

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

MARCH 1, 2017

Referred to Committee on Health and Human Services

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

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

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

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

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

**Legislative Counsel’s Digest:**

1 Existing law requires most health insurance plans which cover prescription  
2 drugs and outpatient care to also include coverage for contraceptive drugs and  
3 devices without an additional copay, coinsurance or a higher deductible than that  
4 which may be charged for other prescription drugs and outpatient care under the  
5 plan. (NRS 689A.0415, 689A.0417, 689B.0376, 689B.0377, 695B.1916,  
6 695B.1918, 695C.1694, 695C.1695) Certain plans, including small employer plans,  
7 benefit contracts provided by fraternal benefit societies, plans issued by a managed  
8 care organization and certain plans offered by governmental entities of this State  
9 are not currently subject to these requirements. (Chapters 287, 689C, 695A and  
10 695G of NRS)

11 The federal Patient Protection and Affordable Care Act, Pub. L. 111-148, as  
12 amended, requires certain contraceptive drugs, devices and services to be covered



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13 by every health insurance plan without any copay, coinsurance or higher  
14 deductible. (42 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130) **Sections 3, 4 and 7-**  
15 **25** of this bill align Nevada law with federal law, requiring all public and private  
16 health insurance plans made available in this State to provide coverage for certain  
17 benefits relating to contraception without any copay, coinsurance or a higher  
18 deductible. **Sections 3, 4 and 7-25** require all forms of contraceptive drugs, devices  
19 and services which are approved by the Food and Drug Administration to be  
20 covered by a health insurance plan, including, without limitation, up to a 12-month  
21 supply of contraceptives or its therapeutic equivalent, insertion or removal of a  
22 contraceptive device, education and counseling relating to contraception,  
23 management of side effects relating to contraception and voluntary sterilization for  
24 women. **Sections 3, 4 and 7-25** allow an insurer to require an insured to pay a  
25 higher deductible, copayment or coinsurance for a drug or device for contraception  
26 if the insured refuses to accept a therapeutic equivalent of the contraceptive drug or  
27 device. In addition, a health insurance plan must include for each method of  
28 contraception which is approved by the Food and Drug Administration at least one  
29 contraceptive drug or device for which no deductible, copayment or coinsurance  
30 may be charged to the insured. **Sections 3, 4 and 7-25** authorize an insurer to  
31 require a program of step therapy or prior authorization to obtain coverage for the  
32 contraceptive drugs, devices and services required by this bill. **Sections 3, 4 and 7-**  
33 **25** also require a health insurance plan to provide coverage for certain therapeutic  
34 equivalent drugs and devices relating to contraception when a therapeutic  
35 equivalent covered by the plan is deemed to be medically inappropriate by a  
36 provider of health care. Additionally, **sections 7, 11, 14, 16, 17, 20 and 25** require  
37 that the benefits provided by a health insurance plan relating to contraception which  
38 are provided to the insured must also be provided to a covered dependent of an  
39 insured.

40 Existing law allows an insurer which is affiliated with a religious organization  
41 and which objects on religious grounds to providing coverage for contraceptive  
42 drugs and devices to exclude coverage in its policies, plans or contracts for such  
43 drugs and devices. (NRS 689A.0415, 689B.0376, 695B.1916, 695C.1694) **Sections**  
44 **7, 11, 14, 16, 17, 20 and 25** of this bill move the religious exemption coverage for  
45 the contraceptive drugs, devices and services required by this bill to the new  
46 provisions relating to coverage of contraception.

47 Existing law requires this State to develop a State Plan for Medicaid which  
48 includes, without limitation, a list of the medical services provided to Medicaid  
49 recipients. (42 U.S.C. § 1396a; NRS 422.063) Existing federal law authorizes a  
50 state to charge a copay, coinsurance or deductible for most Medicaid services, but  
51 prohibits any copay, coinsurance or deductible for certain contraceptive drugs,  
52 devices and services. (42 U.S.C. § 1396o-1) Existing federal law also authorizes a  
53 state to define the parameters of contraceptive coverage provided under Medicaid.  
54 (42 U.S.C. § 1396u-7) Existing Nevada law requires a number of specific medical  
55 services to be covered under Medicaid. (NRS 422.2717-422.27241) **Section 1** of  
56 this bill requires the State Plan for Medicaid to include certain benefits relating to  
57 contraception currently required to be covered by private health insurance plans  
58 pursuant to existing Nevada law and the Patient Protection and Affordable Care  
59 Act, Pub. L. 111-148, as amended, as well as the additional benefits related to  
60 contraception required by **sections 3, 4 and 7-25** of this bill without any copay,  
61 coinsurance or deductible in most cases. The benefits relating to contraceptive  
62 drugs which are provided by **section 1** of this bill are subject to step therapy and  
63 prior authorization requirements pursuant to existing law.

