Senate Bill No. 439–Senators D. Harris, Scheible and Donate

Joint Sponsors: Assemblywomen González, Peters and Taylor

CHAPTER.....

AN ACT relating to communicable diseases; requiring certain state and local agencies to develop policies to provide uninterrupted services during a public health emergency to certain persons; requiring a public or private detention facility to take certain measures to ensure the access of prisoners to treatment for and methods to prevent the acquisition of human immunodeficiency virus; revising provisions governing certain crimes committed by prisoners; requiring certain public and private health insurers to provide certain coverage; requiring such an insurer to reimburse an advanced practice registered nurse or physician assistant at the same rate as a physician for certain services; authorizing providers of health care to receive credit toward requirements for continuing education for certain training relating to the human immunodeficiency virus; requiring certain providers of health care to complete such training; providing that the repeal or revision of certain crimes applies retroactively; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Division of Public and Behavioral Health of the Department of Health and Human Services and district, county and city health departments to perform certain functions relating to public health in this State, including certain duties relating to the control of communicable diseases. (NRS 439.150-439.265, 439.340, 439.350, 439.360, 439.366, 439.367, 439.3675, 439.405, 439.410, 439.460, 439.470) Existing law also requires a district health officer or the Chief Medical Officer to perform certain duties relating to the control of communicable diseases. (Chapter 441A of NRS) Existing law prescribes certain responsibilities of the Division of Health Care Financing and Policy of the Department concerning the administration of the Medicaid program. (NRS 422.061, 422.063) **Section 1** of this bill requires the Department and all district, county and city boards of health to develop policies to provide uninterrupted services during a public health emergency to persons who have been diagnosed with the human immunodeficiency virus or persons who are at a high risk of acquiring the human immunodeficiency virus. **Section 2** of this bill makes a conforming change to indicate the proper placement of **section 1** in the Nevada Revised Statutes.

Existing law requires the Director of the Department of Corrections to establish standards for the medical and dental services of each institution or facility under the control of the Department. (NRS 209.381) Existing law also requires a sheriff, chief of police or town marshal to arrange for the administration of medical care required by prisoners while in his or her custody. (NRS 211.140) **Sections 11 and 12** of this

bill impose certain requirements on the operators of public and private prisons, jails and detention facilities to ensure the access of prisoners to treatment for human immunodeficiency virus and methods of preventing the acquisition of human immunodeficiency virus.

Existing law prohibits a prisoner from using, propelling, discharging, spreading or concealing human excrement or bodily fluid with intent or under circumstances where it is reasonably likely that the excrement or fluid will come in contact with another person. Under most circumstances, a violation is a gross misdemeanor, a category D felony or a category B felony, depending on the circumstances of the prisoner's confinement. However, if the prisoner knew at the time of the offense that any portion of the excrement or bodily fluid contained a communicable disease that causes or is reasonably likely to cause substantial bodily harm, the violation is a category A felony, regardless of whether the communicable disease was transmitted. (NRS 212.189) **Section 13** of this bill instead provides that such a violation is only a category A felony where: (1) the communicable disease was likely to be transmitted by his or her conduct; and (2) the communicable disease was actually transmitted as a result of the conduct. **Section 78** of this bill provides that the provisions of **section 13** apply retroactively to violations that occurred before the effective date of that section, if the person who committed the violation has not been convicted before that date.

Existing law requires public and private health plans, including Medicaid and health plans for state government employees, to cover an examination and testing of a pregnant woman for *Chlamydia trachomatis*, gonorrhea, hepatitis B, hepatitis C and syphilis. (NRS 287.04335, 422.27173, 689A.0412, 689B.0315, 689C.1675, 695A.1856, 695B.1913, 695C.1737, 695G.1714) **Sections 16, 22, 34, 42, 47, 52, 55, 60, 65, 67 and 72** of this bill additionally require such insurance plans to cover: (1) testing for, treatment of and prevention of sexually transmitted diseases; and (2) condoms for certain covered persons.

Existing law requires certain public and private health plans, including health plans for state government employees, to cover drugs that prevent the acquisition of human immunodeficiency virus and any related laboratory or diagnostic procedures. (NRS 287.010, 287.04335, 689A.0437, 689B.0312, 689C.1671, 695A.1843, 695B.1924, 695C.1743, 695G.1705) **Sections 31, 37, 44, 51, 57, 62, 68 and 74** of this bill require such insurance plans to cover all such drugs approved by the United States Food and Drug Administration and all drugs approved by the Food and Drug Administration for treating human immunodeficiency virus or hepatitis C without restrictions, other than step therapy. **Sections 23, 37, 44, 51, 57, 62, 68 and 74** of this bill require such insurance plans to: (1) cover any service to test for, prevent or treat those diseases provided by a provider of primary care if the service is covered when provided by a specialist and certain other requirements are met; and (2) reimburse an advanced practice registered nurse or a physician assistant for such services at a rate equal to that provided to a physician. **Sections 16, 20, 31, 33, 41, 46, 52, 54, 59, 64, 67 and 71** impose similar requirements regarding: (1) coverage of certain drugs approved by the Food and Drug Administration to treat substance use disorder; (2) coverage of services for the treatment of substance use disorder provided by a provider of primary care; and (3) reimbursement for such services provided by an advanced practice registered nurse. **Sections 14.5-15.5** of this bill make conforming changes to exempt local governmental agencies that provide health insurance to employees through a plan of self-insurance from the amendatory provisions of **section 44** while maintaining existing requirements that apply to such insurance. **Sections 36, 38, 49 and 50** of this bill make conforming changes to indicate that the coverage required by **sections 33 and 46** is in addition to certain coverage of services for the treatment of

substance use disorder that certain insurers are required by existing law to provide. **Sections 14 and 39** of this bill make conforming changes to indicate the proper placement of **sections 20, 22, 33 and 34** in the Nevada Revised Statutes. **Section 69** of this bill authorizes the Commissioner of Insurance to suspend or revoke the certificate of a health maintenance organization that fails to comply with the requirements of **section 64 or 65**. The Commissioner would also be authorized to take such action against any health insurer who fails to comply with the requirements of **sections 33, 34, 37, 41-44, 46, 47, 50, 54-57, 59-62, 67, 68 or 71-74** of this bill. (NRS 680A.200, 695C.330)

Existing law requires the Department of Health and Human Services to develop a list of preferred prescription drugs to be used for the Medicaid program. Existing law requires the Department to: (1) include on that list drugs for the prevention of human immunodeficiency virus; and (2) include drugs prescribed to treat the human immunodeficiency virus on a list of drugs that are excluded from the restrictions imposed on drugs that are on the list of preferred prescription drugs. (NRS 422.4025) **Section 25** of this bill requires the Medicaid program to cover a prescription drug that is not on the list of preferred prescription drugs if the drug is: (1) used to treat hepatitis C, used to provide medication-assisted treatment for opioid use disorder, used to support safe withdrawal from substance use disorder or is in the same class as a prescription drug on the list of preferred prescription drugs; and (2) is unsuitable for a recipient of Medicaid for certain reasons.

Existing law requires physicians, osteopathic physicians, physician assistants and nurses to complete certain continuing education in order to renew their licenses. (NRS 630.253, 632.343, 633.471) **Sections 28-30 and 75** of this bill require such a provider of health care who provides or supervises the provision of emergency medical care or primary care in a hospital to complete before the first renewal of their license or, for currently practicing providers, the next renewal of their license, at least 2 hours of training in stigma, discrimination and unrecognized bias toward persons who have acquired or are at a high risk of acquiring human immunodeficiency virus. **Section 27** of this bill authorizes any provider of health care to use training in that subject in place of not more than 2 hours of any other training that the provider is required to complete, other than continuing education relating to ethics.

Senate Bill No. 275 of the 2021 Legislative Session repealed certain criminal offenses for which an element of the offense was having the human immunodeficiency virus. (**Section 24, chapter** 491, Statutes of Nevada 2021, at page 3199) **Section 77** of this bill provides that the repeal of those offenses applies retroactively to violations that occurred before the effective date of Senate Bill No. 275.

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

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

Section 1. Chapter 441A of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Department of Health and Human Services and all district, county and city boards of health shall develop policies to provide uninterrupted services during a public health emergency

to persons who have been diagnosed with the human immunodeficiency virus or who are at a high risk of acquiring the human immunodeficiency virus and who are receiving services from the Department or any division thereof or the district, county or city health department, as applicable. Such policies may provide, without limitation, for the delivery of such services during a public health emergency:

(a) Over the Internet;

(b) Using an application for a mobile device; or

(c) By calling or sending text messages from a telephone number that is not generally blocked or identified as a source of unwanted calls or messages.

2. As used in this section:

(a) "Mobile device" includes, without limitation, a smartphone or a tablet computer.

(b) "Public health emergency" means:

(1) A public health emergency or other health event identified by a health authority pursuant to NRS 439.970; or

(2) A state of emergency or declaration of disaster proclaimed pursuant to NRS 414.070 that relates to or affects public health.

Sec. 2. NRS 441A.334 is hereby amended to read as follows:

441A.334 As used in this section and NRS 441A.335 and 441A.336, ***and section 1 of this act,*** "provider of health care" means a physician, nurse or physician assistant licensed in accordance with state law.

Secs. 3-10. (Deleted by amendment.)

