

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

JOINT SPONSORS: SENATORS FORD, RATTI AND CANCELA

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



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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
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 certain contraceptive drugs, devices and
19 services which are approved by the Food and Drug Administration to be covered by
20 a health insurance plan, including, without limitation, up to a 12-month supply of a
21 drug for contraception or its therapeutic equivalent, insertion of a device for
22 contraception, removal of such a device that was inserted while the insured was
23 covered by the same policy of health insurance, education and counseling relating
24 to contraception, management of side effects relating to contraception and
25 voluntary sterilization for women. **Sections 3, 4 and 7-25** allow an insurer to
26 require an insured to pay a higher deductible, copayment or coinsurance for a drug
27 for contraception if the insured refuses to accept a therapeutic equivalent of the
28 drug. In addition, a health insurance plan must include for each method of
29 contraception which is approved by the Food and Drug Administration and for
30 which the insurer is required to provide coverage at least one contraceptive drug or
31 device for which no deductible, copayment or coinsurance may be charged to the
32 insured. **Sections 3, 4 and 7-25** authorize an insurer to use medical management
33 techniques to determine the frequency of treatment using the contraceptive drugs,
34 devices and services required by this bill. **Sections 3, 4 and 7-25** prohibit an insurer
35 from using medical management techniques to require an insured to use a method
36 of contraception other than that prescribed by a provider of health care. **Sections 3,**
37 **4 and 7-25** additionally require an insurer to provide a process by which an insured
38 may request an exemption from a medical management technique required by an
39 insurer. **Sections 3, 4 and 7-25** also require a health insurance plan to provide
40 coverage for certain therapeutic equivalent drugs relating to contraception when a
41 therapeutic equivalent covered by the plan is deemed to be medically inappropriate
42 by a provider of health care. Additionally, **sections 7, 11, 14, 16, 17, 20 and 25**
43 require that the benefits provided by a health insurance plan relating to
44 contraception which are provided to the insured must also be provided to a covered
45 dependent of an insured.

46 Existing law allows an insurer which is affiliated with a religious organization
47 and which objects on religious grounds to providing coverage for contraceptive
48 drugs and devices to exclude coverage in its policies, plans or contracts for such
49 drugs and devices. (NRS 689A.0415, 689B.0376, 695B.1916, 695C.1694) **Sections**
50 **7, 11, 14, 16, 17, 20 and 25** of this bill move the religious exemption coverage for
51 the contraceptive drugs, devices and services required by this bill to the new
52 provisions relating to coverage of contraception.

53 Existing law requires this State to develop a State Plan for Medicaid which
54 includes, without limitation, a list of the medical services provided to Medicaid
55 recipients. (42 U.S.C. § 1396a; NRS 422.063) Existing federal law authorizes a
56 state to charge a copay, coinsurance or deductible for most Medicaid services, but
57 prohibits any copay, coinsurance or deductible for certain contraceptive drugs,
58 devices and services. (42 U.S.C. § 1396o-1) Existing federal law also authorizes a
59 state to define the parameters of contraceptive coverage provided under Medicaid.
60 (42 U.S.C. § 1396u-7) Existing Nevada law requires a number of specific medical
61 services to be covered under Medicaid. (NRS 422.2717-422.27241) **Section 1** of
62 this bill requires the State Plan for Medicaid to include certain benefits relating to
63 contraception currently required to be covered by private health insurance plans



64 pursuant to existing Nevada law and the Patient Protection and Affordable Care
65 Act, Pub. L. 111-148, as amended, as well as certain additional benefits related to
66 contraception required by **sections 3, 4 and 7-25** of this bill without any copay,
67 coinsurance or deductible in most cases. The benefits relating to drugs for
68 contraception which are provided by **section 1** of this bill are subject to step
69 therapy and prior authorization requirements pursuant to existing law.

70 Existing law authorizes a pharmacist to dispense up to a 90-day supply of a
71 drug pursuant to a valid prescription or order in certain circumstances. (NRS
72 639.2396) **Section 4.5** of this bill requires a pharmacist to dispense up to a 12-
73 month supply of drugs for contraception or a therapeutic equivalent thereof
74 pursuant to a valid prescription or order if: (1) the patient has previously received a
75 3-month supply of the same drug; (2) the patient has previously received a 9-month
76 supply of the same drug or a supply of the same drug for the balance of the plan
77 year in which the 3-month supply was prescribed or ordered, whichever is less; (3)
78 the patient is insured by the same health insurance plan; and (4) a provider of health
79 care has not specified in the prescription or order that a different supply of the drug
80 is necessary.

