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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:

Existing law requires a pharmacist to dispense up to a 12-month supply or an amount equivalent to the balance of the plan year if the patient is covered by a health care plan, whichever is less, of a contraceptive or its therapeutic equivalent pursuant to a valid prescription or order if certain conditions are met. (NRS 639.28075) **Section 2.5** of this bill requires the State Board of Pharmacy to adopt regulations that establish a protocol to allow a pharmacist to dispense a self-administered hormonal contraceptive to any patient. **Section 3** of this bill authorizes a pharmacist to dispense a self-administered hormonal contraceptive

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

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

Existing law authorizes the State Board of Pharmacy to suspend or revoke any certificate to practice as a registered pharmacist if the holder of or applicant for such a certificate commits certain acts. (NRS 639.210) **Section 6** of this bill authorizes the Board to suspend or revoke any certificate to practice as a registered pharmacist if the holder or applicant has dispensed a self-administered hormonal contraceptive under the protocol established pursuant to **section 2.5** without complying with the provisions of **section 3**.

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

Section 1. Chapter 639 of NRS is hereby amended by adding thereto the provisions set forth as sections 2, 2.5 and 3 of this act.

Sec. 2. ***"Self-administered hormonal contraceptive" means a self-administered contraceptive that utilizes a hormone and is approved for use by the United States Food and Drug Administration to prevent pregnancy. The term includes, without limitation, an oral contraceptive, a vaginal contraceptive ring, a contraceptive patch and any other method of hormonal***

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

Sec. 2.5. *1. The Board shall adopt regulations establishing a protocol for dispensing a self-administered hormonal contraceptive, as authorized by section 3 of this act. Those regulations 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.

2. The Board shall adopt regulations that prescribe:

(a) A risk assessment questionnaire that must be provided 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.

3. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Is not of good moral character;
2. Is guilty of habitual intemperance;
3. Becomes or is intoxicated or under the influence of liquor, any depressant drug or a controlled substance, unless taken pursuant to a lawfully issued prescription, while on duty in any establishment licensed by the Board;
4. Is guilty of unprofessional conduct or conduct contrary to the public interest;
5. Has a substance use disorder;
6. Has been convicted of a violation of any law or regulation of the Federal Government or of this or any other state related to controlled substances, dangerous drugs, drug samples, or the wholesale or retail distribution of drugs;
7. Has been convicted of:

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

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

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

8. Has been convicted of violating any of the provisions of NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440, inclusive;
9. Has willfully made to the Board or its authorized representative any false statement which is material to the administration or enforcement of any of the provisions of this chapter;
10. Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent;
11. Has violated any provision of the Federal Food, Drug and Cosmetic Act or any other federal law or regulation relating to prescription drugs;
12. Has violated, attempted to violate, assisted or abetted in the violation of or conspired to violate any of the provisions of this chapter or any law or regulation relating to drugs, the manufacture or distribution of drugs or the practice of pharmacy, or has

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Lawfully prescribed or ordered;

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

(3) Dispensed in accordance with NRS 639.28075;

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

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

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

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

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

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

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

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

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

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

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

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

6. As used in this section:

(a) "Drug Use Review Board" has the meaning ascribed to it in 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. (Deleted by amendment.)

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

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

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

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

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

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

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

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

2. The provisions of this section:

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

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

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

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

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

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 10;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Voluntary sterilization for women;
(b) Surgical sterilization implants for women;
(c) Implantable rods;
(d) Copper-based intrauterine devices;
(e) Progesterone-based intrauterine devices;
(f) Injections;
(g) Combined estrogen- and progestin-based drugs;
(h) Progestin-based drugs;
(i) Extended- or continuous-regimen drugs;
(j) Estrogen- and progestin-based patches;
(k) Vaginal contraceptive rings;
(l) Diaphragms with spermicide;
(m) Sponges with spermicide;
(n) Cervical caps with spermicide;
(o) Female condoms;
(p) Spermicide;

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

(r) Ulipristal acetate for emergency contraception.

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

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

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

14. As used in this section:

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

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

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

(d) "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. 10. NRS 689B.0378 is hereby amended to read as follows:

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

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 11;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;
(d) Copper-based intrauterine devices;
(e) Progesterone-based intrauterine devices;
(f) Injections;
(g) Combined estrogen- and progestin-based drugs;
(h) Progestin-based drugs;
(i) Extended- or continuous-regimen drugs;
(j) Estrogen- and progestin-based patches;
(k) Vaginal contraceptive rings;
(l) Diaphragms with spermicide;
(m) Sponges with spermicide;
(n) Cervical caps with spermicide;
(o) Female condoms;
(p) Spermicide;
(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
(r) Ulipristal acetate for emergency contraception.

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

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

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

15. As used in this section:

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

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

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

(d) "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. 11. NRS 689C.1676 is hereby amended to read as follows:

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

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 10;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

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

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

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

(r) Ulipristal acetate for emergency contraception.

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

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

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

14. As used in this section:

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

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

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

(d) "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. 12. NRS 695A.1865 is hereby amended to read as follows:

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

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 10;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

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

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

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

(r) Ulipristal acetate for emergency contraception.

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

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

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

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

14. As used in this section:

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

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

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

(d) "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. 13. NRS 695B.1919 is hereby amended to read as follows:

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

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 11;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Voluntary sterilization for women;
(b) Surgical sterilization implants for women;
(c) Implantable rods;
(d) Copper-based intrauterine devices;
(e) Progesterone-based intrauterine devices;
(f) Injections;
(g) Combined estrogen- and progestin-based drugs;
(h) Progestin-based drugs;
(i) Extended- or continuous-regimen drugs;
(j) Estrogen- and progestin-based patches;
(k) Vaginal contraceptive rings;
(l) Diaphragms with spermicide;
(m) Sponges with spermicide;
(n) Cervical caps with spermicide;
(o) Female condoms;
(p) Spermicide;

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

(r) Ulipristal acetate for emergency contraception.

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

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

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

15. As used in this section:

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

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

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

(d) "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. 14. NRS 695C.1696 is hereby amended to read as follows:

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

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 11;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Voluntary sterilization for women;
(b) Surgical sterilization implants for women;
(c) Implantable rods;
(d) Copper-based intrauterine devices;
(e) Progesterone-based intrauterine devices;
(f) Injections;
(g) Combined estrogen- and progestin-based drugs;
(h) Progestin-based drugs;
(i) Extended- or continuous-regimen drugs;
(j) Estrogen- and progestin-based patches;
(k) Vaginal contraceptive rings;
(l) Diaphragms with spermicide;
(m) Sponges with spermicide;
(n) Cervical caps with spermicide;
(o) Female condoms;
(p) Spermicide;
(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
(r) Ulipristal acetate for emergency contraception.

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

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

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

15. As used in this section:

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

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

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

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

(d) "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. 15. NRS 695G.1715 is hereby amended to read as follows:

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

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 10;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

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

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

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

(r) Ulipristal acetate for emergency contraception.

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

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

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

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

14. As used in this section:

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

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

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

(d) "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. 16. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

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

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

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

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

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