64 Existing law authorizes a pharmacist to dispense up to a 90-day supply of a  
65 drug pursuant to a valid prescription or order in certain circumstances. (NRS  
66 639.2396) **Section 4.5** of this bill requires a pharmacist to dispense up to a 12-  
67 month supply of contraceptives or a therapeutic equivalent pursuant to a valid



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68 prescription or order if: (1) the patient has previously received a 3-month supply of  
69 the same drug; (2) the patient has previously received a 9-month supply of the same  
70 drug or a supply of the same drug for the balance of the plan year in which the 3-  
71 month supply was prescribed or ordered, whichever is less; (3) the patient is  
72 insured by the same health insurance plan; and (4) a provider of health care has not  
73 specified in the prescription or order that a different supply of the drug is necessary.

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

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

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

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

9           (1) *Lawfully prescribed or ordered;*

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

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

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

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

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

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

20       (f) *Voluntary sterilization for women.*

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

26       3. *Except as otherwise provided in subsections 5 and 6, to*  
27 *obtain any benefit included in the Plan pursuant to subsection 1, a*  
28 *person enrolled in Medicaid must not be required to:*

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

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

32       4. *The Director shall ensure that the provisions of this section*  
33 *are carried out in a manner which complies with the requirements*  
34 *established by the Drug Use Review Board and set forth in the list*



1 *of preferred prescription drugs established by the Department*  
2 *pursuant to NRS 422.4025.*

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

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

14 *7. As used in this section, "therapeutic equivalent" means a*  
15 *drug which:*

16 *(a) Contains an identical amount of the same active*  
17 *ingredients in the same dosage and method of administration as*  
18 *another drug;*

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

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

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

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

26 422.401 As used in NRS 422.401 to 422.406, inclusive, *and*  
27 *section 1 of this act*, unless the context otherwise requires, the  
28 words and terms defined in NRS 422.4015 and 422.402 have the  
29 meanings ascribed to them in those sections.

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

31 287.010 1. The governing body of any county, school  
32 district, municipal corporation, political subdivision, public  
33 corporation or other local governmental agency of the State of  
34 Nevada may:

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

42 (b) Purchase group policies of life, accident or health insurance,  
43 or any combination thereof, for the benefit of such officers and  
44 employees, and the dependents of such officers and employees, as  
45 have authorized the purchase, from insurance companies authorized



1 to transact the business of such insurance in the State of Nevada,  
2 and, where necessary, deduct from the compensation of officers and  
3 employees the premiums upon insurance and pay the deductions  
4 upon the premiums.

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

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

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

40 3. In any county in which a legal services organization exists,  
41 the governing body of the county, or of any school district,  
42 municipal corporation, political subdivision, public corporation or  
43 other local governmental agency of the State of Nevada in the  
44 county, may enter into a contract with the legal services  
45 organization pursuant to which the officers and employees of the



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

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

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

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

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

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

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

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

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

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

29 287.04335 If the Board provides health insurance through a  
30 plan of self-insurance, it shall comply with the provisions of NRS  
31 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645,  
32 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177,  
33 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive,  
34 and 695G.405, *and section 25 of this act* in the same manner as an  
35 insurer that is licensed pursuant to title 57 of NRS is required to  
36 comply with those provisions.

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

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



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

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

8 (c) *For a refill in a plan year following the initial dispensing of*  
9 *a drug or therapeutic equivalent pursuant to paragraphs (a) and*  
10 *(b) of subsection 1, dispense up to a 12-month supply of the drug*  
11 *or therapeutic equivalent.*

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

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

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

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

25 4. *As used in this section:*

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

30 (b) *“Plan year” means the year in which an insured is covered*  
31 *by a health care plan.*

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

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

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

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

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

42 639.2396 1. Except as otherwise provided by subsection 2, a  
43 prescription which bears specific authorization to refill, given by the  
44 prescribing practitioner at the time he or she issued the original  
45 prescription, or a prescription which bears authorization permitting



1 the pharmacist to refill the prescription as needed by the patient,  
2 may be refilled for the number of times authorized or for the period  
3 authorized if it was refilled in accordance with the number of doses  
4 ordered and the directions for use.

