

**Amendment No. 809**

Senate Amendment to Senate Bill No. 233 First Reprint (BDR 38-817)

**Proposed by:** Senator Ratti**Amendment Box:** Consistent with Amendment No. 693.**Amends:** Summary: No Title: No Preamble: No Joint Sponsorship: No Digest: No

Adoption of this amendment will MAINTAIN the unfunded mandate not requested by the affected local government to S.B. 233 R1 (§§ 7, 8).

ASSEMBLY ACTION				Initial and Date	SENATE ACTION				Initial and Date
Adopted	<input type="checkbox"/>	Lost	<input type="checkbox"/>	_____	Adopted	<input type="checkbox"/>	Lost	<input type="checkbox"/>	_____
Concurred In	<input type="checkbox"/>	Not	<input type="checkbox"/>	_____	Concurred In	<input type="checkbox"/>	Not	<input type="checkbox"/>	_____
Receded	<input type="checkbox"/>	Not	<input type="checkbox"/>	_____	Receded	<input type="checkbox"/>	Not	<input type="checkbox"/>	_____

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.

EWR/RBL



Date: 5/18/2017

S.B. No. 233—Requires the State Plan for Medicaid and health insurance plans to provide certain benefits. (BDR 38-817)





SENATE BILL NO. 233—SENATORS RATTI, CANCELA, SPEARMAN, CANNIZZARO, WOODHOUSE; ATKINSON, DENIS, FORD, MANENDO, PARKS AND SEGERBLOM

MARCH 1, 2017

Referred to Committee on Health and Human Services

SUMMARY—Requires the State Plan for Medicaid and health insurance plans to provide certain benefits. (BDR 38-817)

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

CONTAINS UNFUNDED MANDATE (§§ 7, 8)  
(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 and all health insurance plans to provide certain benefits relating to reproductive health care, hormone replacement therapy and preventative health care; revising provisions relating to dispensing of contraceptives; 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) Existing law also requires most health insurance plans to include coverage for certain preventative services, including the human papillomavirus vaccine, cytological screenings and mammograms. (NRS 287.0272, 689A.0405, 689A.044, 689B.0313, 689B.0374, 695B.1912, 695B.1925, 695C.1735, 695C.1745, 695G.171) 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 some of these requirements. (Chapters 287, 689C, 695A and 695G of NRS)

The federal Patient Protection and Affordable Care Act (Public Law 111-148, as amended) requires certain preventative services to be covered by every health insurance plan without any copay, coinsurance or higher deductible, including, without limitation, certain contraceptive drugs, devices and services, certain vaccinations, mammograms, counseling concerning interpersonal and domestic violence, screenings for certain diseases and well-woman preventative visits. (42 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130) This bill places those requirements in Nevada law, requiring all public and private health insurance plans made available in this State to provide coverage for certain preventative services without any copay, coinsurance or a higher deductible. **Sections 7, 8 and 11-57** of this bill 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 refused 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 7, 8 and 11-57** authorize an insurer to require a program of step therapy or prior authorization to obtain coverage for the preventative services required by this bill. **Sections 7, 8 and 11-57** also require 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 up to a 12-month supply of contraceptives or a therapeutic equivalent, insertion or removal of a contraceptive device, education and counseling relating to contraception and voluntary sterilization for women.

Existing law authorizes an insurer 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, 689A.0417, 689B.0376, 689B.0377, 695B.1916, 695B.1918, 695C.1694, 695C.1695) **Sections 20, 27, 33, 38, 45 and 54** of this bill move the religious exemption to the new provisions relating to coverage of contraception.

Existing law requires most health insurance plans which cover prescription drugs and outpatient care to also include coverage for hormone replacement therapy 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) **Sections 7, 8 and 11-57** of this bill expand this requirement to all public and private health insurance plans made available in this State and require health insurance plans to provide coverage for hormone replacement therapy without any copay, coinsurance or higher deductible.

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 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 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 law requires a number of specific medical services to be covered under Medicaid. (NRS 422.2717-422.27241) **Sections 2-5.5** of this bill require the State Plan for Medicaid to include the preventative services currently required to be covered by private health insurance plans pursuant to existing Nevada law, the Patient Protection and Affordable Care Act (Public Law 111-148 as amended) as well as the additional drugs, devices, supplies and services required by **sections 7, 8 and 11-57** without any copay, coinsurance or deductible in most cases. The benefits relating to contraceptive drugs which are provided by **section 2** 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 8.5** of this bill requires a pharmacist to dispense up to a 12-month supply of contraceptives or their therapeutic equivalent 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 shorter; (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.

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

1       **Section 1.** Chapter 422 of NRS is hereby amended by adding thereto the  
2 provisions set forth as sections 2, 3 and 4 of this act.

3       **Sec. 2. 1.** *The Director shall include in the State Plan for Medicaid a*  
4 *requirement that the State pay the nonfederal share of expenditures incurred for:*

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

7       *(1) Lawfully prescribed or ordered ~~and which has been approved~~;*

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

9       *(3) Dispensed in accordance with section 8.5 of this act.*

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

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

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

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

17       *(f) Voluntary sterilization for women. ~~pursuant to 42 C.F.R. §§ 441.250 to~~*  
18 *~~441.259, inclusive; and~~*

19       *~~(f) Hormone replacement therapy.~~*

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

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

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

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

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

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

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

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

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

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

46       **Sec. 3. 1.** *The Director shall include in the State Plan for Medicaid a*  
47 *requirement that the State pay the nonfederal share of expenditures incurred for:*

(a) Counseling, support and supplies for breastfeeding, including, without limitation, renting or purchasing equipment for breastfeeding, to the extent money is available for this purpose;

(b) Screening and counseling for interpersonal and domestic violence;

(c) Counseling for sexually transmitted diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization, to the extent money is available for this purpose;

(e) Screening for blood pressure abnormalities and diabetes, including, without limitation, gestational diabetes;

(f) An annual screening for cervical cancer;

(g) Screening for depression;

(h) Screening and counseling for the human immunodeficiency virus;

(i) Smoking cessation programs, including, without limitation, not more than two cessation attempts per year and four counseling sessions of not more than 10 minutes each;

(j) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; ~~and~~

(k) Such well-woman preventative visits as recommended by the Health Resources and Services Administration ~~+~~; and

(l) Hormone replacement therapy.

2. To obtain any benefit provided in the Plan pursuant to subsection 1, a recipient of Medicaid must not be required to:

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

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

Sec. 4. 1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:

(a) An annual cytologic screening test for women between the ages of 21 and 29 years;

(b) A cytologic screening test for women between the ages of 30 and 65 years:

(1) Every 3 years; or

(2) Every 5 years if carried out at the same time as testing for human papillomavirus; and

(c) An annual mammogram for women.