Sec. 11. Chapter 209 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Department or the operator of a private facility or institution shall not enter into a contract or other agreement with any person or entity to provide medical services to offenders who are diagnosed with human immunodeficiency virus unless the person or entity demonstrates that at least 95 percent of the patients who are diagnosed with human immunodeficiency virus to whom the person or entity provides medical services:

(a) Are offered treatment on the same day as the diagnosis; and

(b) Are able to begin such treatment not later than 7 days after diagnosis.

2. Except as otherwise provided in subsection 3, an institution, facility or private facility or institution shall take reasonable measures to ensure the availability of:

(a) Any drug prescribed for treating the human immunodeficiency virus in the form recommended by the prescribing practitioner to each offender who has been diagnosed with human immunodeficiency virus to the same extent and under the same conditions as other medical care for offenders.

(b) Methods of preventing the acquisition of human immunodeficiency virus, including, without limitation, drugs approved by the United States Food and Drug Administration for that purpose, to all offenders free of charge.

3. An institution, facility or private facility or institution:

(a) Is not required to make available a drug described in subsection 2 for which a prescription is required to an offender for whom such a prescription has not been issued.

(b) Shall take reasonable measures to make available to all offenders a provider of health care who is authorized to issue a prescription for a drug described in subsection 2.

(c) Shall not demand, request or suggest that a provider of health care refrain from issuing a prescription for a drug described in subsection 2 to an offender or take any other measure to prevent a provider of health care from issuing such a prescription.

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

Sec. 12. Chapter 211 of NRS is hereby amended by adding thereto a new section to read as follows:

1. A sheriff, chief of police or town marshal who is responsible for a county, city or town jail or detention facility shall not enter into a contract or other agreement with any person or entity to provide medical services to prisoners who are diagnosed with human immunodeficiency virus unless the person or entity demonstrates that at least 95 percent of the patients who are diagnosed with human immunodeficiency virus to whom the person or entity provides medical services:

(a) Are offered treatment on the same day as the diagnosis; and

(b) Are able to begin such treatment not later than 7 days after diagnosis.

2. Except as otherwise provided in subsection 3, a county, city or town jail or detention facility shall take reasonable measures to ensure the availability of:

(a) Any drug prescribed for treating the human immunodeficiency virus in the form recommended by the prescribing practitioner to each prisoner who has been diagnosed

with human immunodeficiency virus to the same extent and under the same conditions as other medical care for prisoners.

(b) Methods of preventing the acquisition of human immunodeficiency virus, including, without limitation, drugs approved by the United States Food and Drug Administration for that purpose, to all prisoners free of charge.

3. A county, city or town jail or detention facility:

(a) Is not required to make available a drug described in subsection 2 for which a prescription is required to a prisoner for whom such a prescription has not been issued.

(b) Shall take reasonable measures to make available to all prisoners a provider of health care who is authorized to issue a prescription for a drug described in subsection 2.

(c) Shall not demand, request or suggest that a provider of health care refrain from issuing a prescription for a drug described in subsection 2 to an offender or take any other measure to prevent a provider of health care from issuing such a prescription.

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

Sec. 13. NRS 212.189 is hereby amended to read as follows:

212.189 1. Except as otherwise provided in subsection 10, a prisoner who is under lawful arrest, in lawful custody or in lawful confinement shall not knowingly:

(a) Store or stockpile any human excrement or bodily fluid;

(b) Sell, supply or provide any human excrement or bodily fluid to any other person;

(c) Buy, receive or acquire any human excrement or bodily fluid from any other person; or

(d) Use, propel, discharge, spread or conceal, or cause to be used, propelled, discharged, spread or concealed, any human excrement or bodily fluid:

(1) With the intent to have the excrement or bodily fluid come into physical contact with any portion of the body of another person, including, without limitation, an officer or employee of a prison or law enforcement agency, whether or not such physical contact actually occurs; or

(2) Under circumstances in which the excrement or bodily fluid is reasonably likely to come into physical contact with any portion of the body of another person, including, without limitation, an officer or employee of a prison or law enforcement agency, whether or not such physical contact actually occurs.

2. Except as otherwise provided in subsection 4, if a prisoner who is under lawful arrest or in lawful custody violates any provision of subsection 1, the prisoner is guilty of:

(a) For a first offense, a gross misdemeanor.

(b) For a second offense or any subsequent offense, a category D felony and shall be punished as provided in NRS 193.130.

3. Except as otherwise provided in subsection 4, if a prisoner who is in lawful confinement, other than residential confinement, violates any provision of subsection 1, the prisoner is guilty of a category B felony and shall be punished by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 10 years, and may be further punished by a fine of not more than $10,000.

4. If a prisoner who is under lawful arrest, in lawful custody or in lawful confinement violates any provision of paragraph (d) of subsection 1 and, at the time of the offense, the prisoner knew that any portion of the excrement or bodily fluid involved in the offense contained a communicable disease that causes or is reasonably likely to cause substantial bodily harm, ~~[whether or not]~~ ***the communicable disease is likely to be transmitted as a result of the offense and*** the communicable disease was ***actually*** transmitted to a victim as a result of the offense, the prisoner is guilty of a category A felony and shall be punished by imprisonment in the state prison:

(a) For life with the possibility of parole, with eligibility for parole beginning when a minimum of 10 years has been served; or

(b) For a definite term of 25 years, with eligibility for parole beginning when a minimum of 10 years has been served,

➥ and may be further punished by a fine of not more than $50,000.

5. A sentence imposed upon a prisoner pursuant to subsection 2, 3 or 4:

(a) Is not subject to suspension or the granting of probation; and

(b) Must run consecutively after the prisoner has served any sentences imposed upon the prisoner for the offense or offenses for which the prisoner was under lawful arrest, in lawful custody or in lawful confinement when the prisoner violated the provisions of subsection 1.

6. In addition to any other penalty, the court shall order a prisoner who violates any provision of paragraph (d) of subsection 1 to reimburse the appropriate person or governmental body for the cost of any examinations or testing:

(a) Conducted pursuant to paragraphs (a) and (b) of subsection 8; or

(b) Paid for pursuant to subparagraph (2) of paragraph (c) of subsection 8.

7. The warden, sheriff, administrator or other person responsible for administering a prison shall immediately and fully investigate any act described in subsection 1 that is reported or suspected to have been committed in the prison.

8. If there is probable cause to believe that an act described in paragraph (d) of subsection 1 has been committed in a prison:

(a) Each prisoner believed to have committed the act or to have been the bodily source of any portion of the excrement or bodily fluid involved in the act shall submit to any appropriate examinations and testing to determine whether each such prisoner has any communicable disease.

(b) If possible, a sample of the excrement or bodily fluid involved in the act must be recovered and tested to determine whether any communicable disease is present in the excrement or bodily fluid.

(c) If the excrement or bodily fluid involved in the act came into physical contact with any portion of the body of an officer or employee of a prison or law enforcement agency:

(1) The results of any examinations or testing conducted pursuant to paragraphs (a) and (b) must be provided to each such officer, employee or other person; and

(2) For each such officer or employee:

(I) Of a prison, the person or governmental body operating the prison where the act was committed shall pay for any appropriate examinations and testing requested by the officer or employee to determine whether a communicable disease was transmitted to the officer or employee as a result of the act; and

(II) Of any law enforcement agency, the law enforcement agency that employs the officer or employee shall pay for any appropriate examinations and testing requested by the officer or employee to determine whether a communicable disease was transmitted to the officer or employee as a result of the act.

(d) The results of the investigation conducted pursuant to subsection 7 and the results of any examinations or testing conducted pursuant to paragraphs (a) and (b) must be submitted to the district attorney of the county in which the act was committed or to the Office of the Attorney General for possible prosecution of each prisoner who committed the act.

9. If a prisoner is charged with committing an act described in paragraph (d) of subsection 1 and a victim or an intended victim of the act was an officer or employee of a prison or law enforcement

agency, the prosecuting attorney shall not dismiss the charge in exchange for a plea of guilty, guilty but mentally ill or nolo contendere to a lesser charge or for any other reason unless the prosecuting attorney knows or it is obvious that the charge is not supported by probable cause or cannot be proved at the time of trial.

10. The provisions of this section do not apply to a prisoner who is in residential confinement or to a prisoner who commits an act described in subsection 1 if the act:

(a) Is otherwise lawful and is authorized by the warden, sheriff, administrator or other person responsible for administering the prison, or his or her designee, and the prisoner performs the act in accordance with the directions or instructions given to the prisoner by that person;

(b) Involves the discharge of human excrement or bodily fluid directly from the body of the prisoner and the discharge is the direct result of a temporary or permanent injury, disease or medical condition afflicting the prisoner that prevents the prisoner from having physical control over the discharge of his or her own excrement or bodily fluid; or

(c) Constitutes voluntary sexual conduct with another person in violation of the provisions of NRS 212.187.

Sec. 14. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, ***and section 20 of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of

law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department.

Sec. 14.5. Chapter 287 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance shall provide coverage for:

(a) Drugs approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus;

(b) Laboratory testing that is necessary for therapy that uses such a drug; and

(c) The services described in NRS 639.28085, when provided by a pharmacist who participates in the network plan of the governing body.

2. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance shall reimburse a pharmacist who participates in the network plan of the governing body for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

3. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance may subject the benefits required by subsection 1 to reasonable medical management techniques.

4. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance shall 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 governing body.

5. A plan of self-insurance described in subsection 1 that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

6. As used in this section:

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

(b) "Network plan" means a plan of self-insurance provided by the governing body of a local governmental agency 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 governing body. 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.

Sec. 15. NRS 287.010 is hereby amended to read as follows:

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

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

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

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the

State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 686A.135, 687B.352, 687B.408, 687B.723, 687B.725, 689B.030 to ***689B.031, inclusive, 689B.0313 to*** 689B.050, inclusive, 689B.265, 689B.287 and 689B.500 apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and 689B.500 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.

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

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

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.

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

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local

governmental agency with which the legal services organization has contracted; and

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

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

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

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

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

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

Sec. 15.5. NRS 287.040 is hereby amended to read as follows:

287.040 The provisions of NRS 287.010 to 287.040, inclusive, ***and section 14.5 of this act*** do not make it compulsory upon any governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada, except as otherwise provided in NRS 287.021 or subsection 4 of NRS 287.023 or in an agreement entered into pursuant to subsection 3 of NRS 287.015, to pay any premiums, contributions or other costs for group insurance, a plan of benefits or medical or hospital services established pursuant to NRS 287.010, 287.015, 287.020 or paragraph (b), (c) or (d) of subsection 1 of NRS 287.025, for coverage under the Public Employees' Benefits Program, or to make any contributions to a trust fund established pursuant to NRS 287.017, or upon any officer or employee of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of this State to accept any such coverage or to assign his or her wages or salary in payment of premiums or contributions therefor.

Sec. 16. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 686A.135, 687B.352, 687B.409, 687B.723, 687B.725, 689B.0353, 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.1675, 695G.170 to 695G.174, inclusive, ***and sections 71 and***

72 of this act, 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Secs. 17 and 18. (Deleted by amendment.)

Sec. 19. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 20 and 21 of this act.

Sec. 20. ***1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenses for any service for the treatment of substance use disorder provided by a provider of primary care if the service is included in the State Plan when provided by a specialist and:***

(a) The service is within the scope of practice of the provider of primary care; or

(b) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. As used in this section, "primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.

Sec. 21. (Deleted by amendment.)

Sec. 22. NRS 422.27173 is hereby amended to read as follows:

422.27173 The Director shall include in the State Plan for Medicaid a requirement that the State must pay the nonfederal share of expenditures incurred for ***:***

1. Testing for and the treatment and prevention of sexually transmitted diseases, including, without limitation, Chlamydia trachomatis, gonorrhea, syphilis, human immunodeficiency virus and hepatitis B and C, for all recipients of Medicaid, regardless of age. Services covered pursuant to this section must include, without limitation, the examination of a pregnant woman for the discovery of:

~~[1.]~~ ***(a)*** Chlamydia trachomatis, gonorrhea, hepatitis B and hepatitis C in accordance with NRS 442.013.

~~[2.]~~ ***(b)*** Syphilis in accordance with NRS 442.010.

2. Condoms for recipients of Medicaid.

Sec. 23. NRS 422.27235 is hereby amended to read as follows:

422.27235 ***1.*** The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:

~~[1.]~~ ***(a)*** Any laboratory testing that is necessary for therapy that uses a drug approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus ***.*** ~~[; and]~~

~~[2.]~~ ***(b)*** The services of a pharmacist described in NRS 639.28085. The State must provide reimbursement for such services at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. The Director shall include in the State Plan for Medicaid a requirement that the State reimburse an advanced practice registered nurse or a physician assistant for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. As used in this section, "primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.

Sec. 24. (Deleted by amendment.)

Sec. 25. NRS 422.4025 is hereby amended to read as follows:

422.4025 1. The Department shall:

(a) By regulation, develop a list of preferred prescription drugs to be used for the Medicaid program and the Children's Health Insurance Program, and each public or nonprofit health benefit plan that elects to use the list of preferred prescription drugs as its formulary pursuant to NRS 287.012, 287.0433 or 687B.407; and

(b) Negotiate and enter into agreements to purchase the drugs included on the list of preferred prescription drugs on behalf of the health benefit plans described in paragraph (a) or enter into a contract pursuant to NRS 422.4053 with a pharmacy benefit manager, health maintenance organization or one or more public or private entities in this State, the District of Columbia or other states or territories of the United States, as appropriate, to negotiate such agreements.

2. The Department shall, by regulation, establish a list of prescription drugs which must be excluded from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs established pursuant to subsection 1. The list established pursuant to this subsection must include, without limitation:

(a) Prescription drugs that are prescribed for the treatment of the human immunodeficiency virus, including, without limitation, antiretroviral medications;

(b) Antirejection medications for organ transplants;

(c) Antihemophilic medications; and

(d) Any prescription drug which the Board identifies as appropriate for exclusion from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs.

3. The regulations must provide that the Board makes the final determination of:

(a) Whether a class of therapeutic prescription drugs is included on the list of preferred prescription drugs and is excluded from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs;

(b) Which therapeutically equivalent prescription drugs will be reviewed for inclusion on the list of preferred prescription drugs and for exclusion from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs; and

(c) Which prescription drugs should be excluded from any restrictions that are imposed by the Medicaid program on drugs that are on the list of preferred prescription drugs based on continuity of care concerning a specific diagnosis, condition, class of therapeutic prescription drugs or medical specialty.

4. The list of preferred prescription drugs established pursuant to subsection 1 must include, without limitation:

(a) Any prescription drug determined by the Board to be essential for treating sickle cell disease and its variants; and

(b) Prescription drugs to prevent the acquisition of human immunodeficiency virus.

5. The regulations must provide that each new pharmaceutical product and each existing pharmaceutical product for which there is new clinical evidence supporting its inclusion on the list of preferred prescription drugs must be made available pursuant to the Medicaid program with prior authorization until the Board reviews the product or the evidence.

6. ***The Medicaid program must cover a prescription drug that is not included on the list of preferred prescription drugs as if the drug were included on that list if:***

(a) The drug is:

(1) Used to treat hepatitis C;

(2) Used to provide medication-assisted treatment for opioid use disorder;

(3) Used to support safe withdrawal from substance use disorder; or

(4) In the same class as a drug on the list of preferred prescription drugs; and

(b) All preferred prescription drugs within the same class as the drug are unsuitable for a recipient of Medicaid because:

(1) The recipient is allergic to all preferred prescription drugs within the same class as the drug;

(2) All preferred prescription drugs within the same class as the drug are contraindicated for the recipient or are likely to interact in a harmful manner with another drug that the recipient is taking;

(3) The recipient has a history of adverse reactions to all preferred prescription drugs within the same class as the drug; or

(4) The drug has a unique indication that is supported by peer-reviewed clinical evidence or approved by the United States Food and Drug Administration.

7. On or before February 1 of each year, the Department shall:

(a) Compile a report concerning the agreements negotiated pursuant to paragraph (b) of subsection 1 and contracts entered into pursuant to NRS 422.4053 which must include, without limitation, the financial effects of obtaining prescription drugs through those agreements and contracts, in total and aggregated separately for agreements negotiated by the Department, contracts with a pharmacy benefit manager, contracts with a health maintenance organization and contracts with public and private entities from this State, the District of Columbia and other states and territories of the United States; and

(b) Post the report on an Internet website maintained by the Department and submit the report to the Director of the Legislative Counsel Bureau for transmittal to:

(1) In odd-numbered years, the Legislature; or

(2) In even-numbered years, the Legislative Commission.

Sec. 26. NRS 608.156 is hereby amended to read as follows:

608.156 1. ~~[If]~~ ***In addition to any benefits required by NRS 608.1555,*** an employer provides health benefits for his or her

employees, the employer shall provide benefits for the expenses for the treatment of alcohol and substance use disorders. The annual benefits provided by the employer must ~~[consist of:]~~ ***include, without limitation:***

(a) Treatment for withdrawal from the physiological effects of alcohol or drugs, with a maximum benefit of $1,500 per calendar year.

(b) Treatment for a patient admitted to a facility, with a maximum benefit of $9,000 per calendar year.

(c) Counseling for a person, group or family who is not admitted to a facility, with a maximum benefit of $2,500 per calendar year.

2. The maximum amount which may be paid in the lifetime of the insured for any combination of the treatments listed in subsection 1 is $39,000.

3. Except as otherwise provided in NRS 687B.409, these benefits must be paid in the same manner as benefits for any other illness covered by the employer are paid.

4. The employee is entitled to these benefits if treatment is received in any:

(a) Program for the treatment of alcohol or substance use disorders which is certified by the Division of Public and Behavioral Health of the Department of Health and Human Services.

(b) Hospital or other medical facility or facility for the dependent which is licensed by the Division of Public and Behavioral Health of the Department of Health and Human Services, is accredited by The Joint Commission or CARF International and provides a program for the treatment of alcohol or substance use disorders as part of its accredited activities.

Sec. 27. NRS 629.093 is hereby amended to read as follows:

629.093 Unless a specific statute or regulation requires or authorizes a greater number of hours, a provider of health care may use credit earned for continuing education relating to Alzheimer's disease ***or the stigma, discrimination and unrecognized bias toward persons who have acquired or are at a high risk of acquiring human immunodeficiency virus*** in place of not more than 2 hours each year of the continuing education that the provider of health care is required to complete, other than any continuing education relating to ethics that the provider of health care is required to complete.

