Amendment No. 429

Assembly Amendment to Assembly Bill No. 249 (BDR 38-858)
Proposed by: Assembly Committee on Health and Human Services
Amends: Summary: No Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes

Adoption of this amendment will MAINTAIN the unfunded mandate not requested by the affected local government to A.B. 249 (§§ 3, 4).

ASSEMBLY ACTION		Initial and Date	SENATE ACTION		Initial and Date
Adopted ☐	Lost ☐		Adopted ☐	Lost ☐	
Concurred In ☐	Not ☐		Concurred In ☐	Not ☐	
Receded ☐	Not ☐		Receded ☐	Not ☐	

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

CSL/RBL Date: 4/24/2017

A.B. No. 249—Requires the State Plan for Medicaid and all health insurance plans to provide certain benefits relating to contraception.
(BDR 38-858)

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

MARCH 1, 2017

Referred to Committee on Health and Human Services

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

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

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

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

AN ACT relating to health care; requiring the State Plan for Medicaid to provide certain benefits relating to contraception **;** [~~at no additional cost to the enrollee; requiring a pharmacist to dispense up to a 12-month supply~~] **revising provisions relating to dispensing** of contraceptives [~~in certain circumstances;~~] **;** requiring all health insurance plans to provide certain benefits relating to contraception **;** [~~at no additional cost to the insured;~~] and providing other matters properly relating thereto.

Legislative Counsel's Digest:

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

The federal Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended, requires certain contraceptive drugs, devices and services to be covered by every health insurance plan without any copay, coinsurance or higher deductible. (42 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130) **Sections 3, 4 and** [~~6-25~~] **7-25** of this bill align Nevada law with federal law, requiring all public and private health insurance plans made available in this State to provide coverage for certain benefits relating to contraception without any copay, coinsurance or a higher deductible. **Sections 3, 4 and** [~~6-25~~] **7-25** require [~~certain additional~~] **all** forms of contraceptive drugs, devices and services **which are approved by the Food and**

Drug Administration to be covered by a health insurance plan, including, without limitation, up to a 12-month supply of contraceptives or its therapeutic equivalent, insertion or removal of a contraceptive device, education and counseling relating to contraception, management of side effects relating to contraception and voluntary sterilization for ~~[men and]~~ women. **Sections 3, 4 and 7-25 allow an insurer to require an insured to pay a higher deductible, copayment or coinsurance for a drug or device for contraception if the insured refuses to accept a therapeutic equivalent of the contraceptive drug or device. In addition, a health insurance plan must include for each method of contraception which is approved by the Food and Drug Administration at least one contraceptive drug or device for which no deductible, copayment or coinsurance may be charged to the insured. Sections 3, 4 and ~~[6-25 prohibit the use of]~~ 7-25 authorize an insurer to require** a program of step therapy or prior authorization ~~[requirements relating]~~ to **obtain coverage for** the contraceptive drugs, devices and services required by this bill. **Sections 3, 4 and ~~[6-25]~~ 7-25** also require a health insurance plan to provide coverage for certain therapeutic equivalent drugs and devices relating to contraception when a therapeutic equivalent covered by the plan is deemed to be medically inappropriate by a provider of health care. Additionally, **sections ~~[3, 4 and 6-25]~~ 7, 11, 14, 16, 17, 20 and 25** require that **the** benefits provided by a health insurance plan relating to contraception which are provided to the insured must also be provided to ~~[the spouse of]~~ **a covered** dependent of an insured.

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

Existing law requires this State to develop a State Plan for Medicaid which includes, without limitation, a list of the medical services provided to Medicaid ~~[beneficiaries.]~~ **recipients.** (42 U.S.C. § 1396a; NRS 422.063) Existing federal law authorizes a state to charge a copay, coinsurance or deductible for most Medicaid services, but prohibits any copay, coinsurance or deductible for certain ~~[family planning services and supplies.]~~ **contraceptive drugs, devices and services.** (42 U.S.C. § 1396o-1) Existing federal law also authorizes a state to define the parameters of contraceptive coverage provided under Medicaid. (42 U.S.C. § 1396u-7) Existing Nevada law requires a number of specific medical services to be covered under Medicaid. (NRS 422.2717-422.27241) ~~[Sections]~~ **Section 1** ~~[and 2]~~ of this bill ~~[require]~~ **requires** the State Plan for Medicaid to include certain benefits relating to contraception currently required to be covered by private health insurance plans pursuant to existing Nevada law and the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended, as well as the additional benefits related to contraception required by **sections 3, 4 and ~~[6-25]~~ 7-25 of this bill** without any copay, coinsurance or deductible **. ~~[. Sections 1 and 2 also prohibit the use of a program of step therapy and any requirement to obtain prior authorization relating to such benefits which are covered under the State Plan for Medicaid.]~~ in most cases. The benefits relating to contraceptive drugs which are provided by section 1 of this bill are subject to step therapy and prior authorization requirements pursuant to existing law.**

