

21 3. If a covered therapeutic equivalent listed in subsection 1 is
22 not available or a provider of health care deems a covered
23 therapeutic equivalent to be medically inappropriate, an alternate
24 therapeutic equivalent prescribed by a provider of health care must
25 be covered by the society.

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

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

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

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

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

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

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



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

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

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

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

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

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

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



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

4 (r) Ulipristal acetate for emergency contraception.

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

11 12. 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 request
17 an exception relating to any medical management technique used by
18 the society to obtain any benefit required by this section without a
19 higher deductible, copayment or coinsurance.

20 14. As used in this section:

21 (a) "Medical management technique" means a practice which is
22 used to control the cost or utilization of health care services or
23 prescription drug use. The term includes, without limitation, the use
24 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 society
27 under which the financing and delivery of medical care, including
28 items and services paid for as medical care, are provided, in whole
29 or in part, through a defined set of providers under contract with the
30 society. The term does not include an arrangement for the financing
31 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. 13.** NRS 695B.1919 is hereby amended to read as
2 follows:

3 695B.1919 1. Except as otherwise provided in subsection 7,
4 an insurer that offers or issues a contract for hospital or medical
5 service shall 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 NRS 639.28075;

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

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

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

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

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

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

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

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

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

43 (b) Refuse to issue a contract for hospital or medical service or
44 cancel a contract for hospital or medical service solely because the



1 person applying for or covered by the contract uses or may use any
2 such benefit;

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

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

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

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

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

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

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

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

33 9. An insurer may require an insured to pay a higher
34 deductible, copayment or coinsurance for a drug for contraception if
35 the insured refuses to accept a therapeutic equivalent of the 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 be
41 charged to the insured, but the insurer may charge a deductible,
42 copayment or coinsurance for any other drug or device that provides
43 the same method of contraception.

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



- 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) Ulipristal acetate 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 medical
23 services may use medical management techniques, including,
24 without limitation, any available clinical evidence, to determine the
25 frequency of or treatment relating to any benefit required by this
26 section or the type of provider of health care to use for such
27 treatment.

28 13. An insurer shall not use medical management techniques to
29 require an insured to use a method of contraception other than the
30 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 request
34 an exception relating to any medical management technique used by
35 the insurer to obtain any benefit required by this section without a
36 higher deductible, copayment or coinsurance.

37 15. As used in this section:

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

43 (b) "Network plan" means a contract for hospital or medical
44 service offered by an insurer under which the financing and delivery
45 of medical care, including items and services paid for as medical



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

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

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

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

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

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

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

17 695C.1696 1. Except as otherwise provided in subsection 7, a
18 health maintenance organization that offers or issues a health care
19 plan shall include in the plan coverage for:

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

22 (1) Lawfully prescribed or ordered;

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

24 (3) Listed in subsection 11; and

25 (4) Dispensed in accordance with NRS 639.28075;

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

27 (1) Lawfully prescribed or ordered;

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

29 (3) Listed in subsection 11;

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

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

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

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

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

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



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 must
5 be covered by the health maintenance organization.

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

9 (a) Require an enrollee 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 health care plan
12 pursuant to subsection 1;

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

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

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

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

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

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

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

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

43 8. If a health maintenance organization refuses, pursuant to
44 subsection 7, to provide the coverage required by subsection 1, an



1 employer may otherwise provide for the coverage for the employees
2 of the employer.

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

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

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

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

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

43 13. A health maintenance organization shall not use medical
44 management techniques to require an enrollee to use a method of



1 contraception other than the method prescribed or ordered by a
2 provider of health care.

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

10 15. As used in this section:

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

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

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

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

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

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

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

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

35 695G.1715 1. Except as otherwise provided in subsection 7,
36 a managed care organization that offers or issues a health care plan
37 shall include in the plan coverage for:

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

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

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

- 45 (1) Lawfully prescribed or ordered;



- 1 (2) Approved by the Food and Drug Administration; and
- 2 (3) Listed in subsection 10;

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

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

8 ~~((d))~~ (e) Education and counseling relating to the initiation of
9 the use of contraception and any necessary follow-up after initiating
10 such use;

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

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

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

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

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

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

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 any such benefits;

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

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

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

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

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



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

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

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

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

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

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



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

4 (r) Ulipristal acetate for emergency contraception.

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

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

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

22 14. As used in this section:

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

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

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

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

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

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

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



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

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

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

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

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