5 2. ~~1A~~ *Except as otherwise provided in section 4.5 of this act,*  
6 *a* pharmacist may, in his or her professional judgment and pursuant  
7 to a valid prescription that specifies an initial amount of less than a  
8 90-day supply of a drug other than a controlled substance followed  
9 by periodic refills of the initial amount of the drug, dispense not  
10 more than a 90-day supply of the drug if:

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

14 (b) The total number of dosage units that are dispensed pursuant  
15 to the prescription does not exceed the total number of dosage units,  
16 including refills, that are authorized on the prescription by the  
17 prescribing practitioner; and

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

22 3. Nothing in this section shall be construed to alter the  
23 coverage provided under any contract or policy of health insurance,  
24 health plan or program or other agreement arrangement that  
25 provides health coverage.

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

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

29 1. *Except as otherwise provided in subsection 6, an insurer*  
30 *that offers or issues a policy of health insurance shall include in*  
31 *the policy coverage for:*

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

34 (1) *Lawfully prescribed or ordered;*

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

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

37 (b) *Any type of device for contraception or its therapeutic*  
38 *equivalent, which is lawfully prescribed or ordered and which has*  
39 *been approved by the Food and Drug Administration;*

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

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

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

45 (f) *Voluntary sterilization for women.*



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

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

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

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

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

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

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

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

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

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

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

43       7. *An insurer may require an insured to pay a higher*  
44 *deductible, copayment or coinsurance for a drug or device for*



1 *contraception if the insured refuses to accept a therapeutic*  
2 *equivalent of the contraceptive drug or device.*

3 8. *For each method of contraception which is approved by*  
4 *the Food and Drug Administration, a policy of health insurance*  
5 *must include at least one contraceptive drug or device for which*  
6 *no deductible, copayment or coinsurance may be charged to the*  
7 *insured, but the insurer may charge a deductible, copayment or*  
8 *coinsurance for any other contraceptive drug or device that*  
9 *provides the same method of contraception.*

10 9. *An insurer may require an insured to:*

11 (a) *Participate in a reasonable program of step therapy to*  
12 *obtain coverage for any benefit required by subsection 1.*

13 (b) *Obtain prior authorization before obtaining coverage for*  
14 *any benefit required by subsection 1 as part of a determination by*  
15 *the insurer that the benefit is medically necessary or appropriate*  
16 *for the insured.*

17 10. *As used in this section:*

18 (a) *“Provider of health care” has the meaning ascribed to it in*  
19 *NRS 629.031.*

20 (b) *“Therapeutic equivalent” means a drug which:*

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

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

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

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

30 689A.0415 1. ~~Except as otherwise provided in subsection 5,~~  
31 ~~an~~ **An** insurer that offers or issues a policy of health insurance  
32 which provides coverage for prescription drugs or devices shall  
33 include in the policy coverage for ~~f:~~

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

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

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

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

40 (a) Require an insured to pay a higher deductible, copayment or  
41 coinsurance or require a longer waiting period or other condition for  
42 coverage for a prescription for ~~fa-contraceptive-or~~ hormone  
43 replacement therapy than is required for other prescription drugs  
44 covered by the policy;



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

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

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

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

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

23 4. The provisions of this section do not:

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

25 (b) Prohibit an insurer from requiring an insured to pay a  
26 deductible, copayment or coinsurance for the coverage required by  
27 ~~paragraphs (a) and (b) of~~ subsection 1 that is the same as the  
28 insured is required to pay for other prescription drugs covered by the  
29 policy.

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

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

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

41 689A.0417 1. ~~Except as otherwise provided in subsection 5,~~  
42 ~~an~~ An insurer that offers or issues a policy of health insurance  
43 which provides coverage for outpatient care shall include in the  
44 policy coverage for any health care service related to ~~contraceptives~~  
45 ~~or~~ hormone replacement therapy.