Sec. 28. NRS 630.253 is hereby amended to read as follows:

630.253 1. The Board shall, as a prerequisite for the:

(a) Renewal of a license as a physician assistant; or

(b) Biennial registration of the holder of a license to practice medicine,

➥ require each holder to submit evidence of compliance with the requirements for continuing education as set forth in regulations adopted by the Board.

2. These requirements:

(a) May provide for the completion of one or more courses of instruction relating to risk management in the performance of medical services.

(b) Must provide for the completion of a course of instruction, within 2 years after initial licensure, relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. The course must provide at least 4 hours of instruction that includes instruction in the following subjects:

(1) An overview of acts of terrorism and weapons of mass destruction;

(2) Personal protective equipment required for acts of terrorism;

(3) Common symptoms and methods of treatment associated with exposure to, or injuries caused by, chemical, biological, radioactive and nuclear agents;

(4) Syndromic surveillance and reporting procedures for acts of terrorism that involve biological agents; and

(5) An overview of the information available on, and the use of, the Health Alert Network.

(c) Must provide for the completion by a holder of a license to practice medicine of a course of instruction within 2 years after initial licensure that provides at least 2 hours of instruction on evidence-based suicide prevention and awareness as described in subsection 6.

(d) Must provide for the completion of at least 2 hours of training in the screening, brief intervention and referral to treatment approach to substance use disorder within 2 years after initial licensure.

(e) Must provide for the biennial completion by each psychiatrist and each physician assistant practicing under the supervision of a psychiatrist of one or more courses of instruction that provide at least 2 hours of instruction relating to cultural competency and diversity, equity and inclusion. Such instruction:

(1) May include the training provided pursuant to NRS 449.103, where applicable.

(2) Must be based upon a range of research from diverse sources.

(3) Must address persons of different cultural backgrounds, including, without limitation:

(I) Persons from various gender, racial and ethnic backgrounds;

(II) Persons from various religious backgrounds;

(III) Lesbian, gay, bisexual, transgender and questioning persons;

(IV) Children and senior citizens;

(V) Veterans;

(VI) Persons with a mental illness;

(VII) Persons with an intellectual disability, developmental disability or physical disability; and

(VIII) Persons who are part of any other population that a psychiatrist or a physician assistant practicing under the supervision of a psychiatrist may need to better understand, as determined by the Board.

(f) Must allow the holder of a license to receive credit toward the total amount of continuing education required by the Board for the completion of a course of instruction relating to genetic counseling and genetic testing.

(g) Must provide for the completion by a physician or physician assistant who provides or supervises the provision of emergency medical services in a hospital or primary care of at least 2 hours of training in the stigma, discrimination and unrecognized bias toward persons who have acquired or are at a high risk of acquiring human immunodeficiency virus within 2 years after beginning to provide or supervise the provision of such services or care.

3. The Board may determine whether to include in a program of continuing education courses of instruction relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction in addition to the course of instruction required by paragraph (b) of subsection 2.

4. The Board shall encourage each holder of a license who treats or cares for persons who are more than 60 years of age to receive, as a portion of their continuing education, education in geriatrics and gerontology, including such topics as:

(a) The skills and knowledge that the licensee needs to address aging issues;

(b) Approaches to providing health care to older persons, including both didactic and clinical approaches;

(c) The biological, behavioral, social and emotional aspects of the aging process; and

(d) The importance of maintenance of function and independence for older persons.

5. The Board shall encourage each holder of a license to practice medicine to receive, as a portion of his or her continuing education, training concerning methods for educating patients about how to effectively manage medications, including, without limitation, the ability of the patient to request to have the symptom or purpose for which a drug is prescribed included on the label attached to the container of the drug.

6. The Board shall require each holder of a license to practice medicine to receive as a portion of his or her continuing education at least 2 hours of instruction every 4 years on evidence-based suicide prevention and awareness, which may include, without limitation, instruction concerning:

(a) The skills and knowledge that the licensee needs to detect behaviors that may lead to suicide, including, without limitation, post-traumatic stress disorder;

(b) Approaches to engaging other professionals in suicide intervention; and

(c) The detection of suicidal thoughts and ideations and the prevention of suicide.

7. The Board shall encourage each holder of a license to practice medicine or as a physician assistant to receive, as a portion of his or her continuing education, training and education in the diagnosis of rare diseases, including, without limitation:

(a) Recognizing the symptoms of pediatric cancer; and

(b) Interpreting family history to determine whether such symptoms indicate a normal childhood illness or a condition that requires additional examination.

8. A holder of a license to practice medicine may not substitute the continuing education credits relating to suicide prevention and awareness required by this section for the purposes of satisfying an equivalent requirement for continuing education in ethics.

9. Except as otherwise provided in NRS 630.2535, a holder of a license to practice medicine may substitute not more than 2 hours of continuing education credits in pain management, care for persons with an addictive disorder or the screening, brief intervention and referral to treatment approach to substance use disorder for the purposes of satisfying an equivalent requirement for continuing education in ethics.

10. As used in this section:

(a) "Act of terrorism" has the meaning ascribed to it in NRS 202.4415.

(b) "Biological agent" has the meaning ascribed to it in NRS 202.442.

(c) "Chemical agent" has the meaning ascribed to it in NRS 202.4425.

(d) ***"Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.***

(e) "Radioactive agent" has the meaning ascribed to it in NRS 202.4437.

~~[(e)]~~ ***(f)*** "Weapon of mass destruction" has the meaning ascribed to it in NRS 202.4445.

Sec. 29. NRS 632.343 is hereby amended to read as follows:

632.343 1. The Board shall not renew any license issued under this chapter until the licensee has submitted proof satisfactory to the Board of completion, during the 2-year period before renewal of the license, of 30 hours in a program of continuing education approved by the Board in accordance with regulations adopted by the Board. Except as otherwise provided in subsection 3, the licensee is exempt from this provision for the first biennial period after graduation from:

(a) An accredited school of professional nursing;

(b) An accredited school of practical nursing;

(c) An approved school of professional nursing in the process of obtaining accreditation; or

(d) An approved school of practical nursing in the process of obtaining accreditation.

2. The Board shall review all courses offered to nurses for the completion of the requirement set forth in subsection 1. The Board may approve nursing and other courses which are directly related to the practice of nursing as well as others which bear a reasonable relationship to current developments in the field of nursing or any special area of practice in which a licensee engages. These may include academic studies, workshops, extension studies, home study and other courses.

3. The program of continuing education required by subsection 1 must include:

(a) For a person licensed as an advanced practice registered nurse:

(1) A course of instruction to be completed within 2 years after initial licensure that provides at least 2 hours of instruction on suicide prevention and awareness as described in subsection 6.

(2) The ability to receive credit toward the total amount of continuing education required by subsection 1 for the completion of a course of instruction relating to genetic counseling and genetic testing.

(b) For each person licensed pursuant to this chapter, a course of instruction, to be completed within 2 years after initial licensure, relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. The course must provide at least 4 hours of instruction that includes instruction in the following subjects:

(1) An overview of acts of terrorism and weapons of mass destruction;

(2) Personal protective equipment required for acts of terrorism;

(3) Common symptoms and methods of treatment associated with exposure to, or injuries caused by, chemical, biological, radioactive and nuclear agents;

(4) Syndromic surveillance and reporting procedures for acts of terrorism that involve biological agents; and

(5) An overview of the information available on, and the use of, the Health Alert Network.

(c) For each person licensed pursuant to this chapter, one or more courses of instruction that provide at least 2 hours of instruction relating to cultural competency and diversity, equity and inclusion to be completed biennially. Such instruction:

(1) May include the training provided pursuant to NRS 449.103, where applicable.

(2) Must be based upon a range of research from diverse sources.

(3) Must address persons of different cultural backgrounds, including, without limitation:

(I) Persons from various gender, racial and ethnic backgrounds;

(II) Persons from various religious backgrounds;

(III) Lesbian, gay, bisexual, transgender and questioning persons;

(IV) Children and senior citizens;

(V) Veterans;

(VI) Persons with a mental illness;

(VII) Persons with an intellectual disability, developmental disability or physical disability; and

(VIII) Persons who are part of any other population that a person licensed pursuant to this chapter may need to better understand, as determined by the Board.

(d) For a person licensed as an advanced practice registered nurse, at least 2 hours of training in the screening, brief intervention and referral to treatment approach to substance use disorder to be completed within 2 years after initial licensure.

(e) For each person licensed pursuant to this chapter who provides or supervises the provision of emergency medical services in a hospital or primary care, at least 2 hours of training in the stigma, discrimination and unrecognized bias toward persons who have acquired or are at a high risk of acquiring human immunodeficiency virus to be completed within 2 years after beginning to provide or supervise the provision of such services or care.

4. The Board may determine whether to include in a program of continuing education courses of instruction relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction in addition to the course of instruction required by paragraph (b) of subsection 3.

5. The Board shall encourage each licensee who treats or cares for persons who are more than 60 years of age to receive, as a portion of their continuing education, education in geriatrics and gerontology, including such topics as:

(a) The skills and knowledge that the licensee needs to address aging issues;

(b) Approaches to providing health care to older persons, including both didactic and clinical approaches;

(c) The biological, behavioral, social and emotional aspects of the aging process; and

(d) The importance of maintenance of function and independence for older persons.