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 which is lawfully*
13 *prescribed or ordered and which has been approved by the Food*
14 *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 contraception 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. Except as otherwise provided in subsections 4 and 5, to*
22 *obtain any benefit included in the Plan pursuant to subsection 1, a*
23 *person enrolled in Medicaid must not be required to:*

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

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



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

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

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

17 **6. As used in this section, "therapeutic equivalent" means a**
18 **drug which:**

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

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

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

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

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

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

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

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

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



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

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

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

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

42 3. In any county in which a legal services organization exists,
43 the governing body of the county, or of any school district,
44 municipal corporation, political subdivision, public corporation or
45 other local governmental agency of the State of Nevada in the



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

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

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

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

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

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

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

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

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

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

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

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

41 *1. Except as otherwise provided in subsections 2 and 3,*
42 *pursuant to a valid prescription or order for a drug to be used for*
43 *contraception or its therapeutic equivalent which has been*
44 *approved by the Food and Drug Administration a pharmacist*
45 *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 therapeutic equivalent, or any amount which covers the*
7 *remainder of the plan year if the patient is covered by a health*
8 *care plan, whichever is less.*

9 (c) *For a refill in a plan year following the initial dispensing of*
10 *a drug or therapeutic equivalent pursuant to paragraphs (a) and*
11 *(b), dispense up to a 12-month supply of the drug or therapeutic*
12 *equivalent or any amount which covers the remainder of the plan*
13 *year if the patient is covered by a health care plan, whichever is*
14 *less.*

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

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

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

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

28 4. *As used in this section:*

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

33 (b) *“Plan year” means the year designated in the evidence of*
34 *coverage of a health care plan in which a person is covered by*
35 *such plan.*

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

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

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

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



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

2 639.2396 1. Except as otherwise provided by subsection 2, a
3 prescription which bears specific authorization to refill, given by the
4 prescribing practitioner at the time he or she issued the original
5 prescription, or a prescription which bears authorization permitting
6 the pharmacist to refill the prescription as needed by the patient,
7 may be refilled for the number of times authorized or for the period
8 authorized if it was refilled in accordance with the number of doses
9 ordered and the directions for use.

10 2. ~~1A~~ *Except as otherwise provided in section 4.5 of this act,*
11 *a pharmacist may, in his or her professional judgment and pursuant to*
12 *a valid prescription that specifies an initial amount of less than a*
13 *90-day supply of a drug other than a controlled substance followed*
14 *by periodic refills of the initial amount of the drug, dispense not*
15 *more than a 90-day supply of the drug if:*

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

19 (b) The total number of dosage units that are dispensed pursuant
20 to the prescription does not exceed the total number of dosage units,
21 including refills, that are authorized on the prescription by the
22 prescribing practitioner; and

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

27 3. Nothing in this section shall be construed to alter the
28 coverage provided under any contract or policy of health insurance,
29 health plan or program or other agreement arrangement that
30 provides health coverage.

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

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

34 1. *Except as otherwise provided in subsection 7, an insurer*
35 *that offers or issues a policy of health insurance shall include in*
36 *the policy coverage for:*

