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SECOND REPRINT

S.B. 190

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

MARCH 8, 2021

JOINT SPONSORS: ASSEMBLYMEN TORRES, NGUYEN, GORELOW,
MARZOLA, FLORES; BILBRAY-AXELROD, CONSIDINE 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 State Board of
Pharmacy to establish a protocol under which a
pharmacist may 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 2.5** of this bill requires the State Board of Pharmacy to adopt
6 regulations that establish a protocol to allow a pharmacist to dispense a self-
7 administered hormonal contraceptive to any patient. **Section 3** of this bill
8 authorizes a pharmacist to dispense a self-administered hormonal contraceptive



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9 under the protocol established pursuant to **section 2.5** and establishes the
10 procedures the pharmacist must follow to dispense such a contraceptive. **Section 3**
11 requires such a pharmacist to: (1) provide a risk assessment questionnaire
12 prescribed by the Board pursuant to **section 2.5** to the patient before the pharmacist
13 dispenses the self-administered hormonal contraceptive; (2) create a record
14 concerning the dispensing of the self-administered hormonal contraceptive; (3)
15 provide the patient with a written record of the request and the self-administered
16 hormonal contraceptive dispensed and certain additional information; and (4)
17 comply with the regulations adopted pursuant to **section 2.5** and any guidelines
18 recommended by the manufacturer. **Section 3** requires the Board to post on an
19 Internet website a list of pharmacies that dispense self-administered hormonal
20 contraceptives under the protocol established pursuant to **section 2.5**. **Section 8.5**
21 of this bill makes a conforming change to account for the provisions of **sections 2.5**
22 and 3 authorizing a pharmacist to dispense a drug that has not been prescribed by a
23 practitioner.

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 protocol established pursuant to **section 2.5** 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, 2.5 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*



1 *contraceptive identified by the protocol established by the Board*
2 *pursuant to section 2.5 of this act.*

3 **Sec. 2.5.** 1. *The Board shall adopt regulations establishing*
4 *a protocol for dispensing a self-administered hormonal*
5 *contraceptive, as authorized by section 3 of this act. Those*
6 *regulations must include, without limitation:*

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

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

13 2. *The Board shall adopt regulations that prescribe:*

14 (a) *A risk assessment questionnaire that must be provided to a*
15 *patient who requests a self-administered hormonal contraceptive*
16 *pursuant to section 3 of this act.*

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

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

25 (2) *The effectiveness of long-acting, reversible*
26 *contraceptives as an alternative to self-administered hormonal*
27 *contraceptives;*

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

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

32 3. *As used in this section:*

33 (a) *"Attending provider" means a provider of health care who*
34 *provides or has provided care to the patient.*

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

37 **Sec. 3.** 1. *A pharmacist may dispense a self-administered*
38 *hormonal contraceptive under the protocol established pursuant to*
39 *section 2.5 of this act to a patient, regardless of whether the*
40 *patient has obtained a prescription from a practitioner.*

41 2. *A pharmacist must provide the risk assessment*
42 *questionnaire prescribed by the Board pursuant to section 2.5 of*
43 *this act to a patient who requests a self-administered hormonal*
44 *contraceptive before dispensing the self-administered hormonal*
45 *contraceptive to the patient. If the patient completes the*



1 *questionnaire and the results of the questionnaire indicate that it*
2 *is unsafe to dispense the self-administered hormonal contraceptive*
3 *to the patient, the pharmacist:*

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

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

8 3. *A pharmacist who dispenses a self-administered hormonal*
9 *contraceptive under the protocol shall:*

10 (a) *Create a record concerning the dispensing of the self-*
11 *administered hormonal contraceptive which includes, without*
12 *limitation, the name of the patient to whom the self-administered*
13 *hormonal contraceptive was dispensed, the type of self-*
14 *administered hormonal contraceptive dispensed and any other*
15 *relevant information required by the protocol prescribed pursuant*
16 *to section 2.5 of this act. The pharmacist or his or her employer*
17 *shall maintain the record for the amount of time prescribed in that*
18 *protocol.*