Existing law authorizes a pharmacist to dispense up to a 90-day supply of a drug pursuant to a valid prescription **or order** in certain circumstances. (NRS 639.2396) **Section ~~[5]~~ 4.5** of this bill requires a pharmacist to dispense up to a 12-month supply of contraceptives or a therapeutic equivalent ~~[upon the request of a patient and]~~ pursuant to a valid prescription **. [,] or order if: (1) the patient has previously received a 3-month supply of the same drug; (2) the patient has previously received a 9-month supply of the same drug or a supply of the same drug for the balance of the plan year in which the 3-month supply was prescribed or ordered, whichever is less; (3) the patient is insured by the same health insurance plan; and (4) a provider of health care has not specified in the prescription or order that a different supply of the drug is necessary.**

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

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

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

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is ~~[lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;]~~ :

(1) Lawfully prescribed or ordered;

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

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

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

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

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

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

(f) Voluntary sterilization for ~~[men and]~~ women.

2. If a covered therapeutic equivalent ~~[listed]~~ described 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 Plan.

3. ~~[To]~~ Except as otherwise provided in subsections 5 and 6, to obtain any benefit included in the Plan pursuant to subsection 1, a person enrolled in Medicaid must not be required to:

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

~~(b) [Use a program of step therapy;~~

~~(c) Obtain prior authorization; or~~

~~(d)]~~ Be subject to a longer waiting period or any other condition.

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

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

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

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

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

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

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

Sec. 2. ~~[NRS 422.403 is hereby amended to read as follows:~~

~~422.403 1. [The] *Except as otherwise provided in section 1 of this act, the* Department shall, by regulation, establish and manage the use by the Medicaid program of step therapy and prior authorization for prescription drugs.~~

~~2. [The] *Except as otherwise provided in section 1 of this act, the* Drug Use Review Board shall:~~

~~(a) Advise the Department concerning the use by the Medicaid program of step therapy and prior authorization for prescription drugs;~~

~~(b) Develop step therapy protocols and prior authorization policies and procedures for use by the Medicaid program for prescription drugs; and~~

~~(c) Review and approve, based on clinical evidence and best clinical practice guidelines and without consideration of the cost of the prescription drugs being considered, step therapy protocols used by the Medicaid program for prescription drugs.~~

~~3. The Department shall not require the Drug Use Review Board to develop, review or approve prior authorization policies or procedures necessary for the operation of the list of preferred prescription drugs developed for the Medicaid program pursuant to NRS 422.4025.~~

~~4. The Department shall accept recommendations from the Drug Use Review Board as the basis for developing or revising step therapy protocols and prior authorization policies and procedures used by the Medicaid program for prescription drugs.] (Deleted by amendment.)~~

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

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

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

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

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

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

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A

of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 687B.408, 689B.030 to 689B.050, inclusive, ***and section 11 of this act*** and 689B.287 apply to coverage provided pursuant to this paragraph ~~.~~ ***, except that the provisions of section 11 of this act only apply to coverage for active officers and employees of the governing body of a county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada, or the dependents of such officers and employees.***

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

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

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

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

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

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

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

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

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

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

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

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

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and section 25 of this act*** in the same manner

as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

(b) "Plan year" means the year in which an insured is covered by a health care plan.

(c) "Therapeutic equivalent" means a drug which:

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

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

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

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

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

2. ~~[A]~~ ***Except as otherwise provided*** ~~***[by subsection 3,]***~~ ***in section 4.5 of this act, a*** pharmacist may, in his or her professional judgment and pursuant to a valid prescription that specifies an initial amount of less than a 90-day supply of a drug

other than a controlled substance followed by periodic refills of the initial amount of the drug, dispense not more than a 90-day supply of the drug if:

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

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

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

3. ~~*[A pharmacist shall, upon the request of a patient and pursuant to a valid prescription for a drug to be used for contraception or its therapeutic equivalent which has been approved by the Food and Drug Administration that specifies an initial amount of less than a 12 month supply followed by periodic refills of the initial amount of the drug, dispense up to the amount authorized in the prescription including refills, not to exceed a 12 month supply of the drug or its therapeutic equivalent.*~~

~~*4.]*~~ Nothing in this section shall be construed to alter the coverage provided under any contract or policy of health insurance, health plan or program or other agreement arrangement that provides health coverage.