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

39 (1) *Lawfully prescribed or ordered;*

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

41 (3) *Listed in subsection 10; and*

42 (4) *Dispensed in accordance with section 4.5 of this act;*

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

44 (1) *Lawfully prescribed or ordered;*

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



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- 1 ***(3) Listed in subsection 10;***
2 ***(c) Insertion of a device for contraception or removal of such a***
3 ***device if the device was inserted while the insured was covered by***
4 ***the same policy of health insurance;***
5 ***(d) Education and counseling relating to the initiation of the***
6 ***use of contraception and any necessary follow-up after initiating***
7 ***such use;***
8 ***(e) Management of side effects relating to contraception; and***
9 ***(f) Voluntary sterilization for women.***
10 ***2. An insurer must ensure that the benefits required by***
11 ***subsection 1 are made available to an insured through a provider***
12 ***of health care who participates in the network plan of the insurer.***
13 ***3. If a covered therapeutic equivalent listed in subsection 1 is***
14 ***not available or a provider of health care deems a covered***
15 ***therapeutic equivalent to be medically inappropriate, an alternate***
16 ***therapeutic equivalent prescribed by a provider of health care***
17 ***must be covered by the insurer.***
18 ***4. Except as otherwise provided in subsections 8, 9 and 11, an***
19 ***insurer that offers or issues a policy of health insurance shall not:***
20 ***(a) Require an insured to pay a higher deductible, any***
21 ***copayment or coinsurance or require a longer waiting period or***
22 ***other condition for coverage to obtain any benefit included in the***
23 ***policy pursuant to subsection 1;***
24 ***(b) Refuse to issue a policy of health insurance or cancel a***
25 ***policy of health insurance solely because the person applying for***
26 ***or covered by the policy uses or may use any such benefit;***
27 ***(c) Offer or pay any type of material inducement or financial***
28 ***incentive to an insured to discourage the insured from obtaining***
29 ***any such benefit;***
30 ***(d) Penalize a provider of health care who provides any such***
31 ***benefit to an insured, including, without limitation, reducing the***
32 ***reimbursement of the provider of health care;***
33 ***(e) Offer or pay any type of material inducement, bonus or***
34 ***other financial incentive to a provider of health care to deny,***
35 ***reduce, withhold, limit or delay access to any such benefit to an***
36 ***insured; or***
37 ***(f) Impose any other restrictions or delays on the access of an***
38 ***insured any such benefit.***
39 ***5. Coverage pursuant to this section for the covered***
40 ***dependent of an insured must be the same as for the insured.***
41 ***6. Except as otherwise provided in subsection 7, a policy***
42 ***subject to the provisions of this chapter that is delivered, issued for***
43 ***delivery or renewed on or after January 1, 2018, has the legal***
44 ***effect of including the coverage required by subsection 1, and any***



1 *provision of the policy or the renewal which is in conflict with this*
2 *section is void.*

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

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

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

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

25 *(a) Voluntary sterilization for women;*

26 *(b) Surgical sterilization implants for women;*

27 *(c) Implantable rods;*

28 *(d) Copper-based intrauterine devices;*

29 *(e) Progesterone-based intrauterine devices;*

30 *(f) Injections;*

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

32 *(h) Progestin-based drugs;*

33 *(i) Extended- or continuous-regimen drugs;*

34 *(j) Estrogen- and progestin-based patches;*

35 *(k) Vaginal contraceptive rings;*

36 *(l) Diaphragms with spermicide;*

37 *(m) Sponges with spermicide;*

38 *(n) Cervical caps with spermicide;*

39 *(o) Female condoms;*

40 *(p) Spermicide;*

41 *(q) Combined estrogen- and progestin-based drugs for*
42 *emergency contraception or progestin-based drugs for emergency*
43 *contraception; and*

44 *(r) Ulipristal acetate for emergency contraception.*



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

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

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

17 *14. As used in this section:*

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

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

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

31 *(d) "Therapeutic equivalent" means a drug which:*

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

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

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

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

41 689A.0415 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 prescription drugs or devices shall
44 include in the policy coverage for ~~†~~

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



- 1 ~~—(b) Any~~ **any** type of hormone replacement therapy ~~f;~~
2 ~~→~~ which is lawfully prescribed or ordered and which has been
3 approved by the Food and Drug Administration.
- 4 2. An insurer that offers or issues a policy of health insurance
5 that provides coverage for prescription drugs shall not:
- 6 (a) Require an insured to pay a higher deductible, copayment or
7 coinsurance or require a longer waiting period or other condition for
8 coverage for a prescription for ~~fa contraceptive or~~ hormone
9 replacement therapy than is required for other prescription drugs
10 covered by the policy;
- 11 (b) Refuse to issue a policy of health insurance or cancel a
12 policy of health insurance solely because the person applying for or
13 covered by the policy uses or may use in the future ~~any of the~~
14 ~~services listed in subsection 1;~~ **hormone replacement therapy;**
- 15 (c) Offer or pay any type of material inducement or financial
16 incentive to an insured to discourage the insured from accessing
17 ~~any of the services listed in subsection 1;~~ **hormone replacement**
18 **therapy;**
- 19 (d) Penalize a provider of health care who provides ~~any of the~~
20 ~~services listed in subsection 1~~ **hormone replacement therapy** to an
21 insured, including, without limitation, reducing the reimbursement
22 of the provider of health care; or
- 23 (e) Offer or pay any type of material inducement, bonus or other
24 financial incentive to a provider of health care to deny, reduce,
25 withhold, limit or delay ~~any of the services listed in subsection 1~~
26 **hormone replacement therapy** to an insured.
- 27 3. ~~Except as otherwise provided in subsection 5, a~~ **A** policy
28 subject to the provisions of this chapter that is delivered, issued for
29 delivery or renewed on or after October 1, 1999, has the legal effect
30 of including the coverage required by subsection 1, and any
31 provision of the policy or the renewal which is in conflict with this
32 section is void.
- 33 4. The provisions of this section do not:
- 34 (a) Require an insurer to provide coverage for fertility drugs.
35 (b) Prohibit an insurer from requiring an insured to pay a
36 deductible, copayment or coinsurance for the coverage required by
37 ~~paragraphs (a) and (b) of~~ subsection 1 that is the same as the
38 insured is required to pay for other prescription drugs covered by the
39 policy.
- 40 5. ~~An insurer which offers or issues a policy of health~~
41 ~~insurance and which is affiliated with a religious organization is not~~
42 ~~required to provide the coverage required by paragraph (a) of~~
43 ~~subsection 1 if the insurer objects on religious grounds. Such an~~
44 ~~insurer shall, before the issuance of a policy of health insurance and~~
45 ~~before the renewal of such a policy, provide to the prospective~~