2. To obtain any benefit provided in the Plan pursuant to subsection 1, a recipient of Medicaid must not be required to:

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

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

Sec. 5. NRS 422.2718 is hereby amended to read as follows:

422.2718 1. The Director shall include in the State Plan for Medicaid a requirement that the State shall pay the nonfederal share of expenses incurred for ~~administering~~:

(a) Deoxyribonucleic acid testing for high-risk strains of human papillomavirus; and

(b) Administering the human papillomavirus vaccine ~~to women and girls~~ at such ages as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. *To obtain the services listed in subsection 1, a person enrolled in Medicaid must not be required to:*

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

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

3. For the purposes of this section, “human papillomavirus vaccine” means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration to be used for the prevention of human papillomavirus infection and cervical cancer.

**Sec. 5.5.** NRS 422.401 is hereby amended to read as follows:

422.401 As used in NRS 422.401 to 422.406, inclusive, *and sections 2, 3 and 4 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. 5.7.** NRS 422.406 is hereby amended to read as follows:

422.406 1. The Department may, to carry out its duties set forth in NRS 422.401 to 422.406, inclusive, *and sections 2, 3 and 4 of this act*, and to administer the provisions of NRS 422.401 to 422.406, inclusive ~~†~~, *and sections 2, 3 and 4 of this act*:

(a) Adopt regulations; and

(b) Enter into contracts for any services.

2. Any regulations adopted by the Department pursuant to NRS 422.401 to 422.406, inclusive, *and sections 2, 3 and 4 of this act*, must be adopted in accordance with the provisions of chapter 241 of NRS.

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

**Sec. 7.** 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,

1 inclusive, *and sections 20 and 21 of this act* and 689B.287 apply to coverage  
2 provided pursuant to this paragraph.

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

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

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

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

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

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

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

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

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

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

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

40 **Sec. 8.** NRS 287.04335 is hereby amended to read as follows:

41 287.04335 If the Board provides health insurance through a plan of self-  
42 insurance, it shall comply with the provisions of NRS 689B.255, 695G.150,  
43 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to  
44 695G.173, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to  
45 695G.310, inclusive, and 695G.405, *and sections 54, 55 and 56 of this act* in the  
46 same manner as an insurer that is licensed pursuant to title 57 of NRS is required to  
47 comply with those provisions.

48 **Sec. 8.5.** Chapter 639 of NRS is hereby amended by adding thereto a new  
49 section to read as follows:

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



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

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

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

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

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

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

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

20      4. *As used in this section:*

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

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

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

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

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

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

34      **Sec. 9.** NRS 639.2396 is hereby amended to read as follows:

35      639.2396 1. Except as otherwise provided by subsection 2, a prescription  
36      which bears specific authorization to refill, given by the prescribing practitioner at  
37      the time he or she issued the original prescription, or a prescription which bears  
38      authorization permitting the pharmacist to refill the prescription as needed by the  
39      patient, may be refilled for the number of times authorized or for the period  
40      authorized if it was refilled in accordance with the number of doses ordered and the  
41      directions for use.

42      2. ~~1A~~ *Except as otherwise provided in section 8.5 of this act, a* pharmacist  
43      may, in his or her professional judgment and pursuant to a valid prescription that  
44      specifies an initial amount of less than a 90-day supply of a drug other than a  
45      controlled substance followed by periodic refills of the initial amount of the drug,  
46      dispense not more than a 90-day supply of the drug if:

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

49       (b) The total number of dosage units that are dispensed pursuant to the  
50       prescription does not exceed the total number of dosage units, including refills, that  
51       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. 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. 10.** (Deleted by amendment.)

**Sec. 11.** Chapter 689A of NRS is hereby amended by adding thereto the provisions set forth as sections 12 and 13 of this act.

**Sec. 12.** *1. Except as otherwise provided in subsection 4, 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;*

*(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; and*

*(e) Voluntary sterilization for women.*

*2. Except as otherwise provided in subsections 5, 6 and 7, 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 to obtain any benefit provided in the policy of health insurance 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 any such benefit.*

*3. Except as otherwise provided in subsection 4, a policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 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.*

*4. 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.*

*5. 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.*

6. 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.

7. 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.

8. As used in this section:

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

(a) Counseling, support and supplies for breastfeeding, including, without limitation, renting or purchasing breastfeeding equipment;

(b) Screening and counseling for interpersonal and domestic violence;

(c) Counseling for sexually transmitted diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(e) Screening for blood pressure abnormalities and diabetes, including, without limitation, gestational diabetes;

(f) An annual screening for cervical cancer;

(g) Screening for depression;

(h) Screening and counseling for the human immunodeficiency virus;

(i) Smoking cessation programs, including, without limitation, not more than two cessation attempts per year and four counseling sessions of not more than 10 minutes each;

(j) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and

(k) Such well-woman preventative visits as recommended by the Health Resources and Services Administration.

2. Except as otherwise provided in subsection 4, 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 to obtain any benefit provided in the policy of health insurance 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;

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

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

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

9 3. A policy of health insurance subject to the provisions of this chapter that  
10 is delivered, issued for delivery or renewed on or after January 1, 2018, has the  
11 legal effect of including the coverage required by subsection 1, and any provision  
12 of the policy or the renewal which is in conflict with this section is void.

13 4. An insurer may require an insured to:

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

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

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

21 Sec. 14. NRS 689A.0405 is hereby amended to read as follows:

22 689A.0405 1. A policy of health insurance must provide coverage for  
23 benefits payable for expenses incurred for:

24 (a) An annual cytologic screening test for women ~~{18 years of age or older;}~~  
25 ~~between the ages of 21 and 29 years;~~

26 (b) ~~{A baseline mammogram for women between the ages of 35 and 40;}~~ A  
27 cytologic screening test for women between the ages of 30 and 65 years:

28 (1) Every 3 years; or

29 (2) Every 5 years if carried out at the same time as testing for human  
30 papillomavirus; and

31 (c) An annual mammogram for women. ~~{40 years of age or older;}~~

32 2. ~~{A policy of health insurance must not require an insured to obtain prior}~~  
33 ~~authorization for any service provided pursuant to subsection 1.}~~ Except as  
34 otherwise provided in subsection 4, an insurer that offers or issues a policy of  
35 health insurance shall not:

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

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

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

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

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

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

52 3. A policy subject to the provisions of this chapter which is delivered, issued  
53 for delivery or renewed on or after ~~{October 1, 1989;}~~ January 1, 2018, has the

1 legal effect of including the coverage required by subsection 1, and any provision  
2 of the policy or the renewal which is in conflict with subsection 1 is void.