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

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

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

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

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

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

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

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

35 5. ~~An insurer which offers or issues such a policy of health~~  
36 ~~insurance and which is affiliated with a religious organization is not~~  
37 ~~required to provide the coverage for health care service related to~~  
38 ~~contraceptives required by this section if the insurer objects on~~  
39 ~~religious grounds. Such an insurer shall, before the issuance of a~~  
40 ~~policy of health insurance and before the renewal of such a policy,~~  
41 ~~provide to the prospective insured written notice of the coverage~~  
42 ~~that the insurer refuses to provide pursuant to this subsection.~~

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



1     **Sec. 10.** NRS 689A.330 is hereby amended to read as follows:  
2     689A.330 If any policy is issued by a domestic insurer for  
3 delivery to a person residing in another state, and if the insurance  
4 commissioner or corresponding public officer of that other state has  
5 informed the Commissioner that the policy is not subject to approval  
6 or disapproval by that officer, the Commissioner may by ruling  
7 require that the policy meet the standards set forth in NRS 689A.030  
8 to 689A.320, inclusive **H**, and *section 7 of this act*.

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

11     1. *Except as otherwise provided in subsection 6, an insurer*  
12 *that offers or issues a policy of group health insurance shall*  
13 *include in the policy coverage for:*

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

16         (1) *Lawfully prescribed or ordered;*

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

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

19     (b) *Any type of device for contraception or its therapeutic*  
20 *equivalent, which is lawfully prescribed or ordered and which has*  
21 *been approved by the Food and Drug Administration;*

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

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

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

27     (f) *Voluntary sterilization for women.*

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

33     3. *Except as otherwise provided in subsections 8, 9 and 10, an*  
34 *insurer that offers or issues a policy of group health insurance*  
35 *shall not:*

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

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



\* A B 2 4 9 R 1 \*

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

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

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

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

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

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

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

30 7. If an insurer refuses, pursuant to subsection 6, to provide  
31 the coverage required by subsection 1, an employer may otherwise  
32 provide for the coverage for the employees of the employer.

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

37 9. For each method of contraception which is approved by  
38 the Food and Drug Administration, a policy of group health  
39 insurance must include at least one contraceptive drug or device  
40 for which no deductible, copayment or coinsurance may be  
41 charged to the insured, but the insurer may charge a deductible,  
42 copayment or coinsurance for any other contraceptive drug or  
43 device that provides the same method of contraception.

44 10. An insurer may require an insured to:



1 (a) *Participate in a reasonable program of step therapy to*  
2 *obtain coverage for any benefit required by subsection 1.*

3 (b) *Obtain prior authorization before obtaining coverage for*  
4 *any benefit required by subsection 1 as part of a determination by*  
5 *the insurer that the benefit is medically necessary or appropriate*  
6 *for the insured.*

7 *11. As used in this section:*

8 (a) *“Provider of health care” has the meaning ascribed to it in*  
9 *NRS 629.031.*

10 (b) *“Therapeutic equivalent” means a drug which:*

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

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

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

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

21 689B.0376 1. ~~Except as otherwise provided in subsection 5,~~  
22 ~~an~~ *An* insurer that offers or issues a policy of group health  
23 insurance which provides coverage for prescription drugs or devices  
24 shall include in the policy coverage for ~~;~~

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

26 ~~—(b) Any~~ *any* type of hormone replacement therapy ~~;~~

27 ~~↪~~ which is lawfully prescribed or ordered and which has been  
28 approved by the Food and Drug Administration.

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

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

36 (b) Refuse to issue a policy of group health insurance or cancel a  
37 policy of group health insurance solely because the person applying  
38 for or covered by the policy uses or may use in the future ~~any of the~~  
39 ~~services listed in subsection 1;~~ *hormone replacement therapy;*

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

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



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

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

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

13 4. The provisions of this section do not:

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

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

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

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

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

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

40 689B.0377 1. ~~Except as otherwise provided in subsection 5,~~  
41 **an** An insurer that offers or issues a policy of group health  
42 insurance which provides coverage for outpatient care shall include  
43 in the policy coverage for any health care service related to  
44 ~~contraceptives or~~ hormone replacement therapy.



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

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

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

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

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

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

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

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

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



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

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

~~7 —7.1~~ As used in this section, “provider of health care” has the  
8 meaning ascribed to it in NRS 629.031.