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1 ~~insured, written notice of the coverage that the insurer refuses to~~
2 ~~provide pursuant to this subsection.~~

3 ~~—6.~~ As used in this section, “provider of health care” has the
4 meaning ascribed to it in NRS 629.031.

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

6 689A.0417 1. ~~{Except as otherwise provided in subsection 5,~~
7 ~~an}~~ **An** insurer that offers or issues a policy of health insurance
8 which provides coverage for outpatient care shall include in the
9 policy coverage for any health care service related to ~~{contraceptives~~
10 ~~or}~~ hormone replacement therapy.

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

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

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

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

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

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

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

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



1 5. ~~{An insurer which offers or issues such a policy of health~~
2 ~~insurance and which is affiliated with a religious organization is not~~
3 ~~required to provide the coverage for health care service related to~~
4 ~~contraceptives required by this section if the insurer objects on~~
5 ~~religious grounds. Such an insurer shall, before the issuance of a~~
6 ~~policy of health insurance and before the renewal of such a policy,~~
7 ~~provide to the prospective insured written notice of the coverage~~
8 ~~that the insurer refuses to provide pursuant to this subsection.~~

9 —6.† As used in this section, “provider of health care” has the
10 meaning ascribed to it in NRS 629.031.

11 **Sec. 10.** NRS 689A.330 is hereby amended to read as follows:

12 689A.330 If any policy is issued by a domestic insurer for
13 delivery to a person residing in another state, and if the insurance
14 commissioner or corresponding public officer of that other state has
15 informed the Commissioner that the policy is not subject to approval
16 or disapproval by that officer, the Commissioner may by ruling
17 require that the policy meet the standards set forth in NRS 689A.030
18 to 689A.320, inclusive **††**, and **section 7 of this act.**

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

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

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

- 26 **(1) Lawfully prescribed or ordered;**
27 **(2) Approved by the Food and Drug Administration;**
28 **(3) Listed in subsection 11; and**
29 **(4) Dispensed in accordance with section 4.5 of this act;**

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

- 31 **(1) Lawfully prescribed or ordered;**
32 **(2) Approved by the Food and Drug Administration; and**
33 **(3) Listed in subsection 11;**

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

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

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

41 **(f) Voluntary sterilization for women.**

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



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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

18 (a) *Voluntary sterilization for women;*

19 (b) *Surgical sterilization implants for women;*

20 (c) *Implantable rods;*

21 (d) *Copper-based intrauterine devices;*

22 (e) *Progesterone-based intrauterine devices;*

23 (f) *Injections;*

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

25 (h) *Progestin-based drugs;*

26 (i) *Extended- or continuous-regimen drugs;*

27 (j) *Estrogen- and progestin-based patches;*

28 (k) *Vaginal contraceptive rings;*

29 (l) *Diaphragms with spermicide;*

30 (m) *Sponges with spermicide;*

31 (n) *Cervical caps with spermicide;*

32 (o) *Female condoms;*

33 (p) *Spermicide;*

34 (q) *Combined estrogen- and progestin-based drugs for*
35 *emergency contraception or progestin-based drugs for emergency*
36 *contraception; and*

37 (r) *Ulipristal acetate for emergency contraception.*

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



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

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

11 15. *As used in this section:*

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

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

23 (c) *“Provider of health care” has the meaning ascribed to it in*
24 *NRS 629.031.*

25 (d) *“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. 12.** NRS 689B.0376 is hereby amended to read as
35 follows:

36 689B.0376 1. ~~Except as otherwise provided in subsection 5,~~
37 ~~an~~ *An insurer that offers or issues a policy of group health*
38 *insurance which provides coverage for prescription drugs or devices*
39 *shall include in the policy coverage for ~~†~~*

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

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

42 ~~→†~~ *which is lawfully prescribed or ordered and which has been*
43 *approved by the Food and Drug Administration.*

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



1 (a) Require an insured to pay a higher deductible, copayment or
2 coinsurance or require a longer waiting period or other condition for
3 coverage for a prescription for ~~{a contraceptive or}~~ hormone
4 replacement therapy than is required for other prescription drugs
5 covered by the policy;

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

10 (c) Offer or pay any type of material inducement or financial
11 incentive to an insured to discourage the insured 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 insured, 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 insured.

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

28 4. The provisions of this section do not:

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

30 (b) Prohibit an insurer from requiring an insured to pay a
31 deductible, copayment or coinsurance for the coverage required by
32 ~~{paragraphs (a) and (b) of}~~ subsection 1 that is the same as the
33 insured is required to pay for other prescription drugs 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 required by paragraph (a) of~~
38 ~~subsection 1 if the insurer objects on religious grounds. Such an~~
39 ~~insurer shall, before the issuance of a policy of group health~~
40 ~~insurance and before the renewal of such a policy, provide to the~~
41 ~~group policyholder or prospective insured, as applicable, written~~
42 ~~notice of the coverage that the insurer refuses to provide pursuant to~~
43 ~~this subsection. The insurer shall provide notice to each insured, at~~
44 ~~the time the insured receives his or her certificate of coverage or~~



1 ~~evidence of coverage, that the insurer refused to provide coverage~~
2 ~~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.—~~ As used in this section, “provider of health care” has the
8 meaning ascribed to it in NRS 629.031.

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

11 689B.0377 1. ~~{Except as otherwise provided in subsection 5,~~
12 ~~an} An insurer that offers or issues a policy of group health~~
13 insurance which provides coverage for outpatient care shall include
14 in the policy coverage for any health care service related to
15 ~~{contraceptives or}~~ hormone replacement therapy.

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

18 (a) Require an insured to pay a higher deductible, copayment or
19 coinsurance or require a longer waiting period or other condition for
20 coverage for outpatient care related to ~~{contraceptives or}~~ hormone
21 replacement therapy than is required for other outpatient care
22 covered by the policy;

23 (b) Refuse to issue a policy of group health insurance or cancel a
24 policy of group health insurance solely because the person applying
25 for or covered by the policy uses or may use in the future ~~{any of the~~
26 ~~services listed in subsection 1;}~~ *hormone replacement therapy;*

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

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

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

39 3. ~~{Except as otherwise provided in subsection 5, a}~~ A policy
40 subject to the provisions of this chapter that is delivered, issued for
41 delivery or renewed on or after October 1, 1999, has the legal effect
42 of including the coverage required by subsection 1, and any
43 provision of the policy or the renewal which is in conflict with this
44 section is void.



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

6 ~~5. [An insurer which offers or issues a policy of group health
7 insurance and which is affiliated with a religious organization is not
8 required to provide the coverage for health care service related to
9 contraceptives required by this section if the insurer objects on
10 religious grounds. Such an insurer shall, before the issuance of a
11 policy of group health insurance and before the renewal of such a
12 policy, provide to the group policyholder or prospective insured, as
13 applicable, written notice of the coverage that the insurer refuses to
14 provide pursuant to this subsection. The insurer shall provide notice
15 to each insured, at the time the insured receives his or her certificate
16 of coverage or evidence of coverage, that the insurer refused to
17 provide coverage pursuant to this subsection.~~

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

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

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

26 *1. Except as otherwise provided in subsection 7, a carrier that
27 offers or issues a health benefit plan shall include in the plan
28 coverage for:*

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

31 *(1) Lawfully prescribed or ordered;*

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

33 *(3) Listed in subsection 10; and*

34 *(4) Dispensed in accordance with section 4.5 of this act;*

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

36 *(1) Lawfully prescribed or ordered;*

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

38 *(3) Listed in subsection 10;*

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

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

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



1 (f) *Voluntary sterilization for women.*

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

44 13. A carrier must provide an accessible, transparent and
45 expedited process which is not unduly burdensome by which an



1 *insured, or the authorized representative of the insured, may*
2 *request an exception relating to any medical management*
3 *technique used by the carrier to obtain any benefit required by this*
4 *section without a higher deductible, copayment or coinsurance.*

5 *14. As used in this section:*

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

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

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

19 *(d) "Therapeutic equivalent" means a drug which:*

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

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

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

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

29 689C.425 A voluntary purchasing group and any contract
30 issued to such a group pursuant to NRS 689C.360 to 689C.600,
31 inclusive, are subject to the provisions of NRS 689C.015 to
32 689C.355, inclusive, *and section 14 of this act*, to the extent
33 applicable and not in conflict with the express provisions of NRS
34 687B.408 and 689C.360 to 689C.600, inclusive.