3 4. *An insurer may require an insured to:*

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

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

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

11 Sec. 15. NRS 689A.0415 is hereby amended to read as follows:

12 689A.0415 1. ~~{Except as otherwise provided in subsection 5, an}~~ An insurer  
13 that offers or issues a policy of health insurance which provides coverage for  
14 prescription drugs or devices shall include in the policy coverage for ~~+~~

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

16 ~~—(b) Any} any type of hormone replacement therapy ~~+~~~~

17 ~~→} which is lawfully prescribed or ordered and which has been approved by the~~  
18 Food and Drug Administration.

19 2. ~~{An}~~ *Except as otherwise provided in subsection 4, an* insurer that offers  
20 or issues a policy of health insurance that provides coverage for prescription drugs  
21 shall not:

22 (a) Require an insured to pay a higher deductible, *any* copayment or  
23 coinsurance or require a longer waiting period or other condition for coverage for a  
24 prescription for ~~{a contraceptive or}~~ hormone replacement therapy ; ~~{than is~~  
25 ~~required for other prescription drugs covered by the policy;}~~

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

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

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

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

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

44 4. *An insurer may require an insured to:*

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

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

50 5. The provisions of this section do not ~~+~~

51 ~~—(a) Require} require~~ an insurer to provide coverage for fertility drugs.

52 ~~{(b) Prohibit an insurer from requiring an insured to pay a deductible,~~  
53 ~~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. 16.** 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}~~ *Except as otherwise provided in subsection 4, 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, *any* 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.}~~ *An insurer may require an insured to:*

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

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

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

8 **Sec. 17.** NRS 689A.044 is hereby amended to read as follows:

9 689A.044 1. A policy of health insurance must provide coverage for  
10 benefits payable for expenses incurred for ~~administering~~ :

11 *(a) Deoxyribonucleic acid testing for high-risk strains of human*  
12 *papillomavirus; and*

13 *(b) Administering* the human papillomavirus vaccine as recommended for  
14 vaccination by a competent authority, including, without limitation, the Centers for  
15 Disease Control and Prevention of the United States Department of Health and  
16 Human Services, the Food and Drug Administration or the manufacturer of the  
17 vaccine.

18 2. ~~A policy of health insurance must not require an insured to obtain prior~~  
19 ~~authorization for any service provided pursuant to subsection 1.~~ *Except as*  
20 *otherwise provided in subsection 4, an insurer that offers or issues a policy of*  
21 *health insurance shall not:*

22 *(a) Require an insured to pay a higher deductible, any copayment or*  
23 *coinsurance or require a longer waiting period or other condition to obtain any*  
24 *benefit provided in the policy of health insurance pursuant to subsection 1;*

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

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

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

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

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

38 3. A policy subject to the provisions of this chapter which is delivered, issued  
39 for delivery or renewed on or after ~~July 1, 2007,~~ *January 1, 2018*, has the legal  
40 effect of including the coverage required by subsection 1, and any provision of the  
41 policy or the renewal which is in conflict with subsection 1 is void.

42 4. ~~For the purposes of~~ *An insurer may require an insured to:*

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

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

48 5. As used in this section ~~human~~ :

49 *(a) "Human* papillomavirus vaccine" means the Quadrivalent Human  
50 Papillomavirus Recombinant Vaccine or its successor which is approved by the  
51 Food and Drug Administration for the prevention of human papillomavirus  
52 infection and cervical cancer.

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



1       **Sec. 18.** NRS 689A.330 is hereby amended to read as follows:

2       689A.330 If any policy is issued by a domestic insurer for delivery to a  
3 person residing in another state, and if the insurance commissioner or  
4 corresponding public officer of that other state has informed the Commissioner that  
5 the policy is not subject to approval or disapproval by that officer, the  
6 Commissioner may by ruling require that the policy meet the standards set forth in  
7 NRS 689A.030 to 689A.320, inclusive **H**, and sections 12 and 13 of this act.

8       **Sec. 19.** Chapter 689B of NRS is hereby amended by adding thereto the  
9 provisions set forth as sections 20 and 21 of this act.

10       **Sec. 20.** 1. *Except as otherwise provided in subsection 4, an insurer that*  
11 *offers or issues a policy of group health insurance shall include in the policy*  
12 *coverage for:*

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

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

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

20       (d) *Education and counseling relating to contraception; and*

21       (e) *Voluntary sterilization for women.*

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

24       (a) *Require an insured to pay a higher deductible, any copayment or*  
25 *coinsurance or require a longer waiting period or other condition to obtain any*  
26 *benefit provided in the policy of group health insurance pursuant to subsection 1;*

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

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

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

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

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

40       3. *Except as otherwise provided in subsection 4, a policy of group health*  
41 *insurance subject to the provisions of this chapter that is delivered, issued for*  
42 *delivery or renewed on or after January 1, 2018, has the legal effect of including*  
43 *the coverage required by subsection 1, and any provision of the policy or the*  
44 *renewal which is in conflict with this section is void.*

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



1       5. If an insurer refuses, pursuant to subsection 4, to provide the coverage  
2       required by subsection 1, an employer may otherwise provide for the coverage for  
3       the employees of the employer.

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

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

13      8. An insurer may require an insured to:

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

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

19      9. As used in this section:

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

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

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

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

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

28      Sec. 21. 1. An insurer that offers or issues a policy of group health  
29      insurance shall include in the policy coverage for:

30      (a) Counseling, support and supplies for breastfeeding, including, without  
31      limitation, renting or purchasing equipment for breastfeeding;

32      (b) Screening and counseling for interpersonal and domestic violence;

33      (c) Counseling for sexually transmitted diseases;

34      (d) Such prenatal screenings and tests as recommended by the American  
35      College of Obstetricians and Gynecologists or its successor organization;

36      (e) Screening for blood pressure abnormalities and diabetes, including,  
37      without limitation, gestational diabetes;

38      (f) An annual screening for cervical cancer;

39      (g) Screening for depression;

40      (h) Screening and counseling for the human immunodeficiency virus;

41      (i) Smoking cessation programs, including, without limitation, not more than  
42      two cessation attempts per year and four counseling sessions of not more than 10  
43      minutes each;

44      (j) All vaccinations recommended by the Advisory Committee on  
45      Immunization Practices of the Centers for Disease Control and Prevention of the  
46      United States Department of Health and Human Services or its successor  
47      organization; and

48      (k) Such well-woman preventative visits as recommended by the Health  
49      Resources and Services Administration.