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

11 *1. Except as otherwise provided in subsection 6, a carrier that  
12 offers or issues a health benefit plan shall include in the plan  
13 coverage for:*

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

16 *(1) Lawfully prescribed or ordered;*

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

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

19 *(b) Any type of device for contraception or its therapeutic  
20 equivalent which is lawfully prescribed or ordered and which has  
21 been approved by the Food and Drug Administration;*

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

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

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

27 *(f) Voluntary sterilization for women.*

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

33 *3. Except as otherwise provided in subsections 7, 8 and 9, a  
34 carrier that offers or issues a health benefit plan shall not:*

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

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

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



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

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

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

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

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

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

25      7. A carrier may require an insured to pay a higher  
26 deductible, copayment or coinsurance for a drug or device for  
27 contraception if the insured refuses to accept a therapeutic  
28 equivalent of the contraceptive drug or device.

29      8. For each method of contraception which is approved by  
30 the Food and Drug Administration, a health benefit plan must  
31 include at least one contraceptive drug or device for which no  
32 deductible, copayment or coinsurance may be charged to the  
33 insured, but the carrier may charge a deductible, copayment or  
34 coinsurance for any other contraceptive drug or device that  
35 provides the same method of contraception.

36      9. A carrier may require an insured to:

37       (a) Participate in a reasonable program of step therapy to  
38 obtain coverage for any benefit required by subsection 1.

39       (b) Obtain prior authorization before obtaining coverage for  
40 any benefit required by subsection 1 as part of a determination by  
41 the carrier that the benefit is medically necessary or appropriate  
42 for the insured.

43      10. As used in this section:

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



1 (b) *“Therapeutic equivalent” means a drug which:*

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

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

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

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

11 689C.425 A voluntary purchasing group and any contract  
12 issued to such a group pursuant to NRS 689C.360 to 689C.600,  
13 inclusive, are subject to the provisions of NRS 689C.015 to  
14 689C.355, inclusive, *and section 14 of this act*, to the extent  
15 applicable and not in conflict with the express provisions of NRS  
16 687B.408 and 689C.360 to 689C.600, inclusive.

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

19 *1. Except as otherwise provided in subsection 6, a society that*  
20 *offers or issues a benefit contract which provides coverage for*  
21 *prescription drugs or devices shall include in the contract*  
22 *coverage for:*

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

25 (1) *Lawfully prescribed or ordered;*

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

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

28 (b) *Any type of device for contraception or its therapeutic*  
29 *equivalent which is lawfully prescribed or ordered and which has*  
30 *been approved by the Food and Drug Administration;*

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

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

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

36 (f) *Voluntary sterilization for women.*

37 *2. If a covered therapeutic equivalent listed in subsection 1 is*  
38 *not available or a provider of health care deems a covered*  
39 *therapeutic equivalent to be medically inappropriate, an alternate*  
40 *therapeutic equivalent prescribed by a provider of health care*  
41 *must be covered by the society.*

42 *3. Except as otherwise provided in subsections 7, 8 and 9, a*  
43 *society that offers or issues a benefit contract shall not:*

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



1 *other condition for coverage for any benefit included in the benefit*  
2 *contract pursuant to subsection 1;*

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

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

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

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

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

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

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

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

33 *7. A society may require an insured to pay a higher*  
34 *deductible, copayment or coinsurance for a drug or device for*  
35 *contraception if the insured refuses to accept a therapeutic*  
36 *equivalent of the contraceptive drug or device.*

37 *8. For each method of contraception which is approved by*  
38 *the Food and Drug Administration, a benefit contract must*  
39 *include at least one contraceptive drug or device for which no*  
40 *deductible, copayment or coinsurance may be charged to the*  
41 *insured, but the society may charge a deductible, copayment or*  
42 *coinsurance for any other contraceptive drug or device that*  
43 *provides the same method of contraception.*

44 *9. A society may require an insured to:*



1 (a) *Participate in a reasonable program of step therapy to*  
2 *obtain coverage for any benefit required by subsection 1.*

3 (b) *Obtain prior authorization before obtaining coverage for*  
4 *any benefit required by subsection 1 as part of a determination by*  
5 *the society that the benefit is medically necessary or appropriate*  
6 *for the insured.*

7 10. *As used in this section:*

8 (a) *“Provider of health care” has the meaning ascribed to it in*  
9 *NRS 629.031.*

10 (b) *“Therapeutic equivalent” means a drug which:*

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

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

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

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

21 1. *Except as otherwise provided in subsection 6, an insurer*  
22 *that offers or issues a contract for hospital or medical service shall*  
23 *include in the contract coverage for:*

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

26 (1) *Lawfully prescribed or ordered;*

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

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

29 (b) *Any type of device for contraception or its therapeutic*  
30 *equivalent which is lawfully prescribed or ordered and which has*  
31 *been approved by the Food and Drug Administration;*

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

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

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

37 (f) *Voluntary sterilization for women.*

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

43 3. *Except as otherwise provided in subsections 8, 9 and 10, an*  
44 *insurer that offers or issues a contract for hospital or medical*  
45 *service shall not:*



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

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

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

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

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

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

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

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

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

37 7. If an insurer refuses, pursuant to subsection 6, to provide  
38 the coverage required by subsection 1, an employer may otherwise  
39 provide for the coverage for the employees of the employer.