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

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

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

43 *(1) Lawfully prescribed or ordered;*

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

45 *(3) Listed in subsection 10; and*



- 1 (4) *Dispensed in accordance with section 4.5 of this act;*
2 (b) *Any type of device for contraception which is:*
3 (1) *Lawfully prescribed or ordered;*
4 (2) *Approved by the Food and Drug Administration; and*
5 (3) *Listed in subsection 10;*
6 (c) *Insertion of a device for contraception or removal of such a*
7 *device if the device was inserted while the insured was covered by*
8 *the same benefit contract;*
9 (d) *Education and counseling relating to the initiation of the*
10 *use of contraception and any necessary follow-up after initiating*
11 *such use;*
12 (e) *Management of side effects relating to contraception; and*
13 (f) *Voluntary sterilization for women.*
14 2. *A society must ensure that the benefits required by*
15 *subsection 1 are made available to an insured through a provider*
16 *of health care who participates in the network plan of the society.*
17 3. *If a covered therapeutic equivalent listed in subsection 1 is*
18 *not available or a provider of health care deems a covered*
19 *therapeutic equivalent to be medically inappropriate, an alternate*
20 *therapeutic equivalent prescribed by a provider of health care*
21 *must be covered by the society.*
22 4. *Except as otherwise provided in subsections 8, 9 and 11, a*
23 *society that offers or issues a benefit contract shall not:*
24 (a) *Require an insured to pay a higher deductible, any*
25 *copayment or coinsurance or require a longer waiting period or*
26 *other condition for coverage for any benefit included in the benefit*
27 *contract pursuant to subsection 1;*
28 (b) *Refuse to issue a benefit contract or cancel a benefit*
29 *contract solely because the person applying for or covered by the*
30 *contract uses or may use any such benefit;*
31 (c) *Offer or pay any type of material inducement or financial*
32 *incentive to an insured to discourage the insured from obtaining*
33 *any such benefit;*
34 (d) *Penalize a provider of health care who provides any such*
35 *benefit to an insured, including, without limitation, reducing the*
36 *reimbursement to the provider of health care;*
37 (e) *Offer or pay any type of material inducement, bonus or*
38 *other financial incentive to a provider of health care to deny,*
39 *reduce, withhold, limit or delay access to any such benefit to an*
40 *insured; or*
41 (f) *Impose any other restrictions or delays on the access of an*
42 *insured to any such benefit.*
43 5. *Coverage pursuant to this section for the covered*
44 *dependent of an insured must be the same as for the insured.*



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

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

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

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

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

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



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

4 (r) Ulipristal acetate for emergency contraception.

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

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

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

20 14. As used in this section:

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

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

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

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

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

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

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



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

3 1. *Except as otherwise provided in subsection 7, an insurer*
4 *that offers or issues a contract for hospital or medical service shall*
5 *include in the contract coverage for:*

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

8 (1) *Lawfully prescribed or ordered;*

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

10 (3) *Listed in subsection 11; and*

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

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

13 (1) *Lawfully prescribed or ordered;*

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

15 (3) *Listed in subsection 11;*

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

19 (d) *Education and counseling relating to the initiation of the*
20 *use of contraception and any necessary follow-up after initiating*
21 *such use;*

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

23 (f) *Voluntary sterilization for women.*

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

28 3. *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 4. *Except as otherwise provided in subsections 9, 10 and 12,*
34 *an insurer that offers or issues a contract for hospital or medical*
35 *service 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 contract for*
39 *hospital or medical service pursuant to subsection 1;*

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



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

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

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

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

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

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

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



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

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

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

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

38 15. *As used in this section:*

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

44 (b) *“Network plan” means a contract for hospital or medical*
45 *service offered by an insurer under which the financing and*



1 *delivery of medical care, including items and services paid for as*
2 *medical care, are provided, in whole or in part, through a defined*
3 *set of providers under contract with the insurer. The term does not*
4 *include an arrangement for the financing of premiums.*