6. The Board shall require each person licensed as an advanced practice registered nurse to receive as a portion of his or her continuing education at least 2 hours of instruction every 4 years on evidence-based suicide prevention and awareness or another course of instruction on suicide prevention and awareness that is approved by the Board which the Board has determined to be effective and appropriate.

7. The Board shall encourage each person licensed as an advanced practice registered nurse to receive, as a portion of his or her continuing education, training and education in the diagnosis of rare diseases, including, without limitation:

(a) Recognizing the symptoms of pediatric cancer; and

(b) Interpreting family history to determine whether such symptoms indicate a normal childhood illness or a condition that requires additional examination.

8. As used in this section:

(a) "Act of terrorism" has the meaning ascribed to it in NRS 202.4415.

(b) "Biological agent" has the meaning ascribed to it in NRS 202.442.

(c) "Chemical agent" has the meaning ascribed to it in NRS 202.4425.

(d) ***"Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.***

(e) "Radioactive agent" has the meaning ascribed to it in NRS 202.4437.

~~[(e)]~~ ***(f)*** "Weapon of mass destruction" has the meaning ascribed to it in NRS 202.4445.

Sec. 30. NRS 633.471 is hereby amended to read as follows:

633.471 1. Except as otherwise provided in subsection ~~[14]~~ ***15*** and NRS 633.491, every holder of a license, except a physician assistant, issued under this chapter, except a temporary or a special license, may renew the license on or before January 1 of each calendar year after its issuance by:

(a) Applying for renewal on forms provided by the Board;

(b) Paying the annual license renewal fee specified in this chapter;

(c) Submitting a list of all actions filed or claims submitted to arbitration or mediation for malpractice or negligence against the holder during the previous year;

(d) Subject to subsection ~~[13,]~~ ***14,*** submitting evidence to the Board that in the year preceding the application for renewal the holder has attended courses or programs of continuing education approved by the Board in accordance with regulations adopted by the Board totaling a number of hours established by the Board which must not be less than 35 hours nor more than that set in the requirements for continuing medical education of the American Osteopathic Association; and

(e) Submitting all information required to complete the renewal.

2. The Secretary of the Board shall notify each licensee of the requirements for renewal not less than 30 days before the date of renewal.

3. The Board shall request submission of verified evidence of completion of the required number of hours of continuing medical education annually from no fewer than one-third of the applicants for renewal of a license to practice osteopathic medicine or a license to practice as a physician assistant. Subject to subsection ~~[13,]~~ ***14,*** upon a request from the Board, an applicant for renewal of a license to practice osteopathic medicine or a license to practice as a physician assistant shall submit verified evidence satisfactory to the Board that in the year preceding the application for renewal the applicant attended courses or programs of continuing medical education approved by the Board totaling the number of hours established by the Board.

4. The Board shall require each holder of a license to practice osteopathic medicine to complete a course of instruction within 2 years after initial licensure that provides at least 2 hours of instruction on evidence-based suicide prevention and awareness as described in subsection 9.

5. The Board shall encourage each holder of a license to practice osteopathic medicine to receive, as a portion of his or her continuing education, training concerning methods for educating patients about how to effectively manage medications, including, without limitation, the ability of the patient to request to have the symptom or purpose for which a drug is prescribed included on the label attached to the container of the drug.

6. The Board shall encourage each holder of a license to practice osteopathic medicine or as a physician assistant to receive, as a portion of his or her continuing education, training and education in the diagnosis of rare diseases, including, without limitation:

(a) Recognizing the symptoms of pediatric cancer; and

(b) Interpreting family history to determine whether such symptoms indicate a normal childhood illness or a condition that requires additional examination.

7. The Board shall require, as part of the continuing education requirements approved by the Board, the biennial completion by a holder of a license to practice osteopathic medicine of at least 2 hours of continuing education credits in ethics, pain management, care of persons with addictive disorders or the screening, brief intervention and referral to treatment approach to substance use disorder.

8. The continuing education requirements approved by the Board must allow the holder of a license as an osteopathic physician or physician assistant to receive credit toward the total amount of

continuing education required by the Board for the completion of a course of instruction relating to genetic counseling and genetic testing.

9. The Board shall require each holder of a license to practice osteopathic medicine to receive as a portion of his or her continuing education at least 2 hours of instruction every 4 years on evidence-based suicide prevention and awareness which may include, without limitation, instruction concerning:

(a) The skills and knowledge that the licensee needs to detect behaviors that may lead to suicide, including, without limitation, post-traumatic stress disorder;

(b) Approaches to engaging other professionals in suicide intervention; and

(c) The detection of suicidal thoughts and ideations and the prevention of suicide.

10. A holder of a license to practice osteopathic medicine may not substitute the continuing education credits relating to suicide prevention and awareness required by this section for the purposes of satisfying an equivalent requirement for continuing education in ethics.

11. The Board shall require each holder of a license to practice osteopathic medicine to complete at least 2 hours of training in the screening, brief intervention and referral to treatment approach to substance use disorder within 2 years after initial licensure.

12. The Board shall require each psychiatrist or a physician assistant practicing under the supervision of a psychiatrist to biennially complete one or more courses of instruction that provide at least 2 hours of instruction relating to cultural competency and diversity, equity and inclusion. Such instruction:

(a) May include the training provided pursuant to NRS 449.103, where applicable.

(b) Must be based upon a range of research from diverse sources.

(c) Must address persons of different cultural backgrounds, including, without limitation:

(1) Persons from various gender, racial and ethnic backgrounds;

(2) Persons from various religious backgrounds;

(3) Lesbian, gay, bisexual, transgender and questioning persons;

(4) Children and senior citizens;

(5) Veterans;

(6) Persons with a mental illness;

(7) Persons with an intellectual disability, developmental disability or physical disability; and

(8) Persons who are part of any other population that a psychiatrist or physician assistant practicing under the supervision of a psychiatrist may need to better understand, as determined by the Board.

13. ***The Board shall require each holder of a license to practice osteopathic medicine or as a physician assistant who provides or supervises the provision of emergency medical services in a hospital or primary care to complete at least 2 hours of training in the stigma, discrimination and unrecognized bias toward persons who have acquired or are at a high risk of acquiring human immunodeficiency virus within 2 years after beginning to provide or supervise the provision of such services or care.***

14. The Board shall not require a physician assistant to receive or maintain certification by the National Commission on Certification of Physician Assistants, or its successor organization, or by any other nationally recognized organization for the accreditation of physician assistants to satisfy any continuing education requirement pursuant to paragraph (d) of subsection 1 and subsection 3.

~~[14.]~~ ***15.*** Members of the Armed Forces of the United States and the United States Public Health Service are exempt from payment of the annual license renewal fee during their active duty status.

16. As used in this section, "primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.

Sec. 31. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0412, 689A.0413, ***689A.0437,*** 689A.044, 689A.0445, 689B.031, ***689B.0312,*** 689B.0313, 689B.0315, 689B.0317, 689B.0374, ***689C.1671,*** 689C.1675, ***695A.1843,*** 695A.1856, 695B.1912, 695B.1913, 695B.1914, ***695B.1924,*** 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1737, ***695C.1743,*** 695C.1745, 695C.1751, 695G.170, ***695G.1705,*** 695G.171, 695G.1714 and 695G.177, ***and sections 33, 41, 46, 54, 59, 64 and 71 of this act,*** any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization

for that care from the insurer or organization. The insurer or organization shall:

(a) File its procedure for obtaining approval of care pursuant to this section for approval by the Commissioner; and

(b) Respond to any request for approval by the insured or member pursuant to this section within 20 days after it receives the request.

2. The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

Sec. 32. Chapter 689A of NRS is hereby amended by adding thereto the provisions set forth as sections 33, 34 and 35 of this act.

Sec. 33. ***1. An insurer that offers or issues a policy of health insurance shall include in the policy coverage for:***

(a) All drugs approved by the United States Food and Drug Administration to:

(1) Provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(2) Support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. An insurer shall provide the coverage required by paragraph (a) of subsection 1 regardless of whether the drug is included in the formulary of the insurer.

3. An insurer shall not:

(a) Subject the benefits required by paragraph (a) of subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1; or

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

4. An insurer shall 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.

5. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription drugs. The term includes, without limitation, the use of step therapy, prior authorization and 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) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.

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

Sec. 34. ***1. An insurer that offers or issues a policy of health insurance shall include in the policy:***

(a) Coverage of testing for and the treatment and prevention of sexually transmitted diseases, including, without limitation, Chlamydia trachomatis, gonorrhea, syphilis, human immunodeficiency virus and hepatitis B and C, for all insureds, regardless of age. Such coverage must include, without limitation, the coverage required by NRS 689A.0412 and 689A.0437.

(b) Unrestricted coverage of condoms for insureds who are 13 years of age or older.

2. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

Sec. 35. (Deleted by amendment.)

Sec. 36. NRS 689A.030 is hereby amended to read as follows:

689A.030 A policy of health insurance must not be delivered or issued for delivery to any person in this State unless it otherwise complies with this Code, and complies with the following:

1. The entire money and other considerations for the policy must be expressed therein.

2. The time when the insurance takes effect and terminates must be expressed therein.

3. It must purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two or more eligible members of that family, including the husband, wife, domestic partner as defined in NRS 122A.030, dependent children, from the time of birth, adoption or placement for the purpose of adoption as provided in NRS 689A.043, or any child on or before the last day of the month in which the child attains 26 years of age, and any other person dependent upon the policyholder.