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

44 9. For each method of contraception which is approved by  
45 the Food and Drug Administration, a contract for hospital or



\* A B 2 4 9 R 1 \*

1 *medical service must include at least one contraceptive drug or*  
2 *device for which no deductible, copayment or coinsurance may be*  
3 *charged to the insured, but the insurer may charge a deductible,*  
4 *copayment or coinsurance for any other contraceptive drug or*  
5 *device that provides the same method of contraception.*

6 *10. An insurer may require an insured to:*

7 *(a) Participate in a reasonable program of step therapy to*  
8 *obtain coverage for any benefit required by subsection 1.*

9 *(b) Obtain prior authorization before obtaining coverage for*  
10 *any benefit required by subsection 1 as part of a determination by*  
11 *the insurer that the benefit is medically necessary or appropriate*  
12 *for the insured.*

13 *11. As used in this section:*

14 *(a) "Provider of health care" has the meaning ascribed to it in*  
15 *NRS 629.031.*

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

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

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

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

25 **Sec. 18.** NRS 695B.1916 is hereby amended to read as  
26 follows:

27 695B.1916 1. ~~Except as otherwise provided in subsection 5,~~  
28 ~~an~~ **An** insurer that offers or issues a contract for hospital or medical  
29 service which provides coverage for prescription drugs or devices  
30 shall include in the contract coverage for ~~†~~

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

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

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

35 2. An insurer that offers or issues a contract for hospital or  
36 medical service that provides coverage for prescription drugs shall  
37 not:

38 (a) Require an insured to pay a higher deductible, copayment or  
39 coinsurance or require a longer waiting period or other condition for  
40 coverage for a prescription for ~~†a contraceptive or†~~ hormone  
41 replacement therapy than is required for other prescription drugs  
42 covered by the contract;

43 (b) Refuse to issue a contract for hospital or medical service or  
44 cancel a contract for hospital or medical service solely because the  
45 person applying for or covered by the contract uses or may use in



1 the future ~~{any of the services listed in subsection 1;}~~ *hormone*  
2 *replacement therapy*;

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

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

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

15 3. ~~{Except as otherwise provided in subsection 5, a}~~ A contract  
16 subject to the provisions of this chapter that is delivered, issued for  
17 delivery or renewed on or after October 1, 1999, has the legal effect  
18 of including the coverage required by subsection 1, and any  
19 provision of the contract or the renewal which is in conflict with this  
20 section is void.

21 4. The provisions of this section do not:

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

23 (b) Prohibit an insurer from requiring an insured to pay a  
24 deductible, copayment or coinsurance for the coverage required by  
25 ~~{paragraphs (a) and (b) of}~~ subsection 1 that is the same as the  
26 insured is required to pay for other prescription drugs covered by the  
27 contract.

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

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

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



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

3       695B.1918 1. ~~{Except as otherwise provided in subsection 5,~~  
4 ~~an}~~ **An** insurer that offers or issues a contract for hospital or medical  
5 service which provides coverage for outpatient care shall include in  
6 the contract coverage for any health care service related to  
7 ~~{contraceptives or}~~ hormone replacement therapy.