50      2. Except as otherwise provided in subsection 4, an insurer that offers or  
51      issues a policy of group health insurance shall not:

1 *(a) Require an insured to pay a higher deductible, any copayment or*  
2 *coinsurance or require a longer waiting period or other condition to obtain any*  
3 *benefit provided in the policy of group health insurance pursuant to subsection 1;*

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

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

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

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

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

17 3. *A policy subject to the provisions of this chapter that is delivered, issued*  
18 *for delivery or renewed on or after January 1, 2018, has the legal effect of*  
19 *including the coverage required by subsection 1, and any provision of the policy*  
20 *or the renewal which is in conflict with this section is void.*

21 4. *An insurer may require an insured to:*

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

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

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

29 **Sec. 22.** NRS 689B.0313 is hereby amended to read as follows:

30 689B.0313 1. A policy of group health insurance must provide coverage for  
31 benefits payable for expenses incurred for ~~administering~~ :

32 *(a) Deoxyribonucleic acid testing for high-risk strains of human*  
33 *papillomavirus; and*

34 *(b) Administering the human papillomavirus vaccine as recommended for*  
35 *vaccination by a competent authority, including, without limitation, the Centers for*  
36 *Disease Control and Prevention of the United States Department of Health and*  
37 *Human Services, the Food and Drug Administration or the manufacturer of the*  
38 *vaccine.*

39 2. ~~[A policy of group health insurance must not require an insured to obtain~~  
40 ~~prior authorization for any service provided pursuant to subsection 1.] Except as~~  
41 ~~otherwise provided in subsection 4, an insurer that offers or issues a policy of~~  
42 ~~group health insurance shall not:~~

43 *(a) Require an insured to pay a higher deductible, any copayment or*  
44 *coinsurance or require a longer waiting period or other condition to obtain any*  
45 *benefit provided in the policy of group health insurance pursuant to subsection 1;*

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

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

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

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

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

6 3. A policy subject to the provisions of this chapter which is delivered, issued  
7 for delivery or renewed on or after ~~July 1, 2007~~ *January 1, 2018*, has the legal  
8 effect of including the coverage required by subsection 1, and any provision of the  
9 policy or the renewal which is in conflict with subsection 1 is void.

10 4. ~~For the purposes of~~ *An insurer may require an insured to:*

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

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

16 5. *As used in this section* ~~“human”~~ *:*

17 *(a) “Human papillomavirus vaccine” means the Quadrivalent Human*  
18 *Papillomavirus Recombinant Vaccine or its successor which is approved by the*  
19 *Food and Drug Administration for the prevention of human papillomavirus*  
20 *infection and cervical cancer.*

21 *(b) “Provider of health care” has the meaning ascribed to it in NRS 629.031.*

22 Sec. 23. NRS 689B.0374 is hereby amended to read as follows:

23 689B.0374 1. A policy of group health insurance must provide coverage for  
24 benefits payable for expenses incurred for:

25 *(a) An annual cytologic screening test for women* ~~18 years of age or older;~~  
26 *between the ages of 21 and 29 years;*

27 *(b)* ~~A baseline mammogram for women between the ages of 35 and 40;~~ *A*  
28 *cytologic screening test for women between the ages of 30 and 65 years:*

29 *(1) Every 3 years; or*

30 *(2) Every 5 years if carried out at the same time as testing for human*  
31 *papillomavirus; and*

32 *(c) An annual mammogram for women.* ~~40 years of age or older;~~

33 2. ~~A policy of group health insurance must not require an insured to obtain~~  
34 ~~prior authorization for any service provided pursuant to subsection 1.~~ *Except as*  
35 *otherwise provided in subsection 4, an insurer that offers or issues a policy of*  
36 *group health insurance shall not:*

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

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

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

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

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

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

3. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~{October 1, 1989,}~~ **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 subsection 1 is void.

4. *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.*

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

Sec. 24. 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}~~ **Except as otherwise provided in subsection 4, 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, **any** 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. *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.*

5. The provisions of this section do not ~~+~~

~~—(a) Require~~ **require** an insurer to provide coverage for fertility drugs.

~~1 (b) Prohibit an insurer from requiring an insured to pay a deductible,~~  
~~2 copayment or coinsurance for the coverage required by paragraphs (a) and (b) of~~  
~~3 subsection 1 that is the same as the insured is required to pay for other prescription~~  
~~4 drugs covered by the policy.~~

~~5 — 5. An insurer which offers or issues a policy of group health insurance and~~  
~~6 which is affiliated with a religious organization is not required to provide the~~  
~~7 coverage required by paragraph (a) of subsection 1 if the insurer objects on~~  
~~8 religious grounds. Such an insurer shall, before the issuance of a policy of group~~  
~~9 health insurance and before the renewal of such a policy, provide to the group~~  
~~10 policyholder or prospective insured, as applicable, written notice of the coverage~~  
~~11 that the insurer refuses to provide pursuant to this subsection. The insurer shall~~  
~~12 provide notice to each insured, at the time the insured receives his or her certificate~~  
~~13 of coverage or evidence of coverage, that the insurer refused to provide coverage~~  
~~14 pursuant to this subsection.~~

~~15 — 6. If an insurer refuses, pursuant to subsection 5, to provide the coverage~~  
~~16 required by paragraph (a) of subsection 1, an employer may otherwise provide for~~  
~~17 the coverage for the employees of the employer.~~

~~18 — 7. 6. As used in this section, “provider of health care” has the meaning~~  
~~19 ascribed to it in NRS 629.031.~~

**Sec. 25.** NRS 689B.0377 is hereby amended to read as follows:

~~21 689B.0377 1. ~~{Except as otherwise provided in subsection 5, an}~~ An insurer~~  
~~22 that offers or issues a policy of group health insurance which provides coverage for~~  
~~23 outpatient care shall include in the policy coverage for any health care service~~  
~~24 related to ~~{contraceptives or}~~ hormone replacement therapy.~~

~~25 2. ~~{An}~~ Except as otherwise provided in subsection 4, an insurer that offers~~  
~~26 or issues a policy of group health insurance that provides coverage for outpatient~~  
~~27 care shall not:~~

~~28 (a) Require an insured to pay a higher deductible, any copayment or~~  
~~29 coinsurance or require a longer waiting period or other condition for coverage for~~  
~~30 outpatient care related to ~~{contraceptives or}~~ hormone replacement therapy ; ~~{than~~~~  
~~31 ~~is required for other outpatient care covered by the policy;}~~~~

~~32 (b) Refuse to issue a policy of group health insurance or cancel a policy of~~  
~~33 group health insurance solely because the person applying for or covered by the~~  
~~34 policy uses or may use in the future ~~{any of the services listed in subsection 1;}~~~~  
~~35 ~~hormone replacement therapy;~~~~