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

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

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

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

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

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

18 695B.1916 1. ~~Except as otherwise provided in subsection 5,~~
19 ~~an~~ An insurer that offers or issues a contract for hospital or medical
20 service which provides coverage for prescription drugs or devices
21 shall include in the contract coverage for ~~f~~

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

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

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

26 2. An insurer that offers or issues a contract for hospital or
27 medical service that provides coverage for prescription drugs shall
28 not:

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

34 (b) Refuse to issue a contract for hospital or medical service or
35 cancel a contract for hospital or medical service solely because the
36 person applying for or covered by the contract uses or may use in
37 the future ~~any of the services listed in subsection 1;~~ hormone
38 replacement therapy;

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

43 (d) Penalize a provider of health care who provides ~~any of the~~
44 ~~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** contract
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 contract 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 contract.

20 5. ~~An insurer which offers or issues a contract for hospital or
21 medical service and which is affiliated with a religious organization
22 is not 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 contract for hospital or
25 medical service and before the renewal of such a contract, provide
26 to the group policyholder or prospective insured, as applicable,
27 written notice of the coverage that the insurer refuses to provide
28 pursuant to this subsection. The insurer shall provide notice to each
29 insured, at the time the insured receives his or her certificate of
30 coverage or evidence of coverage, that the insurer refused to provide
31 coverage 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. 19.** NRS 695B.1918 is hereby amended to read as
39 follows:

40 695B.1918 1. ~~Except as otherwise provided in subsection 5,~~
41 **an** **An** insurer that offers or issues a contract for hospital or medical
42 service which provides coverage for outpatient care shall include in
43 the contract coverage for any health care service related to
44 ~~contraceptives or~~ hormone replacement therapy.



1 2. An insurer that offers or issues a contract for hospital or
2 medical service 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 contract;

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

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

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

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

24 3. ~~Except as otherwise provided in subsection 5, a~~ A contract
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 contract or the renewal which is in conflict with this
29 section is void.
30

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

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



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

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

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

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

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

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

- (1) Lawfully prescribed or ordered;*
- (2) Approved by the Food and Drug Administration;*
- (3) Listed in subsection 11; and*
- (4) Dispensed in accordance with section 4.5 of this act;*

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

- (1) Lawfully prescribed or ordered;*
- (2) Approved by the Food and Drug Administration; and*
- (3) Listed in subsection 11;*

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

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

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

(f) Voluntary sterilization for women.

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

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

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

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



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

20 *6. Except as otherwise provided in subsection 7, 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 *7. 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 *8. If a health maintenance organization refuses, pursuant to*
36 *subsection 7, to provide the coverage required by subsection 1, an*
37 *employer may otherwise provide for the coverage for the*
38 *employees of the employer.*

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

43 *10. For each of the 18 methods of contraception listed in*
44 *subsection 11 that have been approved by the Food and Drug*
45 *Administration, a health care plan must include at least one drug*



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1 or device for contraception within each method for which no
2 deductible, copayment or coinsurance may be charged to the
3 enrollee, but the health maintenance organization may charge a
4 deductible, copayment or coinsurance for any other drug or device
5 that provides the same method of contraception.

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

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

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

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

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

45 15. As used in this section:



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

6 (b) *“Network plan” means a health care plan offered by a*
7 *health maintenance organization under which the financing and*
8 *delivery of medical care, including items and services paid for as*
9 *medical care, are provided, in whole or in part, through a defined*
10 *set of providers under contract with the health maintenance*
11 *organization. The term does not include an arrangement for the*
12 *financing of premiums.*

13 (c) *“Provider of health care” has the meaning ascribed to it in*
14 *NRS 629.031.*

15 (d) *“Therapeutic equivalent” means a drug which:*

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

19 (2) *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 (3) *Meets any other criteria required by the Food and Drug*
23 *Administration for classification as a therapeutic equivalent.*

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

25 695C.050 1. Except as otherwise provided in this chapter or
26 in specific provisions of this title, the provisions of this title are not
27 applicable to any health maintenance organization granted a
28 certificate of authority under this chapter. This provision does not
29 apply to an insurer licensed and regulated pursuant to this title
30 except with respect to its activities as a health maintenance
31 organization authorized and regulated pursuant to this chapter.

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

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

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



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

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

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

14 695C.1694 1. ~~Except as otherwise provided in subsection 5,~~
15 ~~a~~ A health maintenance organization which offers or issues a health
16 care plan that provides coverage for prescription drugs or devices
17 shall include in the plan coverage for ~~†~~:

18 ~~—(a) Any type of drug or device for contraception; and~~
19 ~~—(b) Any~~ *any* type of hormone replacement therapy ~~†~~;
20 ~~→~~ which is lawfully prescribed or ordered and which has been
21 approved by the Food and Drug Administration.