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

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

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

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

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

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

30 (2) *Any written information required by the regulations*
31 *adopted pursuant to section 2.5 of this act.*

32 (d) *Comply with the regulations adopted pursuant to section*
33 *2.5 of this act and any guidelines for dispensing the self-*
34 *administered hormonal contraceptive recommended by the*
35 *manufacturer.*

36 4. *A pharmacist shall provide to any patient who requests a*
37 *self-administered hormonal contraceptive under the protocol a*
38 *written record of the request, regardless of whether the self-*
39 *administered hormonal contraceptive is dispensed. The record*
40 *must include, without limitation:*

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

43 (b) *A written record of the self-administered hormonal*
44 *contraceptive requested and any self-administered hormonal*
45 *contraceptive dispensed.*



1 **5. Any pharmacy that wishes to dispense self-administered**
2 **hormonal contraceptives under the protocol must notify the Board**
3 **of that fact. The Board shall post on an Internet website**
4 **maintained by the Board a list of the names, addresses and contact**
5 **information of pharmacies that have provided such notice.**

6 **6. As used in this section:**

7 **(a) "Attending provider" means a provider of health care who**
8 **provides or has provided care to the patient.**

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

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

12 639.001 As used in this chapter, unless the context otherwise
13 requires, the words and terms defined in NRS 639.0015 to 639.016,
14 inclusive, **and section 2 of this act** have the meanings ascribed to
15 them in those sections.

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

17 639.0124 **1.** "Practice of pharmacy" includes, but is not
18 limited to, the:

19 ~~[1-]~~ **(a)** Performance or supervision of activities associated with
20 manufacturing, compounding, labeling, dispensing and distributing
21 of a drug, including the receipt, handling and storage of
22 prescriptions and other confidential information relating to patients.

23 ~~[2-]~~ **(b)** Interpretation and evaluation of prescriptions or orders
24 for medicine.

25 ~~[3-]~~ **(c)** Participation in drug evaluation and drug research.

26 ~~[4-]~~ **(d)** Advising of the therapeutic value, reaction, drug
27 interaction, hazard and use of a drug.

28 ~~[5-]~~ **(e)** Selection of the source, storage and distribution of a
29 drug.

30 ~~[6-]~~ **(f)** Maintenance of proper documentation of the source,
31 storage and distribution of a drug.

32 ~~[7-]~~ **(g)** Interpretation of clinical data contained in a person's
33 record of medication.

34 ~~[8-]~~ **(h)** Development of written guidelines and protocols in
35 collaboration with a practitioner which are intended for a patient in a
36 licensed medical facility or in a setting that is affiliated with a
37 medical facility where the patient is receiving care and which
38 authorize collaborative drug therapy management. The written
39 guidelines and protocols must comply with NRS 639.2629.

40 ~~[9-]~~ **(i)** Implementation and modification of drug therapy,
41 administering drugs and ordering and performing tests in
42 accordance with a collaborative practice agreement.

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



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

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

6 639.210 The Board may suspend or revoke any certificate,
7 license, registration or permit issued pursuant to this chapter, and
8 deny the application of any person for a certificate, license,
9 registration or permit, if the holder or applicant:

- 10 1. Is not of good moral character;
- 11 2. Is guilty of habitual intemperance;
- 12 3. Becomes or is intoxicated or under the influence of liquor,
13 any depressant drug or a controlled substance, unless taken pursuant
14 to a lawfully issued prescription, while on duty in any establishment
15 licensed by the Board;
- 16 4. Is guilty of unprofessional conduct or conduct contrary to
17 the public interest;
- 18 5. Has a substance use disorder;
- 19 6. Has been convicted of a violation of any law or regulation of
20 the Federal Government or of this or any other state related to
21 controlled substances, dangerous drugs, drug samples, or the
22 wholesale or retail distribution of drugs;
- 23 7. Has been convicted of:
 - 24 (a) A felony relating to holding a certificate, license, registration
25 or permit pursuant to this chapter;
 - 26 (b) A felony pursuant to NRS 639.550 or 639.555; or
 - 27 (c) Other crime involving moral turpitude, dishonesty or
28 corruption;
- 29 8. Has been convicted of violating any of the provisions of
30 NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440,
31 inclusive;
- 32 9. Has willfully made to the Board or its authorized
33 representative any false statement which is material to the
34 administration or enforcement of any of the provisions of this
35 chapter;
- 36 10. Has obtained any certificate, certification, license or permit
37 by the filing of an application, or any record, affidavit or other
38 information in support thereof, which is false or fraudulent;
- 39 11. Has violated any provision of the Federal Food, Drug and
40 Cosmetic Act or any other federal law or regulation relating to
41 prescription drugs;
- 42 12. Has violated, attempted to violate, assisted or abetted in the
43 violation of or conspired to violate any of the provisions of this
44 chapter or any law or regulation relating to drugs, the manufacture
45 or distribution of drugs or the practice of pharmacy, or has



1 knowingly permitted, allowed, condoned or failed to report a
2 violation of any of the provisions of this chapter or any law or
3 regulation relating to drugs, the manufacture or distribution of drugs
4 or the practice of pharmacy committed by the holder of a certificate,
5 license, registration or permit;

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

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

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

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

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

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

25 19. *Has dispensed a self-administered hormonal*
26 *contraceptive under the protocol established pursuant to section*
27 *2.5 of this act without complying with section 3 of this act; or*

28 20. Has operated a medical facility, as defined in NRS
29 449.0151, at any time during which:

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

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

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

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

36 422.27172 1. The Director shall include in the State Plan for
37 Medicaid a requirement that the State pay the nonfederal share of
38 expenditures incurred for:

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

41 (1) Lawfully prescribed or ordered;

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

43 (3) Dispensed in accordance with NRS 639.28075;



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

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

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

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

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

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

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

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

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

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

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

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

34 6. As used in this section:

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

37 (b) "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. 8.** (Deleted by amendment.)

2 **Sec. 8.5.** NRS 683A.179 is hereby amended to read as
3 follows:

4 683A.179 1. A pharmacy benefit manager shall not:

5 (a) Prohibit a pharmacist or pharmacy from providing
6 information to a covered person concerning:

7 (1) The amount of any copayment or coinsurance for a
8 prescription drug; or

9 (2) The availability of a less expensive alternative or generic
10 drug including, without limitation, information concerning clinical
11 efficacy of such a drug;

12 (b) Penalize a pharmacist or pharmacy for providing the
13 information described in paragraph (a) or selling a less expensive
14 alternative or generic drug to a covered person;

15 (c) Prohibit a pharmacy from offering or providing delivery
16 services directly to a covered person as an ancillary service of the
17 pharmacy; or

18 (d) If the pharmacy benefit manager manages a pharmacy
19 benefits plan that provides coverage through a network plan, charge
20 a copayment or coinsurance for a prescription drug in an amount
21 that is greater than the total amount paid to a pharmacy that is in the
22 network of providers under contract with the third party.

23 2. The provisions of this section:

24 (a) Must not be construed to authorize a pharmacist to dispense
25 a drug that has not been prescribed by a practitioner, as defined in
26 NRS 639.0125 **H**, *except to the extent authorized by a specific*
27 *provision of law, including, without limitation, NRS 453C.120 and*
28 *section 3 of this act.*

29 (b) Do not apply to an institutional pharmacy, as defined in NRS
30 639.0085, or a pharmacist working in such a pharmacy as an
31 employee or independent contractor.

32 3. As used in this section, "network plan" means a health
33 benefit plan offered by a health carrier under which the financing
34 and delivery of medical care is provided, in whole or in part,
35 through a defined set of providers under contract with the carrier.
36 The term does not include an arrangement for the financing of
37 premiums.

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

39 689A.0418 1. Except as otherwise provided in subsection 7,
40 an insurer that offers or issues a policy of health insurance shall
41 include in the policy 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 policy of health insurance;

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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



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

4 (r) Ulipristal acetate for emergency contraception.