4. The style, arrangement and overall appearance of the policy must not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers must be plainly printed in light-faced type of a style in general use, the size of which must be uniform and not less than 10 points with a lowercase unspaced alphabet length not less than 120 points. "Text" includes all printed matter except the name and address of the insurer, the name or the title of the policy, the brief description, if any, and captions and subcaptions.

5. The exceptions and reductions of indemnity must be set forth in the policy and, other than those contained in NRS 689A.050 to 689A.290, inclusive, must be printed, at the insurer's option, with the benefit provision to which they apply or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of that exception or reduction must be included with the benefit provision to which it applies.

6. Each such form, including riders and endorsements, must be identified by a number in the lower left-hand corner of the first page thereof.

7. The policy must not contain any provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless that portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the Commissioner.

8. The policy must provide benefits for expense arising from care at home or health supportive services if that care or service was prescribed by a physician and would have been covered by the policy if performed in a medical facility or facility for the dependent as defined in chapter 449 of NRS.

9. ~~[The]~~ ***Except as otherwise provided in this subsection, the*** policy must provide ~~[, at the option of the applicant,]~~ benefits for expenses incurred for the treatment of alcohol or substance use disorder ***.*** ~~[, unless]~~ ***Except for the benefits required by section 34 of this act, such benefits must be provided:***

(a) At the option of the applicant; and

(b) Unless the policy provides coverage only for a specified disease or provides for the payment of a specific amount of money if the insured is hospitalized or receiving health care in his or her home.

10. The policy must provide benefits for expense arising from hospice care.

Sec. 37. NRS 689A.0437 is hereby amended to read as follows:

689A.0437 1. An insurer that offers or issues a policy of health insurance shall include in the policy coverage for:

(a) ~~[Drugs]~~ ***All drugs*** approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus ~~[;]~~ ***or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing practitioner, regardless of whether the drug is included in the formulary of the insurer;***

(b) Laboratory testing that is necessary for therapy that uses ~~[such]~~ a drug ~~[;]~~ ***to prevent the acquisition of human immunodeficiency virus;***

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

~~[(c)]~~ ***(d)*** The services described in NRS 639.28085, when provided by a pharmacist who participates in the network plan of the insurer.

2. An insurer that offers or issues a policy of health insurance shall reimburse ~~[a]~~ ***:***

(a) A pharmacist who participates in the network plan of the insurer for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the insurer for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. An insurer ~~[may subject]~~ ***shall not:***

(a) Subject the benefits required by subsection 1 to ~~[reasonable]~~ medical management techniques ~~[.]~~ ***, other than step therapy;***

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the insured is diagnosed.

4. An insurer shall 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.

5. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~[October]~~ ***January*** 1, ~~[2021,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription drugs. The term includes, without limitation, the use of step therapy, prior authorization and 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) ***"Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.***

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

Sec. 38. NRS 689A.046 is hereby amended to read as follows:

689A.046 1. ~~[The]~~ ***In addition to the benefits required by section 33 of this act, the*** benefits provided by a policy for health insurance for treatment of alcohol or substance use disorder must ~~[consist of:]~~ ***include, without limitation:***

(a) Treatment for withdrawal from the physiological effect of alcohol or drugs, with a minimum benefit of $1,500 per calendar year.

(b) Treatment for a patient admitted to a facility, with a minimum benefit of $9,000 per calendar year.

(c) Counseling for a person, group or family who is not admitted to a facility, with a minimum benefit of $2,500 per calendar year.

2. Except as otherwise provided in NRS 687B.409, these benefits must be paid in the same manner as benefits for any other illness covered by a similar policy are paid.

3. The insured person is entitled to these benefits if treatment is received in any:

(a) Facility for the treatment of alcohol or substance use disorder which is certified by the Division of Public and Behavioral Health of the Department of Health and Human Services.

(b) Hospital or other medical facility or facility for the dependent which is licensed by the Division of Public and Behavioral Health of the Department of Health and Human Services, accredited by The Joint Commission or CARF International and provides a program for the treatment of alcohol or substance use disorder as part of its accredited activities.

Sec. 39. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~[.]~~ ***, and sections 33 and 34 of this act.***

Sec. 40. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 41, 42 and 43 of this act.

Sec. 41. ***1. An insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:***

(a) All drugs approved by the United States Food and Drug Administration to:

(1) Provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(2) Support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. An insurer shall provide the coverage required by paragraph (a) of subsection 1 regardless of whether the drug is included in the formulary of the insurer.

3. An insurer shall not:

(a) Subject the benefits required by paragraph (a) of subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1; or

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

4. An insurer shall 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.

5. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription drugs. The term includes, without limitation, the use of step therapy, prior authorization and 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) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.

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

Sec. 42. ***1. An insurer that offers or issues a policy of group health insurance shall include in the policy:***

(a) Coverage of testing for and the treatment of and prevention of sexually transmitted diseases, including, without limitation, Chlamydia trachomatis, gonorrhea, syphilis, human immunodeficiency virus and hepatitis B and C, for all insureds, regardless of age. Such coverage must include, without limitation, the coverage required by NRS 689B.0312 and 689B.0315.

(b) Unrestricted coverage of condoms for insureds who are 13 years of age or older.

2. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

Sec. 43. (Deleted by amendment.)

Sec. 44. NRS 689B.0312 is hereby amended to read as follows:

689B.0312 1. An insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:

(a) ~~[~~Drugs~~]~~ ***All drugs*** approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus ~~[;]~~ ***or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing practitioner, regardless of whether the drug is included in the formulary of the insurer;***

(b) Laboratory testing that is necessary for therapy that uses ~~[~~such~~]~~ a drug ~~[;]~~ ***to prevent the acquisition of human immunodeficiency virus;***

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of

primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

~~[(c)]~~ ***(d)*** The services described in NRS 639.28085, when provided by a pharmacist who participates in the network plan of the insurer.

2. An insurer that offers or issues a policy of group health insurance shall reimburse ~~[a]~~ ***:***

(a) A pharmacist who participates in the network plan of the insurer for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the insurer for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. An insurer ~~[may subject]~~ ***shall not:***

(a) Subject the benefits required by subsection 1 to ~~[reasonable]~~ medical management techniques ~~[.]~~ ***, other than step therapy;***

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the insured is diagnosed.

4. An insurer shall 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.

5. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~[October]~~ ***January*** 1, ~~[2021,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription

drugs. The term includes, without limitation, the use of step therapy, prior authorization and 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) ***"Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.***

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

Sec. 45. Chapter 689C of NRS is hereby amended by adding thereto the provisions set forth as sections 46, 47 and 48 of this act.

Sec. 46. ***1. A carrier that offers or issues a health benefit plan shall include in the plan coverage for:***

(a) All drugs approved by the United States Food and Drug Administration to:

(1) Provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(2) Support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. A carrier shall provide the coverage required by paragraph (a) of subsection 1 regardless of whether the drug is included in the formulary of the carrier.

3. A carrier shall not:

(a) Subject the benefits required by paragraph (a) of subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1; or

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

4. A carrier shall 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.

5. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription drugs. The term includes, without limitation, the use of step therapy, prior authorization and 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) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.

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

Sec. 47. *1. A carrier that offers or issues a health benefit plan shall include in the plan:*

(a) Coverage of testing for and the treatment and prevention of sexually transmitted diseases, including, without limitation, Chlamydia trachomatis, gonorrhea, syphilis, human immunodeficiency virus and hepatitis B and C, for all insureds, regardless of age. Such coverage must include, without limitation, the coverage required by NRS 689C.1671 and 689C.1675.

(b) Unrestricted coverage of condoms for insureds who are 13 years of age or older.

2. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

Sec. 48. (Deleted by amendment.)

Sec. 49. NRS 689C.166 is hereby amended to read as follows:

689C.166 Each group health insurance policy must contain in substance a provision for benefits payable for expenses incurred for the treatment of alcohol or substance use disorder, as provided in NRS 689C.167 ~~[.]~~ ***and section 46 of this act.***

Sec. 50. NRS 689C.167 is hereby amended to read as follows:

689C.167 1. ~~[The]~~ ***In addition to the benefits required by section 46 of this act, the*** benefits provided by a group policy for health insurance, as required by NRS 689C.166, for the treatment of alcohol or substance use disorders must ~~[consist of:]~~ ***include, without limitation:***

(a) Treatment for withdrawal from the physiological effects of alcohol or drugs, with a minimum benefit of $1,500 per calendar year.

(b) Treatment for a patient admitted to a facility, with a minimum benefit of $9,000 per calendar year.

(c) Counseling for a person, group or family who is not admitted to a facility, with a minimum benefit of $2,500 per calendar year.

2. Except as otherwise provided in NRS 687B.409, these benefits must be paid in the same manner as benefits for any other illness covered by a similar policy are paid.

3. The insured person is entitled to these benefits if treatment is received in any:

(a) Facility for the treatment of alcohol or substance use disorders which is certified by the Division of Public and Behavioral Health of the Department of Health and Human Services.