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

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

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

~~45 3. ~~{Except as otherwise provided in subsection 5, a}~~ A policy subject to the~~  
~~46 provisions of this chapter that is delivered, issued for delivery or renewed on or~~  
~~47 after October 1, 1999, has the legal effect of including the coverage required by~~  
~~48 subsection 1, and any provision of the policy or the renewal which is in conflict~~  
~~49 with this section is void.~~

~~50 4. ~~{The provisions of this section do not prohibit an insurer from requiring an~~~~  
~~51 ~~insured to pay a deductible, copayment or coinsurance for the coverage required by~~~~  
~~52 ~~subsection 1 that is the same as the insured is required to pay for other outpatient~~~~  
~~53 ~~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. 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.*

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

Sec. 26. Chapter 689C of NRS is hereby amended by adding thereto the provisions set forth as sections 27 to 30, inclusive, of this act.

Sec. 27. 1. *Except as otherwise provided in subsection 4, 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;*

*(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; and*

*(e) Voluntary sterilization for women.*

2. *Except as otherwise provided in subsections 5, 6 and 7, 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 provided 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 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 any such benefit.*

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

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

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

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

21       7. A carrier may require an insured to:

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

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

27       8. As used in this section:

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

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

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

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

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

36       Sec. 28. 1. A carrier that offers or issues a health benefit plan shall  
37 include in the plan coverage for:

38       (a) Counseling, support and supplies for breastfeeding, including, without  
39 limitation, renting or purchasing equipment for breastfeeding;

40       (b) Screening and counseling for interpersonal and domestic violence;

41       (c) Counseling for sexually transmitted diseases;

42       (d) Hormone replacement therapy;

43       (e) Such prenatal screenings and tests as recommended by the American  
44 College of Obstetricians and Gynecologists or its successor organization;

45       (f) Screening for blood pressure abnormalities and diabetes, including,  
46 without limitation, gestational diabetes;

47       (g) An annual screening for cervical cancer;

48       (h) Screening for depression;

49       (i) Screening and counseling for the human immunodeficiency virus;

50       (j) Smoking cessation programs, including, without limitation, not more than  
51 two cessation attempts per year and four counseling sessions of not more than 10  
52 minutes each;



1       (k) All vaccinations recommended by the Advisory Committee on  
2       Immunization Practices of the Centers for Disease Control and Prevention of the  
3       United States Department of Health and Human Services or its successor  
4       organization; and

5       (l) Such well-woman preventative visits as recommended by the Health  
6       Resources and Services Administration.

7       2. Except as otherwise provided in subsection 4, a carrier that offers or  
8       issues a health benefit plan shall not:

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

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

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

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

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

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

25      3. A plan subject to the provisions of this chapter that is delivered, issued  
26      for delivery or renewed on or after January 1, 2018, has the legal effect of  
27      including the coverage required by subsection 1, and any provision of the plan or  
28      the renewal which is in conflict with this section is void.

29      4. A carrier may require an insured to:

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

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

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

37      **Sec. 29. 1. A health benefit plan must provide coverage for benefits**  
38      **payable for expenses incurred for:**

39      (a) Deoxyribonucleic acid testing for high-risk strains of human  
40      papillomavirus; and

41      (b) Administering the human papillomavirus vaccine as recommended for  
42      vaccination by a competent authority, including, without limitation, the Centers  
43      for Disease Control and Prevention of the United States Department of Health  
44      and Human Services, the Food and Drug Administration or the manufacturer of  
45      the vaccine.

46      2. Except as otherwise provided in subsection 4, a carrier that offers or  
47      issues a health benefit plan shall not:

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

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



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

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

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

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

11 3. A plan subject to the provisions of this chapter which is delivered, issued  
12 for delivery or renewed on or after January 1, 2018, has the legal effect of  
13 including the coverage required by subsection 1, and any provision of the plan or  
14 the renewal which is in conflict with subsection 1 is void.

15 4. A carrier may require an insured to:

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

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

21 5. As used in this section:

22 (a) "Human papillomavirus vaccine" means the Quadrivalent Human  
23 Papillomavirus Recombinant Vaccine or its successor which is approved by the  
24 Food and Drug Administration for the prevention of human papillomavirus  
25 infection and cervical cancer.

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

27 Sec. 30. 1. A health benefit plan must provide coverage for benefits  
28 payable for expenses incurred for:

29 (a) An annual cytologic screening test for women between the ages of 21 and  
30 29 years;

31 (b) A cytologic screening test for women between the ages of 30 and 65  
32 years:

33 (1) Every 3 years; or

34 (2) Every 5 years if carried out at the same time as testing for human  
35 papillomavirus; and

36 (c) An annual mammogram for women.

37 2. Except as otherwise provided in subsection 4, a carrier that offers or  
38 issues a health benefit plan shall not:

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

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

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

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

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

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

3       3. *A plan subject to the provisions of this chapter which is delivered, issued*  
4 *for delivery or renewed on or after January 1, 2018, has the legal effect of*  
5 *including the coverage required by subsection 1, and any provision of the plan or*  
6 *the renewal which is in conflict with subsection 1 is void.*

7       4. *A carrier may require an insured to:*

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

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

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

15       Sec. 31. NRS 689C.425 is hereby amended to read as follows:

16       689C.425 A voluntary purchasing group and any contract issued to such a  
17 group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the  
18 provisions of NRS 689C.015 to 689C.355, inclusive, *and sections 27 to 30,*  
19 *inclusive, of this act* to the extent applicable and not in conflict with the express  
20 provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

21       Sec. 32. Chapter 695A of NRS is hereby amended by adding thereto the  
22 provisions set forth as sections 33 to 36, inclusive, of this act.

23       Sec. 33. 1. *Except as otherwise provided in subsection 4, a society that*  
24 *offers or issues a benefit contract which provides coverage for prescription drugs*  
25 *or devices shall include in the contract coverage for:*

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

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

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

33       (d) *Education and counseling relating to contraception; and*

34       (e) *Voluntary sterilization for women.*

35       2. *Except as otherwise provided in subsections 5, 6 and 7, a society that*  
36 *offers or issues a benefit contract shall not:*

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

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

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

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

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

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

3. Except as otherwise provided in subsection 4, 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. As used in this section:

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

(a) Counseling, support and supplies for breastfeeding, including, without limitation, renting or purchasing equipment for breastfeeding;

(b) Screening and counseling for interpersonal and domestic violence;

(c) Counseling for sexually transmitted diseases;

(d) Hormone replacement therapy;

(e) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(f) Screening for blood pressure abnormalities and diabetes, including, without limitation, gestational diabetes;

(g) An annual screening for cervical cancer;

(h) Screening for depression;

(i) Screening and counseling for the human immunodeficiency virus;

(j) Smoking cessation programs, including, without limitation, not more than two cessation attempts per year and four counseling sessions of not more than 10 minutes each;

1       (k) All vaccinations recommended by the Advisory Committee on  
2       Immunization Practices of the Centers for Disease Control and Prevention of the  
3       United States Department of Health and Human Services or its successor  
4       organization; and

5       (l) Such well-woman preventative visits as recommended by the Health  
6       Resources and Services Administration.