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

11 12. An insurer shall not use 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. An insurer 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 insurer 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 policy of health insurance offered
27 by an insurer under which the financing and delivery of medical
28 care, 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 insurer. 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. 10.** NRS 689B.0378 is hereby amended to read as
2 follows:

3 689B.0378 1. Except as otherwise provided in subsection 7,
4 an insurer that offers or issues a policy of group health insurance
5 shall include in the policy 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 policy of group health insurance;

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

44 (a) Voluntary sterilization for women;

45 (b) Surgical sterilization implants for women;



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

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

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

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

34 15. As used in this section:

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

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



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

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

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

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

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

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

14 689C.1676 1. Except as otherwise provided in subsection 7, a
15 carrier that offers or issues a health benefit plan shall include in the
16 plan coverage for:

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

19 (1) Lawfully prescribed or ordered;

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

21 (3) Listed in subsection 10; and

22 (4) Dispensed in accordance with NRS 639.28075;

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

24 (1) Lawfully prescribed or ordered;

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

26 (3) Listed in subsection 10;

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

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

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

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

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

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

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



1 4. Except as otherwise provided in subsections 8, 9 and 11, a
2 carrier that offers or issues a health benefit plan 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 to obtain any benefit included in the health benefit
6 plan pursuant to subsection 1;

7 (b) Refuse to issue a health benefit plan or cancel a health
8 benefit plan solely because the person applying for or covered by
9 the plan 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 to 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 to 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 health
24 benefit plan subject to the provisions of this chapter that is
25 delivered, issued for delivery or renewed on or after January 1,
26 ~~2018,~~ 2022, has the legal effect of including the coverage required
27 by subsection 1, and any provision of the plan or the renewal which
28 is in conflict with this section is void.

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

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

39 9. For each of the 18 methods of contraception listed in
40 subsection 10 that have been approved by the Food and Drug
41 Administration, a health benefit plan must include at least one drug
42 or device for contraception within each method for which no
43 deductible, copayment or coinsurance may be charged to the
44 insured, but the carrier 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, a carrier 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. A carrier 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. A carrier 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 carrier 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 health benefit plan offered by a
2 carrier under which the financing and delivery of medical care,
3 including items and services paid for as medical care, are provided,
4 in whole or in part, through a defined set of providers under contract
5 with the carrier. The term does not include an arrangement for the
6 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. 12.** NRS 695A.1865 is hereby amended to read as
19 follows:

20 695A.1865 1. Except as otherwise provided in subsection 7,
21 a society that offers or issues a benefit contract which provides
22 coverage for prescription drugs or devices shall include in the
23 contract 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 10; and
29 (4) Dispensed in accordance with NRS 639.28075;

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 10;

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

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

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

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

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



1 2. A society 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 society.

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 society.

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

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

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

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

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

24 (e) Offer or pay any type of material inducement, bonus or other
25 financial incentive to a provider of health care to deny, reduce,
26 withhold, limit or delay access to any such benefit to an 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 dependent
30 of an insured must be the same as for the insured.

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

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



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

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

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

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

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

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

43 13. A society must provide an accessible, transparent and
44 expedited process which is not unduly burdensome by which an
45 insured, or the authorized representative of the insured, may request



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

4 14. As used in this section:

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

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

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

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

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

22 (2) 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 (3) Meets any other criteria required by the Food and Drug
26 Administration for classification as a therapeutic equivalent.

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

29 695B.1919 1. Except as otherwise provided in subsection 7,
30 an insurer that offers or issues a contract for hospital or medical
31 service shall include in the contract coverage for:

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

34 (1) Lawfully prescribed or ordered;

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

36 (3) Listed in subsection 11; and

37 (4) Dispensed in accordance with NRS 639.28075;

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

39 (1) Lawfully prescribed or ordered;

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

41 (3) Listed in subsection 11;

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



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

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

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

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

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

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

19 4. Except as otherwise provided in subsections 9, 10 and 12, an
20 insurer that offers or issues a contract for hospital or medical service
21 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 contract for
25 hospital or medical service pursuant to subsection 1;

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

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

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

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

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

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

43 6. Except as otherwise provided in subsection 7, a contract
44 for hospital or medical service subject to the provisions of this
45 chapter that is delivered, issued for delivery or renewed on or after



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

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

12 8. If an insurer refuses, pursuant to subsection 7, to provide the
13 coverage required by subsection 1, an employer may otherwise
14 provide for the coverage for the employees of the employer.