(b) Hospital or other medical facility or facility for the dependent which is licensed by the Division of Public and Behavioral Health of the Department of Health and Human Services, is accredited by The Joint Commission or CARF International and provides a program for the treatment of alcohol or substance use disorders as part of its accredited activities.

Sec. 51. NRS 689C.1671 is hereby amended to read as follows:

689C.1671 1. A carrier that offers or issues a health benefit plan shall include in the plan coverage for:

(a) ~~[Drugs]~~ ***All drugs*** approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus ~~[;]~~ ***or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing practitioner, regardless of whether the drug is included in the formulary of the carrier;***

(b) Laboratory testing that is necessary for therapy that uses ~~[such]~~ a drug ~~[.]~~ ***to prevent the acquisition of human immunodeficiency virus;***

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

~~[(c)]~~ ***(d)*** The services described in NRS 639.28085, when provided by a pharmacist who participates in the health benefit plan of the carrier.

2. A carrier that offers or issues a health benefit plan shall reimburse ~~[a]~~ ***:***

(a) A pharmacist who participates in the health benefit plan of the carrier for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the carrier for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. A carrier ~~[may subject]~~ ***shall not:***

(a) Subject the benefits required by subsection 1 to ~~[reasonable]~~ medical management techniques ~~[.]~~ ***, other than step therapy;***

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the insured is diagnosed.

4. A carrier shall 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.

5. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after

~~[October]~~ ***January*** 1, ~~[2021,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription drugs. The term includes, without limitation, the use of step therapy, prior authorization and 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) ***"Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.***

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

Sec. 52. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, ***and sections 46 and 47 of this act*** to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 53. Chapter 695A of NRS is hereby amended by adding thereto the provisions set forth as sections 54, 55 and 56 of this act.

Sec. 54. ***1. A society that offers or issues a benefit contract shall include in the contract coverage for:***

(a) All drugs approved by the United States Food and Drug Administration to:

(1) Provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(2) Support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. A society shall provide the coverage required by paragraph (a) of subsection 1 regardless of whether the drug is included in the formulary of the society.

3. A society shall not:

(a) Subject the benefits required by paragraph (a) of subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1; or

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

4. A society shall 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.

5. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the contract that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription drugs. The term includes, without limitation, the use of step therapy, prior authorization and 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) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.

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

Sec. 55. *1. A society that offers or issues a benefit contract shall include in the contract:*

(a) Coverage of testing for and the treatment and prevention of sexually transmitted diseases, including, without limitation, Chlamydia trachomatis, gonorrhea, syphilis, human immunodeficiency virus and hepatitis B and C, for all insureds, regardless of age. Such coverage must include, without limitation, the coverage required by NRS 695A.1843 and 695A.1856.

(b) Unrestricted coverage of condoms for insureds who are 13 years of age or older.

2. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the contract that conflicts with the provisions of this section is void.

Sec. 56. (Deleted by amendment.)

Sec. 57. NRS 695A.1843 is hereby amended to read as follows:

695A.1843 1. A society that offers or issues a benefit contract shall include in the benefit coverage for:

(a) ~~[~~Drugs~~]~~ ***All*** approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus ~~[~~;~~]~~ ***or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing practitioner, regardless of whether the drug is included in the formulary of the society;***

(b) Laboratory testing that is necessary for therapy that uses ~~[~~such~~]~~ a drug ~~[~~;~~]~~ ***to prevent the acquisition of human immunodeficiency virus;***

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

~~[~~(c)~~]~~ ***(d)*** The services described in NRS 639.28085, when provided by a pharmacist who participates in the network plan of the society.

2. A society that offers or issues a benefit contract shall reimburse ~~[~~a~~]~~ ***:***

(a) A pharmacist who participates in the network plan of the society for the services described in NRS 639.28085 at a rate equal

to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the society for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. A society ~~[may subject]~~ ***shall not:***

(a) Subject the benefits required by subsection 1 to ~~[reasonable]~~ medical management techniques ~~[.]~~ ***, other than step therapy;***

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the insured is diagnosed.

4. A society shall 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.

5. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~[October]~~ ***January*** 1, ~~[2021,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription drugs. The term includes, without limitation, the use of step therapy, prior authorization and 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) ***"Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.***

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

Sec. 58. Chapter 695B of NRS is hereby amended by adding thereto the provisions set forth as sections 59, 60 and 61 of this act.

Sec. 59. ***1. A hospital or medical services corporation that offers or issues a policy of health insurance shall include in the policy coverage for:***

(a) All drugs approved by the United States Food and Drug Administration to:

(1) Provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(2) Support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. A hospital or medical services corporation shall provide the coverage required by paragraph (a) of subsection 1 regardless of whether the drug is included in the formulary of the hospital or medical services corporation.

3. A hospital or medical services corporation shall not:

(a) Subject the benefits required by paragraph (a) of subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1; or

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

4. A hospital or medical services corporation shall 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 hospital or medical services corporation.

5. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

6. As used in this section:

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

(b) "Network plan" means a policy of health insurance offered by a hospital or medical services corporation 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 hospital or medical services corporation. The term does not include an arrangement for the financing of premiums.

(c) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.

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

Sec. 60. ***1. A hospital or medical services corporation that offers or issues a policy of health insurance shall include in the policy:***

(a) Coverage of testing for and the treatment and prevention of sexually transmitted diseases, including, without limitation, Chlamydia trachomatis, gonorrhea, syphilis, human immunodeficiency virus and hepatitis B and C, for all insureds, regardless of age. Such coverage must include, without limitation, the coverage required by NRS 695B.1913 and 695B.1924.

(b) Unrestricted coverage of condoms for insureds who are 13 years of age or older.

2. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

Sec. 61. (Deleted by amendment.)

Sec. 62. NRS 695B.1924 is hereby amended to read as follows:

695B.1924 1. A hospital or medical services corporation that offers or issues a policy of health insurance shall include in the policy coverage for:

(a) ~~[~~Drugs~~]~~ ***All drugs*** approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus ~~[~~;~~]~~ ***or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing***

practitioner, regardless of whether the drug is included in the formulary of the hospital or medical services organization;

(b) Laboratory testing that is necessary for therapy using ~~[such]~~ a drug ~~[.]~~ ***to prevent the acquisition of human immunodeficiency virus;***

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

~~[(c)]~~ ***(d)*** The services described in NRS 639.28085, when provided by a pharmacist who participates in the network plan of the hospital or medical services corporation.

2. A hospital or medical services corporation that offers or issues a policy of health insurance shall reimburse ~~[a]~~ ***:***

(a) A pharmacist who participates in the network plan of the hospital or medical services corporation for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the hospital or medical services corporation for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. A hospital or medical services corporation ~~[may subject]~~ ***shall not:***

(a) Subject the benefits required by subsection 1 to ~~[reasonable]~~ medical management techniques ~~[.]~~ ***, other than step therapy;***

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the insured is diagnosed.

4. A hospital or medical services corporation shall 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 hospital or medical services corporation.

5. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~[October]~~ ***January*** 1, ~~[2021,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy that conflicts with the provisions of this section is void.

6. As used in this section:

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

(b) "Network plan" means a policy of health insurance offered by a hospital or medical services corporation 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 hospital or medical services corporation. The term does not include an arrangement for the financing of premiums.

(c) ***"Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.***

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

Sec. 63. Chapter 695C of NRS is hereby amended by adding thereto the provisions set forth as sections 64, 65 and 66 of this act.

Sec. 64. ***1. A health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:***

(a) All drugs approved by the United States Food and Drug Administration to:

(1) Provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(2) Support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. A health maintenance organization shall provide the coverage required by paragraph (a) of subsection 1 regardless of whether the drug is included in the formulary of the health maintenance organization.

3. A health maintenance organization shall not:

(a) Subject the benefits required by paragraph (a) of subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1; or

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

4. A health maintenance organization shall 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.

5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription drugs. The term includes, without limitation, the use of step therapy, prior authorization and 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) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.

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

Sec. 65. ***1. A health maintenance organization that offers or issues a health care plan shall include in the plan:***

(a) Coverage of testing for and the treatment and prevention of sexually transmitted diseases, including, without limitation, Chlamydia trachomatis, gonorrhea, syphilis, human immunodeficiency virus and hepatitis B and C, for all enrollees, regardless of age. Such coverage must include, without limitation, the coverage required by NRS 695C.1737 and 695C.1743.

(b) Unrestricted coverage of condoms for enrollees who are 13 years of age or older.

2. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

Sec. 66. (Deleted by amendment.)

Sec. 67. NRS 695C.050 is hereby amended to read as follows:

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

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

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

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.1759, 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from

any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694 to 695C.1698, inclusive, 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333, 695C.17345, 695C.17347, 695C.1735, 695C.1737, 695C.1743, 695C.1745 and 695C.1757 ***and sections 64 and 65 of this act*** apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 68. NRS 695C.1743 is hereby amended to read as follows:

695C.1743 1. A health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:

(a) ~~[~~Drugs~~]~~ ***All drugs*** approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus ~~[;]~~ ***or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing practitioner, regardless of whether the drug is included in the formulary of the health maintenance organization;***

(b) Laboratory testing that is necessary for therapy that uses ~~[~~such~~]~~ a drug ~~[;]~~ ***to prevent the acquisition of human immunodeficiency virus;***

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

~~[~~(c)~~]~~ ***(d)*** The services described in NRS 639.28085, when provided by a pharmacist who participates in the network plan of the health maintenance organization.