Sec. 6. ~~[NRS 687B.225 is hereby amended to read as follows:~~

~~687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0413, 689A.044, 689A.0445, 689B.031, 689B.0313, 689B.0317, 689B.0374, 695B.1912, 695B.1914, 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1745, 695C.1751, 695G.170, 695G.171~~ ~~*,*~~ ~~[and] 695G.177~~ ~~[,]~~ ~~*and sections 7, 11, 14, 16, 17, 20 and 25 of this act,*~~ ~~any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:~~

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

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

~~2. The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.]~~ **(Deleted by amendment.)**

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

1. ~~[An]~~ Except as otherwise provided in subsection 6, an insurer that offers or issues a policy of health insurance shall include in the policy coverage for:

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is ~~[lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;]~~ :

(1) Lawfully prescribed or ordered;

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

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

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

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

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

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

(f) Voluntary sterilization for ~~[men and]~~ women.

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

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

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

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

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

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

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

(f) Impose any other restrictions or delays on the access of an insured ~~[to the services listed in subsection 1, including, without limitation, a program of step therapy or prior authorization.]~~ any such benefit.

4. Coverage pursuant to this section for ~~[a covered spouse or]~~ the covered dependent of an insured must be the same as for the insured.

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

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

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

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

9. An insurer may require an insured to:

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

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

10. As used in this section ~~[, "provider]~~ :

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

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

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

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

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

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

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

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

~~(b) Any]~~ ***any*** type of hormone replacement therapy ~~[.~~

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

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

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

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

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

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

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

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

4. The provisions of this section do not:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. ~~[An]~~ Except as otherwise provided in subsection 6, an insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is ~~[lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;]~~ :

(1) Lawfully prescribed or ordered;

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

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

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

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

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

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

(f) Voluntary sterilization for ~~[men and]~~ women.

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

3. ~~[An]~~ Except as otherwise provided in subsections 8, 9 and 10, an insurer that offers or issues a policy of group health insurance shall not:

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

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

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

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

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

(f) Impose any other restrictions or delays on the access of an insured to any such benefit . ~~[, including, without limitation, a program of step therapy or prior authorization.]~~

4. Coverage pursuant to this section for ~~[a covered spouse or]~~ the covered dependent of an insured must be the same as for the insured.

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

6. An insurer that offers or issues a policy of group health insurance and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of group health insurance

and before the renewal of such a policy, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

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

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

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

10. An insurer may require an insured to:

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

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

11. As used in this section ~~[, "provider]~~ :

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

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

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

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

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

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

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

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

~~(b) Any]~~ ***any*** type of hormone replacement therapy ~~[.~~

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

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

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

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

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

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

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

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

4. The provisions of this section do not:

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

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

5. ~~[An insurer which offers or issues a policy of group health insurance and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of group health insurance and before the renewal of such a policy, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall 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.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

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

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

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

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

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

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

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

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

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

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

~~5. [An insurer which offers or issues a policy of group health insurance and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of group health insurance and before the renewal of such a policy, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall 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.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

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

1. ~~[A]~~ Except as otherwise provided in subsection 6, a carrier that offers or issues a health benefit plan shall include in the plan coverage for:

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is ~~[lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;]~~ :

(1) Lawfully prescribed or ordered;

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

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

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

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

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

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

(f) Voluntary sterilization for ~~[men and]~~ women.

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

3. ~~[A]~~ Except as otherwise provided in subsections 7, 8 and 9, a carrier that offers or issues a health benefit plan shall not:

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

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

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

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

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

(f) Impose any other restrictions or delays on the access of an insured to any such benefit. ~~[, including, without limitation, a program of step therapy or prior authorization.]~~

4. Coverage pursuant to this section for ~~[a covered spouse or]~~ the covered dependent of an insured must be the same as for the insured.

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

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

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

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

9. A carrier may require an insured to:

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

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

10. As used in this section ~~[, "provider"]~~ :

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

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

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

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

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

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

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

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

1. ~~[A]~~ Except as otherwise provided in subsection 6, a society that offers or issues a benefit contract which provides coverage for prescription drugs or devices shall include in the contract coverage for:

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is ~~[lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;]~~ :

(1) Lawfully prescribed or ordered;

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

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

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

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

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

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

(f) Voluntary sterilization for ~~[men and]~~ women.