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

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

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

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

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

42 (e) Offer or pay any type of material inducement, bonus or other
43 financial incentive to a provider of health care to deny, reduce,
44 withhold, limit or delay ~~† any of the services listed in subsection 1;~~
45 *hormone replacement therapy* to an enrollee.



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

7 4. The provisions of this section do not:

8 (a) Require a health maintenance organization to provide
9 coverage for fertility drugs.

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

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

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

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

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

36 695C.1695 1. ~~{Except as otherwise provided in subsection 5,
37 a†~~ A health maintenance organization that offers or issues a health
38 care plan which provides coverage for outpatient care shall include
39 in the plan coverage for any health care service related to
40 ~~{contraceptives or}~~ hormone replacement therapy.

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

43 (a) Require an enrollee to pay a higher deductible, copayment or
44 coinsurance or require a longer waiting period or other condition for
45 coverage for outpatient care related to ~~{contraceptives or}~~ hormone



1 replacement therapy than is required for other outpatient care
2 covered by the plan;

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

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

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

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

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

25 4. The provisions of this section do not prohibit a health
26 maintenance organization from requiring an enrollee to pay a
27 deductible, copayment or coinsurance for the coverage required by
28 subsection 1 that is the same as the enrollee is required to pay for
29 other outpatient care covered by the plan.

30 5. ~~A health maintenance organization which offers or issues a~~
31 ~~health care plan and which is affiliated with a religious organization~~
32 ~~is not required to provide the coverage for health care service related~~
33 ~~to contraceptives required by this section if the health maintenance~~
34 ~~organization objects on religious grounds. The health maintenance~~
35 ~~organization shall, before the issuance of a health care plan and~~
36 ~~before renewal of enrollment in such a plan, provide to the group~~
37 ~~policyholder or prospective enrollee, as applicable, written notice of~~
38 ~~the coverage that the health maintenance organization refuses to~~
39 ~~provide pursuant to this subsection. The health maintenance~~
40 ~~organization shall provide notice to each enrollee, at the time the~~
41 ~~enrollee receives his or her evidence of coverage, that the health~~
42 ~~maintenance organization refused to provide coverage pursuant to~~
43 ~~this subsection.~~

44 ~~6. If a health maintenance organization refuses, pursuant to~~
45 ~~subsection 5, to provide the coverage required by paragraph (a) of~~



1 ~~subsection 1, an employer may otherwise provide for the coverage~~
2 ~~for the employees of the employer.~~

3 ~~7.1~~ As used in this section, "provider of health care" has the
4 meaning ascribed to it in NRS 629.031.

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

6 695C.330 1. The Commissioner may suspend or revoke any
7 certificate of authority issued to a health maintenance organization
8 pursuant to the provisions of this chapter if the Commissioner finds
9 that any of the following conditions exist:

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

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

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

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

25 (1) Does not meet the requirements of subsection 1 of NRS
26 695C.080; or

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

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

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

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

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

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

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



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

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

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

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

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

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

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

27 *1. Except as otherwise provided in subsection 7, a managed
28 care organization that offers or issues a health care plan shall
29 include in the plan coverage for:*

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

32 *(1) Lawfully prescribed or ordered;*

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

34 *(3) Listed in subsection 10; and*

35 *(4) Dispensed in accordance with section 4.5 of this act;*

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

37 *(1) Lawfully prescribed or ordered;*

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

39 *(3) Listed in subsection 10;*

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

43 *(d) Education and counseling relating to the initiation of the
44 use of contraception and any necessary follow-up after initiating
45 such use;*



* A B 2 4 9 R 3 *

- 1 (e) *Management of side effects relating to contraception; and*
- 2 (f) *Voluntary sterilization for women.*

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

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

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

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

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

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

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

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

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

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

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

42 7. *A managed care organization that offers or issues a health*
43 *care plan and which is affiliated with a religious organization is*
44 *not required to provide the coverage required by subsection 1 if*
45 *the managed care organization objects on religious grounds. Such*



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

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

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

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

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

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



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

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

12 14. *As used in this section:*

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

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

25 (c) *“Provider of health care” has the meaning ascribed to it in*
26 *NRS 629.031.*

27 (d) *“Therapeutic equivalent” means a drug which:*

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

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

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

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

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