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

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

26 11. 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) Ulipristal acetate for emergency contraception.

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

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

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

21 15. As used in this section:

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

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

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

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

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

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

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



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

3 695C.1696 1. Except as otherwise provided in subsection 7, a
4 health maintenance organization that offers or issues a health care
5 plan shall include in the plan 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 enrollee was covered by
20 the same health care plan;

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

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 health maintenance organization.

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

39 (a) Require an enrollee 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 health care plan
42 pursuant to subsection 1;

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



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

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

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

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

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

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

20 7. A health maintenance organization that offers or issues a
21 health care plan and which is affiliated with a religious organization
22 is not required to provide the coverage required by subsection 1 if
23 the health maintenance organization objects on religious grounds.
24 Such an organization shall, before the issuance of a health care plan
25 and before the renewal of such a plan, provide to the prospective
26 enrollee written notice of the coverage that the health maintenance
27 organization refuses to provide pursuant to this subsection.

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

32 9. A health maintenance organization may require an enrollee
33 to pay a higher deductible, copayment or coinsurance for a drug for
34 contraception if the enrollee refuses to accept a therapeutic
35 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 health care plan must include at least one drug or
39 device for contraception within each method for which no
40 deductible, copayment or coinsurance may be charged to the
41 enrollee, but the health maintenance organization 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:



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

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

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

38 15. As used in this section:

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

44 (b) "Network plan" means a health care plan offered by a health
45 maintenance organization under which the financing and delivery of



1 medical care, including items and services paid for as medical care,
2 are provided, in whole or in part, through a defined set of providers
3 under contract with the health maintenance organization. The term
4 does not 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. 15.** NRS 695G.1715 is hereby amended to read as
17 follows:

18 695G.1715 1. Except as otherwise provided in subsection 7,
19 a managed care organization that offers or issues a health care plan
20 shall include in the plan coverage for:

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

23 (1) Lawfully prescribed or ordered;

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

25 (3) Listed in subsection 10; and

26 (4) Dispensed in accordance with NRS 639.28075;

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

28 (1) Lawfully prescribed or ordered;

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

30 (3) Listed in subsection 10;

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

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

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

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

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

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

6 4. Except as otherwise provided in subsections 8, 9 and 11, a
7 managed care organization that offers or issues a health care plan
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 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 benefits;

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

19 (d) Penalize a provider of health care who provides any such
20 benefits to an insured, 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 benefits to an insured; or

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

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

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

43 8. A managed care organization may require an insured to pay
44 a higher deductible, copayment or coinsurance for a drug for



1 contraception if the insured refuses to accept a therapeutic
2 equivalent of the drug.

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

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

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

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

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

43 13. A managed care organization must provide an accessible,
44 transparent and expedited process which is not unduly burdensome
45 by which an insured, or the authorized representative of the insured,



1 may request an exception relating to any medical management
2 technique used by the managed care organization to obtain any
3 benefit required by this section without a higher deductible,
4 copayment or coinsurance.

5 14. As used in this section:

6 (a) "Medical management technique" means a practice which is
7 used to control the cost or utilization of health care services or
8 prescription drug use. The term includes, without limitation, the use
9 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 care plan offered by a
12 managed care organization under which the financing and delivery
13 of medical care, including items and services paid for as medical
14 care, are provided, in whole or in part, through a defined set of
15 providers under contract with the managed care organization. The
16 term does not include an arrangement for the financing of
17 premiums.

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

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

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

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

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

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

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

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

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

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