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

3. ~~[A]~~ Except as otherwise provided in subsections 7, 8 and 9, a society that offers or issues a benefit contract shall not:

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

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

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

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

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

(f) Impose any other restrictions or delays on the access of an insured to any such benefit . ~~[, including, without limitation, a program of step therapy or prior authorization.]~~

4. Coverage pursuant to this section for ~~[a covered spouse or]~~ the covered dependent of an insured must be the same as for the insured.

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

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

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

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

9. A society may require an insured to:

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

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

10. As used in this section ~~[, "provider]~~ :

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

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

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

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

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

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

1. ~~[An]~~ Except as otherwise provided in subsection 6, an insurer that offers or issues a contract for hospital or medical service shall include in the contract coverage for:

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is ~~[lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;]~~ :

(1) Lawfully prescribed or ordered;

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

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

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

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

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

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

(f) Voluntary sterilization for ~~[men and]~~ women.

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

3. ~~[An]~~ Except as otherwise provided in subsections 8, 9 and 10, an insurer that offers or issues a contract for hospital or medical service shall not:

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

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

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

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

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

(f) Impose any other restrictions or delays on the access of an insured to any such benefit . ~~[, including, without limitation, a program of step therapy or prior authorization.]~~

4. Coverage pursuant to this section for ~~[a covered spouse or]~~ the covered dependent of an insured must be the same as for the insured.

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

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

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

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

9. For each method of contraception which is approved by the Food and Drug Administration, a contract for hospital or medical service must include at least one contraceptive drug or device for which no deductible, copayment or coinsurance may be charged to the insured, but the insurer may charge a deductible, copayment or coinsurance for any other contraceptive drug or device that provides the same method of contraception.

10. An insurer may require an insured to:

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

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

11. As used in this section ~~[, "provider]~~ :

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

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

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

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

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

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

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

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

~~(b) Any]~~ ***any*** type of hormone replacement therapy ~~[,~~

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

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

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

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

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

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

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

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

4. The provisions of this section do not:

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

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

5. ~~[An insurer which offers or issues a contract for hospital or medical service and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a contract for hospital or medical service and before the renewal of such a contract, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall 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.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

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

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

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

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

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

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

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

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

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

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

5. ~~[An insurer which offers or issues a contract for hospital or medical service and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a contract for hospital or medical service and before the renewal of such a~~

~~contract, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall 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.~~ 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. ~~[4]~~ Except as otherwise provided in subsection 6, 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 ~~[lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;]~~ :

(1) Lawfully prescribed or ordered;

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

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

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

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

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

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

(f) Voluntary sterilization for ~~[men and]~~ women.

2. 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.

3. ~~[4]~~ Except as otherwise provided in subsections 8, 9 and 10, a health maintenance organization that offers or issues a health care plan shall not:

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

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

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

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

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

(f) Impose any other restrictions or delays on the access of an enrollee to any such benefit . ~~[, including, without limitation, a program of step therapy or prior authorization.]~~

4. Coverage pursuant to this section for ~~[a covered spouse or]~~ the covered dependent of an enrollee must be the same as for the enrollee.

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

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

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

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

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

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

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

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

11. As used in this section ~~[, "provider"]~~ :

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

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

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

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

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

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

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

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any

provision of law relating to solicitation or advertising by practitioners of a healing art.

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

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, 695C.1735 to 695C.1755, inclusive, 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

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

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

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

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

~~(b) Any]~~ ***any*** type of hormone replacement therapy ~~[.~~

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

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

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

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

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

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

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

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

4. The provisions of this section do not:

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

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

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

~~6. If a health maintenance organization 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.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

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

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

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

(a) Require an enrollee to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to ~~[contraceptives or]~~ hormone replacement therapy than is required for other outpatient care covered by the plan;

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

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

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

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

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

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

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

~~6. If a health maintenance organization 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.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. ~~[A]~~ Except as otherwise provided in subsection 6, a managed care organization that offers or issues a health care plan shall include in the plan coverage for:

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is ~~[lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;]~~ :

(1) Lawfully prescribed or ordered;

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

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

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

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

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

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

(f) Voluntary sterilization for ~~[men and]~~ women.

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

3. ~~[A]~~ Except as otherwise provided in subsections 7, 8 and 9, a managed care organization that offers or issues a health care plan shall not:

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

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

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

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

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

(f) Impose any other restrictions or delays on the access of an insured to any such benefits . ~~[, including, without limitation, a program of step therapy or prior authorization.]~~

4. Coverage pursuant to this section for ~~[a covered spouse or]~~ the covered dependent of an insured must be the same as for the insured.

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

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

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

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

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

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

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

10. As used in this section ~~[, "provider]~~ :

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

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

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

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

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

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

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