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

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

15       (b) Refuse to issue a contract for hospital or medical service or  
16 cancel a contract for hospital or medical service solely because the  
17 person applying for or covered by the contract uses or may use in  
18 the future ~~{any of the services listed in subsection 1;}~~ **hormone**  
19 **replacement therapy;**

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

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

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

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

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

43       5. ~~{An insurer which offers or issues a contract for hospital or~~  
44 ~~medical service and which is affiliated with a religious organization~~  
45 ~~is not required to provide the coverage for health care service related~~



~~1 to contraceptives required by this section if the insurer objects on  
2 religious grounds. Such an insurer shall, before the issuance of a  
3 contract for hospital or medical service and before the renewal of  
4 such a contract, provide to the group policyholder or prospective  
5 insured, as applicable, written notice of the coverage that the insurer  
6 refuses to provide pursuant to this subsection. The insurer shall  
7 provide notice to each insured, at the time the insured receives his or  
8 her certificate of coverage or evidence of coverage, that the insurer  
9 refused to provide coverage pursuant to this subsection.~~

~~10 —6.— If an insurer refuses, pursuant to subsection 5, to provide the  
11 coverage required by paragraph (a) of subsection 1, an employer  
12 may otherwise provide for the coverage for the employees of the  
13 employer.~~

~~14 —7.—~~ As used in this section, “provider of health care” has the  
15 meaning ascribed to it in NRS 629.031.

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

18 *1. Except as otherwise provided in subsection 6, a health  
19 maintenance organization that offers or issues a health care plan  
20 shall include in the plan coverage for:*

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

23 *(1) Lawfully prescribed or ordered;*

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

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

26 *(b) Any type of device for contraception or its therapeutic  
27 equivalent which is lawfully prescribed or ordered and which has  
28 been approved by the Food and Drug Administration;*

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

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

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

34 *(f) Voluntary sterilization for women.*

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

40 *3. Except as otherwise provided in subsections 8, 9 and 10, a  
41 health maintenance organization that offers or issues a health  
42 care plan shall not:*

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



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

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

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

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

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

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

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

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

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

35 *7. If a health maintenance organization, pursuant to*  
36 *subsection 6, refuses to provide the coverage required by*  
37 *subsection 1, an employer may otherwise provide for the coverage*  
38 *for the employees of the employer.*

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

43 *9. For each method of contraception which is approved by*  
44 *the Food and Drug Administration, a health care plan must*  
45 *include at least one contraceptive drug or device for which no*



1 *deductible, copayment or coinsurance may be charged to the*  
2 *enrollee, but the health maintenance organization may charge a*  
3 *deductible, copayment or coinsurance for any other contraceptive*  
4 *drug or device that provides the same method of contraception.*

5 *10. A health maintenance organization may require an*  
6 *enrollee to:*

7 *(a) Participate in a reasonable program of step therapy to*  
8 *obtain coverage for any benefit required by subsection 1.*

9 *(b) Obtain prior authorization before obtaining coverage for*  
10 *any benefit required by subsection 1 as part of a determination by*  
11 *the health maintenance organization that the benefit is medically*  
12 *necessary or appropriate for the enrollee.*

13 *11. As used in this section:*

14 *(a) "Provider of health care" has the meaning ascribed to it in*  
15 *NRS 629.031.*

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

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

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

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

25 **Sec. 21.** NRS 695C.050 is hereby amended to read as follows:

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

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

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

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



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

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

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

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

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

20 ~~(b) Any~~ *any* type of hormone replacement therapy ~~the~~

21 ~~which~~ which is lawfully prescribed or ordered and which has been  
22 approved by the Food and Drug Administration.

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

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

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

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

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

43 (e) Offer or pay any type of material inducement, bonus or other  
44 financial incentive to a provider of health care to deny, reduce,



1 withhold, limit or delay ~~any of the services listed in subsection 1~~  
2 *hormone replacement therapy* to an enrollee.

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

9 4. The provisions of this section do not:

10 (a) Require a health maintenance organization to provide  
11 coverage for fertility drugs.