7       2. Except as otherwise provided in subsection 4, a society that offers or  
8       issues a benefit contract shall not:

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

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

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

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

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

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

25      3. A benefit contract subject to the provisions of this chapter that is  
26      delivered, issued for delivery or renewed on or after January 1, 2018, has the  
27      legal effect of including the coverage required by subsection 1, and any provision  
28      of the benefit contract or the renewal which is in conflict with this section is void.

29      4. A society may require an insured to:

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

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

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

37      Sec. 35. 1. A benefit contract must provide coverage for benefits payable  
38      for expenses incurred for:

39      (a) Deoxyribonucleic acid testing for high-risk strains of human  
40      papillomavirus; and

41      (b) Administering the human papillomavirus vaccine, as recommended for  
42      vaccination by a competent authority, including, without limitation, the Centers  
43      for Disease Control and Prevention of the United States Department of Health  
44      and Human Services, the Food and Drug Administration or the manufacturer of  
45      the vaccine.

46      2. Except as otherwise provided in subsection 4, a society that offers or  
47      issues a benefit contract shall not:

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

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

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

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

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

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

11      3. A benefit contract subject to the provisions of this chapter which is  
12      delivered, issued for delivery or renewed on or after January 1, 2018, has the  
13      legal effect of including the coverage required by subsection 1, and any provision  
14      of the benefit contract or the renewal which is in conflict with subsection 1 is  
15      void.

16      4. A society may require an insured to:

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

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

22      5. As used in this section:

23      (a) "Human papillomavirus vaccine" means the Quadrivalent Human  
24      Papillomavirus Recombinant Vaccine or its successor which is approved by the  
25      Food and Drug Administration for the prevention of human papillomavirus  
26      infection and cervical cancer.

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

28      Sec. 36. 1. A benefit contract must provide coverage for benefits payable  
29      for expenses incurred for:

30      (a) An annual cytologic screening test for women between the ages of 21 and  
31      29 years;

32      (b) A cytologic screening test for women between the ages of 30 and 65  
33      years:

34          (1) Every 3 years; or

35          (2) Every 5 years if carried out at the same time as testing for human  
36          papillomavirus; and

37      (c) An annual mammogram for women.

38      2. Except as otherwise provided in subsection 4, a society that offers or  
39      issues a benefit contract shall not:

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

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

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

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

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

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

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

8       4. *A society may require an insured to:*

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

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

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

16       Sec. 37. Chapter 695B of NRS is hereby amended by adding thereto the  
17 provisions set forth as sections 38 and 39 of this act.

18       Sec. 38. 1. *Except as otherwise provided in subsection 4, an insurer that*  
19 *offers or issues a contract for hospital or medical service shall include in the*  
20 *contract coverage for:*

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

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

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

28       (d) *Education and counseling relating to contraception; and*

29       (e) *Voluntary sterilization for women.*

30       2. *Except as otherwise provided in subsections 6, 7 and 8, an insurer that*  
31 *offers or issues a contract for hospital or medical service shall not:*

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

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

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

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

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

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

49       3. *Except as otherwise provided in subsection 4, a contract for hospital or*  
50 *medical service subject to the provisions of this chapter that is delivered, issued*  
51 *for delivery or renewed on or after January 1, 2018, has the legal effect of*  
52 *including the coverage required by subsection 1, and any provision of the*  
53 *contract or the renewal which is in conflict with this section is void.*

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

8       5. *If an insurer refuses, pursuant to subsection 4, to provide the coverage*  
9 *required by subsection 1, an employer may otherwise provide for the coverage for*  
10 *the employees of the employer.*

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

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

20       8. *An insurer may require an insured to:*

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

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

26       9. *As used in this section:*

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

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

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

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

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

35       **Sec. 39. 1.** *An insurer that offers or issues a contract for hospital or*  
36 *medical service shall include in the contract coverage for:*

37       (a) *Counseling, support and supplies for breastfeeding, including, without*  
38 *limitation, renting or purchasing equipment for breastfeeding;*

39       (b) *Screening and counseling for interpersonal and domestic violence;*

40       (c) *Counseling for sexually transmitted diseases;*

41       (d) *Such prenatal screenings and tests as recommended by the American*  
42 *College of Obstetricians and Gynecologists or its successor organization;*

43       (e) *Screening for blood pressure abnormalities and diabetes, including,*  
44 *without limitation, gestational diabetes;*

45       (f) *An annual screening for cervical cancer;*

46       (g) *Screening for depression;*

47       (h) *Screening and counseling for the human immunodeficiency virus;*

48       (i) *Smoking cessation programs, including, without limitation, not more than*  
49 *two cessation attempts per year and four counseling sessions of not more than 10*  
50 *minutes each;*

51       (j) *All vaccinations recommended by the Advisory Committee on*  
52 *Immunization Practices of the Centers for Disease Control and Prevention of the*



1 *United States Department of Health and Human Services or its successor*  
2 *organization; and*

3 *(k) Such well-woman preventative visits as recommended by the Health*  
4 *Resources and Services Administration.*

5 2. *Except as otherwise provided in subsection 4, an insurer that offers or*  
6 *issues a contract for hospital or medical service shall not:*

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

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

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

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

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

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

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

29 4. *An insurer may require an insured to:*

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

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

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

37 Sec. 40. NRS 695B.1912 is hereby amended to read as follows:

38 695B.1912 1. ~~{A policy of health insurance issued by a hospital or medical~~  
39 ~~service corporation}~~ *An insurer that offers or issues a contract for hospital or*  
40 *medical service must provide coverage for benefits payable for expenses incurred*  
41 *for:*

42 *(a) An annual cytologic screening test for women* ~~{18 years of age or older;}~~  
43 *between the ages of 21 and 29 years;*

44 *(b)* ~~{A baseline mammogram for women between the ages of 35 and 40;}~~ *A*  
45 *cytologic screening test for women between the ages of 30 and 65 years:*

46 *(1) Every 3 years; or*

47 *(2) Every 5 years if carried out at the same time as testing for human*  
48 *papillomavirus; and*

49 *(c) An annual mammogram for women.* ~~{40 years of age or older;}~~

50 2. ~~{A policy of health insurance issued by a hospital or medical service~~  
51 ~~corporation must not require an insured to obtain prior authorization for any service~~  
52 ~~provided pursuant to subsection 1.}~~ *Except as otherwise provided in subsection 4,*



*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 provided in a 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 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 any such benefit.*

3. A ~~policy~~ contract for hospital or medical service subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~October 1, 1989~~ January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the ~~policy~~ contract or the renewal which is in conflict with subsection 1 is void.