2. A health maintenance organization that offers or issues a health care plan shall reimburse ~~[~~a~~]~~ ***:***

(a) A pharmacist who participates in the network plan of the health maintenance organization for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the health

maintenance organization for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. A health maintenance organization ~~[may subject]~~ ***shall not:***

(a) Subject the benefits required by subsection 1 to ~~[reasonable]~~ medical management techniques ~~[.]~~ ***, other than step therapy;***

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the enrollee is diagnosed.

4. A health maintenance organization shall 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.

5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~[October]~~ ***January*** 1, ~~[2021,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription drugs. The term includes, without limitation, the use of step therapy, prior authorization and 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) ***"Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.***

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

Sec. 69. NRS 695C.330 is hereby amended to read as follows:

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

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

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, ***and sections 64 and 65 of this act*** or 695C.207;

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

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

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

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

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

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

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

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

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

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

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees or creditors or to the general public;

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

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

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

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

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

Sec. 70. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 71, 72 and 73 of this act.

Sec. 71. ***1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:***

(a) All drugs approved by the United States Food and Drug Administration to:

(1) Provide medication-assisted treatment for opioid use disorder, including, without limitation, buprenorphine, methadone and naltrexone.

(2) Support safe withdrawal from substance use disorder, including, without limitation, lofexidine.

(b) Any service for the treatment of substance use disorder provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation.

2. A managed care organization shall provide the coverage required by paragraph (a) of subsection 1 regardless of whether the drug is included in the formulary of the managed care organization.

3. A managed care organization shall not:

(a) Subject the benefits required by paragraph (a) of subsection 1 to medical management techniques, other than step therapy;

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1; or

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service.

4. A managed care organization shall 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.

5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription drugs. The term includes, without limitation, the use of step therapy, prior authorization and 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) "Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.

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

Sec. 72. ***1. A managed care organization that offers or issues a health care plan shall include in the plan:***

(a) Coverage of testing for, treatment of and prevention of sexually transmitted diseases, including, without limitation, Chlamydia trachomatis, gonorrhea, syphilis, human immunodeficiency virus and hepatitis B and C, for all insureds, regardless of age. Such coverage must include, without limitation, the coverage required by NRS 695G.1705 and 695G.1714.

(b) Unrestricted coverage of condoms for insureds who are 13 years of age or older.

2. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

Sec. 73. (Deleted by amendment.)

Sec. 74. NRS 695G.1705 is hereby amended to read as follows:

695G.1705 1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:

(a) ~~[~~Drugs~~]~~ ***All drugs*** approved by the United States Food and Drug Administration for preventing the acquisition of human immunodeficiency virus ~~[:]~~ ***or treating human immunodeficiency virus or hepatitis C in the form recommended by the prescribing practitioner, regardless of whether the drug is included in the formulary of the managed care organization;***

(b) Laboratory testing that is necessary for therapy that uses ~~[~~such~~]~~ a drug ~~[:]~~ ***to prevent the acquisition of human immunodeficiency virus;***

(c) Any service to test for, prevent or treat human immunodeficiency virus or hepatitis C provided by a provider of primary care if the service is covered when provided by a specialist and:

(1) The service is within the scope of practice of the provider of primary care; or

(2) The provider of primary care is capable of providing the service safely and effectively in consultation with a specialist and the provider engages in such consultation; and

~~[~~(c)~~]~~ ***(d)*** The services described in NRS 639.28085, when provided by a pharmacist who participates in the network plan of the managed care organization.

2. A managed care organization that offers or issues a health care plan shall reimburse ~~[~~a~~]~~ ***:***

(a) A pharmacist who participates in the network plan of the managed care organization for the services described in NRS 639.28085 at a rate equal to the rate of reimbursement provided to a physician, physician assistant or advanced practice registered nurse for similar services.

(b) An advanced practice registered nurse or a physician assistant who participates in the network plan of the managed care organization for any service to test for, prevent or treat human immunodeficiency virus or hepatitis C at a rate equal to the rate of reimbursement provided to a physician for similar services.

3. A managed care organization ~~[may subject]~~ ***shall not:***

(a) Subject the benefits required by subsection 1 to ~~[reasonable]~~ medical management techniques ~~[.]~~ ***, other than step therapy;***

(b) Limit the covered amount of a drug described in paragraph (a) of subsection 1;

(c) Refuse to cover a drug described in paragraph (a) of subsection 1 because the drug is dispensed by a pharmacy through mail order service; or

(d) Prohibit or restrict access to any service or drug to treat human immunodeficiency virus or hepatitis C on the same day on which the insured is diagnosed.

4. A managed care organization shall 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.

5. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after ~~[October]~~ ***January*** 1, ~~[2021,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the plan that conflicts with the provisions of this section is void.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or use of health care services or prescription drugs. The term includes, without limitation, the use of step therapy, prior authorization and 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) ***"Primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.***

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

Sec. 75. 1. The first application that a physician, osteopathic physician or physician assistant licensed pursuant to chapter 630 or 633 of NRS or a nurse who provides or supervises the provision of emergency medical services in a hospital or primary care and who is licensed on January 1, 2024, submits to renew his or her license on or after that date must include, without limitation, proof that the applicant has completed at least 2 hours of training in the stigma, discrimination and unrecognized bias toward persons who have acquired or are at a high risk of acquiring human immunodeficiency virus, as required by NRS 630.253, 632.343 and 633.471, as amended by sections 28, 29 and 30 of this act, respectively, as applicable.

2. As used in this section, "primary care" means the practice of family medicine, pediatrics, internal medicine, obstetrics and gynecology and midwifery.

Sec. 76. The Legislature hereby finds and declares that:

1. In *Lapinski v. State*, 84 Nev. 611, 613 (1968), the Nevada Supreme Court held that "the power to define crimes and penalties lies exclusively in the legislature."

2. The Nevada Supreme Court has further held in *Tellis v. State*, 84 Nev. 587, 591 (1968), *Sparkman v. State*, 95 Nev. 76, 82 (1979) and *State v. Dist. Ct. (Pullin)*, 124 Nev. 564, 567-68 (2008), that the penalty for a crime is determined by the law in effect at the time the offender committed the crime and not the law in effect at the time the offender is sentenced unless the Legislature has expressed its clear intent that a statute ameliorating the penalty apply retroactively.

3. NRS 441A.118 states that "[t]he Legislature hereby finds and declares that the spread of communicable diseases is best addressed through public health measures rather than criminalization."

4. For those reasons, the Legislature is exercising its exclusive power to define the acts which subject a person to criminal penalties by:

(a) Retroactively applying the provisions of section 24 of chapter 491, Statutes of Nevada 2021, at page 3199, which repealed certain criminal offenses that were based on a person having the

human immunodeficiency virus, to apply to conduct that occurred before those offenses were repealed; and

(b) Making certain offenses which were punishable as category A felonies before the effective date of section 13 of this act based on the potential to spread a communicable disease instead punishable as category B felonies, category D felonies or gross misdemeanors.

Sec. 77. 1. The provisions of section 24 of chapter 491, Statutes of Nevada 2021, at page 3199, apply to any violation of NRS 201.205 or 201.358, as those sections existed before the enactment of section 24 of chapter 491, Statutes of Nevada 2021, at page 3199, if the violation occurred before, on or after June 6, 2021, and the person was convicted on or after the effective date of this section.

2. If, before June 6, 2021, a person committed a violation of a NRS 201.205 or 201.358, as those sections existed before the enactment of section 24 of chapter 491, Statutes of Nevada 2021, at page 3199, and the person was not charged for that violation before the effective date of this section, the person must not be charged for that violation.

3. Each court in this State shall cancel each outstanding bench warrant issued by the court for a person who failed to appear in court in relation to an alleged violation of NRS 201.205 or 201.358, as those sections existed before the enactment of section 24 of chapter 491, Statutes of Nevada 2021, at page 3199.

4. The Central Repository for Nevada Records of Criminal History shall remove from each database or compilation of records of criminal history maintained by the Central Repository all records of bench warrants issued for a person who failed to appear in court in relation to an alleged violation of NRS 201.205 or 201.358, as those sections existed before the enactment of section 24 of chapter 491, Statutes of Nevada 2021, at page 3199.

Sec. 78. 1. The provisions of NRS 212.189, as amended by section 13 of this act, apply to any violation of that section, that occurred before, on or after the effective date of that section, if the person was not convicted before the effective date of that section.

2. If a person commits a violation of a NRS 212.189 which is punishable as a category A felony before the effective date of section 13 of this act, and the violation is punishable as a category B felony, a category D felony or a gross misdemeanor pursuant to NRS 212.189, as amended by section 13 of this act, the person must not be charged with or convicted of a category A felony, if the violation occurs on or after the effective date of section 13 of this act, and may only be charged with and convicted of a category B

felony, category D felony or gross misdemeanor, as applicable, on or after the effective date of section 13 of this act.

Sec. 79. 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. 80. 1. This section and sections 3 to 10, inclusive, 13, 76, 77 and 78 of this act become effective upon passage and approval.

2. Sections 1, 2, 11, 12, 14 to 75, inclusive, and 79 of this act become effective:

(a) Upon passage and approval for the purpose 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, 2024, for all other purposes.

20 ~~~~~ 23