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

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

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

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

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

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

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



- 1 (a) Require an enrollee to pay a higher deductible, copayment or  
2 coinsurance or require a longer waiting period or other condition for  
3 coverage for outpatient care related to ~~contraceptives or~~ hormone  
4 replacement therapy than is required for other outpatient care  
5 covered by the plan;
- 6 (b) Refuse to issue a health care plan or cancel a health care plan  
7 solely because the person applying for or covered by the plan uses  
8 or may use in the future ~~any of the services listed in subsection 1;~~  
9 *hormone replacement therapy;*
- 10 (c) Offer or pay any type of material inducement or financial  
11 incentive to an enrollee to discourage the enrollee from accessing  
12 ~~any of the services listed in subsection 1;~~ *hormone replacement*  
13 *therapy;*
- 14 (d) Penalize a provider of health care who provides ~~any of the~~  
15 ~~services listed in subsection 1;~~ *hormone replacement therapy* to an  
16 enrollee, including, without limitation, reducing the reimbursement  
17 of the provider of health care; or
- 18 (e) Offer or pay any type of material inducement, bonus or other  
19 financial incentive to a provider of health care to deny, reduce,  
20 withhold, limit or delay ~~any of the services listed in subsection 1;~~  
21 *hormone replacement therapy* to an enrollee.
- 22 3. ~~Except as otherwise provided in subsection 5, evidence~~  
23 *Evidence* of coverage subject to the provisions of this chapter that is  
24 delivered, issued for delivery or renewed on or after October 1,  
25 1999, has the legal effect of including the coverage required by  
26 subsection 1, and any provision of the evidence of coverage or the  
27 renewal which is in conflict with this section is void.
- 28 4. The provisions of this section do not prohibit a health  
29 maintenance organization from requiring an enrollee to pay a  
30 deductible, copayment or coinsurance for the coverage required by  
31 subsection 1 that is the same as the enrollee is required to pay for  
32 other outpatient care covered by the plan.
- 33 5. ~~A health maintenance organization which offers or issues a~~  
34 ~~health care plan and which is affiliated with a religious organization~~  
35 ~~is not required to provide the coverage for health care service related~~  
36 ~~to contraceptives required by this section if the health maintenance~~  
37 ~~organization objects on religious grounds. The health maintenance~~  
38 ~~organization shall, before the issuance of a health care plan and~~  
39 ~~before renewal of enrollment in such a plan, provide to the group~~  
40 ~~policyholder or prospective enrollee, as applicable, written notice of~~  
41 ~~the coverage that the health maintenance organization refuses to~~  
42 ~~provide pursuant to this subsection. The health maintenance~~  
43 ~~organization shall provide notice to each enrollee, at the time the~~  
44 ~~enrollee receives his or her evidence of coverage, that the health~~



~~1 maintenance organization refused to provide coverage pursuant to  
2 this subsection.~~

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

~~7 —7.1~~ As used in this section, “provider of health care” has the  
8 meaning ascribed to it in NRS 629.031.

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

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

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

20 (b) The health maintenance organization issues evidence of  
21 coverage or uses a schedule of charges for health care services  
22 which do not comply with the requirements of NRS 695C.1691 to  
23 695C.200, inclusive, *and section 20 of this act* or 695C.207;

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

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

28 (1) Does not meet the requirements of subsection 1 of NRS  
29 695C.080; or

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

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

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

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

41 (1) Resolving complaints in a manner reasonably to dispose  
42 of valid complaints; and  
43



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

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

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

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

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

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

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

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

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

33 ***1. Except as otherwise provided in subsection 6, a managed***  
34 ***care organization that offers or issues a health care plan shall***  
35 ***include in the plan coverage for:***

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

38 ***(1) Lawfully prescribed or ordered;***

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

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

41 ***(b) Any type of device for contraception or its therapeutic***  
42 ***equivalent which is lawfully prescribed or ordered and which has***  
43 ***been approved by the Food and Drug Administration;***

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



1 (d) Education and counseling relating to the initiation of the  
2 use of contraceptives and any necessary follow-up after initiating  
3 such use;

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

5 (f) Voluntary sterilization for women.

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

11 3. Except as otherwise provided in subsections 7, 8 and 9, a  
12 managed care organization that offers or issues a health care plan  
13 shall not:

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

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

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

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

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

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

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

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

41 6. A managed care organization that offers or issues a health  
42 care plan and which is affiliated with a religious organization is  
43 not required to provide the coverage required by subsection 1 if  
44 the managed care organization objects on religious grounds. Such  
45 an organization shall, before the issuance of a health care plan



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

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

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

15 *9. A managed care organization may require an insured to:*

16 *(a) Participate in a reasonable program of step therapy to*  
17 *obtain coverage for any benefit required by subsection 1.*

18 *(b) Obtain prior authorization before obtaining coverage for*  
19 *any benefit required by subsection 1 as part of a determination by*  
20 *the managed care organization that the benefit is medically*  
21 *necessary or appropriate for the insured.*

22 *10. As used in this section:*

23 *(a) "Provider of health care" has the meaning ascribed to it in*  
24 *NRS 629.031.*

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

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

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

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

34 **Sec. 26.** The provisions of NRS 354.599 do not apply to any  
35 additional expenses of a local government that are related to the  
36 provisions of this act.

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