4. *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.*

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

Sec. 41. 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. ~~Except as otherwise provided in subsection 4, 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, any 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 for hospital or medical service* 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. *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.*

5. The provisions of this section do not ~~1:~~

~~(a) Require~~ *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.~~ 6. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 42. 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~~ *Except as otherwise provided in subsection 4, 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, *any* 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 for hospital or medical service* 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. 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.*

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

Sec. 43. NRS 695B.1925 is hereby amended to read as follows:

695B.1925 1. ~~A policy of health insurance issued by a hospital or medical service corporation~~ *An insurer that offers or issues a contract for hospital or medical service* must provide coverage for benefits payable for expenses incurred for ~~administering~~ :

*(a) Deoxyribonucleic acid testing for high-risk strains of human papillomavirus; and*

*(b) Administering the human papillomavirus vaccine* ~~to women and girls~~ at such ages as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United

1 States Department of Health and Human Services, the Food and Drug  
2 Administration or the manufacturer of the vaccine.

3 ~~2. A policy of health insurance issued by a hospital or medical service~~  
4 ~~corporation must not require an insured to obtain prior authorization for any service~~  
5 ~~provided pursuant to subsection 1.~~ *Except as otherwise required by subsection 4,*  
6 *an insurer that offers or issues a contract for hospital or medical service shall*  
7 *not:*

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

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

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

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

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

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

25 3. A ~~policy~~ *contract for hospital or medical service* subject to the  
26 provisions of this chapter which is delivered, issued for delivery or renewed on or  
27 after ~~July 1, 2007~~ *January 1, 2018*, has the legal effect of including the coverage  
28 required by subsection 1, and any provision of the ~~policy~~ *contract* or the renewal  
29 which is in conflict with subsection 1 is void.

30 4. ~~For the purposes of~~ *An insurer may require an insured to:*

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

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

36 5. As used in this section ~~the "human"~~:

37 *(a) "Human papillomavirus vaccine" means the Quadrivalent Human*  
38 *Papillomavirus Recombinant Vaccine or its successor which is approved by the*  
39 *Food and Drug Administration for the prevention of human papillomavirus*  
40 *infection and cervical cancer.*

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

42 Sec. 44. Chapter 695C of NRS is hereby amended by adding thereto the  
43 provisions set forth as sections 45 and 46 of this act.

44 Sec. 45. 1. *Except as otherwise provided in subsection 4, a health*  
45 *maintenance organization that offers or issues a health care plan shall include in*  
46 *the plan coverage for:*

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

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

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

1       (d) Education and counseling relating to contraception; and

2       (e) Voluntary sterilization for women.

3       2. Except as otherwise provided in subsections 6, 7 and 8, a health  
4 maintenance organization that offers or issues a health care plan shall not:

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

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

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

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

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

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

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

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

33       5. If a health maintenance organization, pursuant to subsection 4, refuses  
34 to provide the coverage required by subsection 1, an employer may otherwise  
35 provide for the coverage for the employees of the employer.

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

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

46       8. A health maintenance organization may require an enrollee to:

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

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

53       9. As used in this section:

(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) A higher deductible, copayment or coinsurance may be charged for a drug or device for contraception which is not a therapeutic equivalent.

Sec. 46. 1. A health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:

(a) Counseling, support and supplies for breastfeeding, including, without limitation, renting or purchasing equipment for breastfeeding;

(b) Screening and counseling for interpersonal and domestic violence;

(c) Counseling for sexually transmitted diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(e) Screening for blood pressure abnormalities and diabetes, including, without limitation, gestational diabetes;

(f) An annual screening for cervical cancer;

(g) Screening for depression;

(h) Screening and counseling for the human immunodeficiency virus;

(i) Smoking cessation programs, including, without limitation, not more than two cessation attempts per year and four counseling sessions of not more than 10 minutes each;

(j) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and

(k) Such well-woman preventative visits as recommended by the Health Resources and Services Administration.

2. Except as otherwise provided in subsection 4, 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 provided 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.

3. 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.

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

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

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

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

9 **Sec. 47.** NRS 695C.050 is hereby amended to read as follows:

10 695C.050 1. Except as otherwise provided in this chapter or in specific  
11 provisions of this title, the provisions of this title are not applicable to any health  
12 maintenance organization granted a certificate of authority under this chapter. This  
13 provision does not apply to an insurer licensed and regulated pursuant to this title  
14 except with respect to its activities as a health maintenance organization authorized  
15 and regulated pursuant to this chapter.

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

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

23 4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693,  
24 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733,  
25 695C.17335, 695C.1734, ~~695C.1735 to~~ 695C.1751, 695C.1755, ~~inclusive,~~  
26 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health  
27 maintenance organization that provides health care services through managed care  
28 to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to  
29 the Children's Health Insurance Program pursuant to a contract with the Division of  
30 Health Care Financing and Policy of the Department of Health and Human  
31 Services. This subsection does not exempt a health maintenance organization from  
32 any provision of this chapter for services provided pursuant to any other contract.

33 5. The provisions of NRS 695C.1694, 695C.1695, 695C.1708, 695C.1731,  
34 695C.17345 ~~and~~, 695C.1735, 695C.1745 and 695C.1757 and sections 45 and 46  
35 *of this act* apply to a health maintenance organization that provides health care  
36 services through managed care to recipients of Medicaid under the State Plan for  
37 Medicaid.

38 **Sec. 48.** NRS 695C.1694 is hereby amended to read as follows:

39 695C.1694 1. ~~Except as otherwise provided in subsection 5, a~~ A health  
40 maintenance organization which offers or issues a health care plan that provides  
41 coverage for prescription drugs or devices shall include in the plan coverage for ~~+~~

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

43 ~~— (b) Any~~ any type of hormone replacement therapy ~~+~~

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

46 2. ~~+~~ Except as otherwise provided in subsection 4, a health maintenance  
47 organization that offers or issues a health care plan that provides coverage for  
48 prescription drugs shall not:

49 (a) Require an enrollee to pay a higher deductible, any copayment or  
50 coinsurance or require a longer waiting period or other condition for coverage for ~~+~~  
51 ~~prescription for a contraceptive or~~ hormone replacement therapy ; ~~than is required~~  
52 ~~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. *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.*

5. The provisions of this section do not ~~1:~~

~~—(a) Require~~ *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.~~ 6. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 49. 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}~~ *Except as otherwise provided in subsection 4, 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, *any* 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.}~~ *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.*

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

Sec. 50. NRS 695C.1735 is hereby amended to read as follows:

695C.1735 1. A health ~~health maintenance~~ *care plan of a health maintenance organization* must provide coverage for benefits payable for expenses incurred for:

(a) An annual cytologic screening test for women ~~18 years of age or older;~~ *between the ages of 21 and 29 years;*

(b) ~~A baseline mammogram for women between the ages of 35 and 40;~~ *A cytologic screening test for women between the ages of 30 and 65 years:*

*(1) Every 3 years; or*

*(2) Every 5 years if carried out at the same time as testing for human papillomavirus; and*

(c) An annual mammogram for women ~~40 years of age or older;~~

2. ~~A health maintenance plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.~~ *Except as otherwise provided in subsection 4, 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 provided 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 benefit provided in the health care plan pursuant to subsection 1;*

*(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.*

3. A ~~policy~~ *health care plan* subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~October 1, 1989;~~ *January 1, 2018*, has the legal effect of including the coverage required by subsection 1, and any provision of the ~~policy~~ *plan* or the renewal which is in conflict with subsection 1 is void.

4. *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.*

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

Sec. 51. NRS 695C.1745 is hereby amended to read as follows:

695C.1745 1. A health care plan of a health maintenance organization must provide coverage for benefits payable for expenses incurred for ~~administering~~ :

*(a) Deoxyribonucleic acid testing for high-risk strains of human papillomavirus; and*

*(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for*

1 Disease Control and Prevention of the United States Department of Health and  
2 Human Services, the Food and Drug Administration or the manufacturer of the  
3 vaccine.

4 2. ~~1. A health care plan of a health maintenance organization must not require~~  
5 ~~an insured to obtain prior authorization for any service provided pursuant to~~  
6 ~~subsection 1.~~ *Except as otherwise provided in subsection 4, a health maintenance*  
7 *organization that offers or issues a health care plan shall not:*

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

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

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

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

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

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

24 3. Any evidence of coverage subject to the provisions of this chapter which is  
25 delivered, issued for delivery or renewed on or after ~~July 1, 2007,~~ *January 1,*  
26 *2018*, has the legal effect of including the coverage required by subsection 1, and  
27 any provision of the evidence of coverage or the renewal which is in conflict with  
28 subsection 1 is void.

29 4. ~~For the purposes of~~ *A health maintenance organization may require*  
30 *an enrollee to:*

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

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

37 5. *As used in this section* ~~1. "human"~~ *:*

38 *(a) "Human* papillomavirus vaccine" means the Quadrivalent Human  
39 Papillomavirus Recombinant Vaccine or its successor which is approved by the  
40 Food and Drug Administration for the prevention of human papillomavirus  
41 infection and cervical cancer.

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

43 **Sec. 52.** NRS 695C.330 is hereby amended to read as follows:

44 695C.330 1. The Commissioner may suspend or revoke any certificate of  
45 authority issued to a health maintenance organization pursuant to the provisions of  
46 this chapter if the Commissioner finds that any of the following conditions exist:

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

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, *and sections 45 and 46 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. 53.** Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 54, 55 and 56 of this act.

**Sec. 54. 1.** *Except as otherwise provided in subsection 4, a managed care organization that offers or issues a health care plan shall include in the plan coverage for:*

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

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

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

8       (d) Education and counseling relating to contraception;

9       (e) Voluntary sterilization for women; and

10      (f) Hormone replacement therapy.

11      2. Except as otherwise provided in subsections 5, 6 and 7, a managed care  
12      organization that offers or issues a health care plan which provides coverage for  
13      prescription drugs shall not:

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

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

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

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

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

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

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

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

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

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

52      7. A managed care organization may require an insured to:

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

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

7       8. As used in this section:

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

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

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

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

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

16       Sec. 55. 1. A managed care organization that offers or issues a health  
17 care plan shall include in the plan coverage for:

18       (a) Counseling, support and supplies for breastfeeding, including, without  
19 limitation, renting or purchasing equipment for breastfeeding;

20       (b) Screening and counseling for interpersonal and domestic violence;

21       (c) Counseling for sexually transmitted diseases;

22       (d) Hormone replacement therapy;

23       (e) Such prenatal screenings and tests as recommended by the American  
24 College of Obstetricians and Gynecologists or its successor organization;

25       (f) Screening for blood pressure abnormalities and diabetes, including,  
26 without limitation, gestational diabetes;

27       (g) Screening for cervical cancer on an annual basis;

28       (h) Screening for depression;

29       (i) Screening and counseling for the human immunodeficiency virus;

30       (j) Smoking cessation programs, including, without limitation, not more than  
31 two cessation attempts per year and four counseling sessions of not more than 10  
32 minutes each;

33       (k) All vaccinations recommended by the Advisory Committee on  
34 Immunization Practices of the Centers for Disease Control and Prevention of the  
35 United States Department of Health and Human Services or its successor  
36 organization; and

37       (l) Such well-woman preventative visits as recommended by the Health  
38 Resources and Services Administration.

39       2. Except as otherwise provided in subsection 4, a managed care  
40 organization that offers or issues a health care plan shall not:

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

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

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

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

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

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

6       3. A health care plan subject to the provisions of this chapter that is  
7       delivered, issued for delivery or renewed on or after January 1, 2018, has the  
8       legal effect of including the coverage required by subsection 1, and any provision  
9       of the plan or the renewal which is in conflict with this section is void.

10      4. A managed care organization may require an insured to:

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

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

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

19      Sec. 56. 1. A health care plan issued by a managed care organization  
20      must provide coverage for benefits payable for expenses incurred for:

21      (a) An annual cytologic screening test for women between the ages of 21 and  
22      29 years;

23      (b) A cytologic screening test for women between the ages of 30 and 65  
24      years:

25          (1) Every three years; or

26          (2) Every five years if carried out at the same time as testing for human  
27          papillomavirus; and

28      (c) An annual mammogram for women.

29      2. Except as otherwise provided in subsection 4, a managed care  
30      organization that offers or issues a health care plan which provides coverage for  
31      prescription drugs shall not:

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

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

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

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

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

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

48      3. A health care plan subject to the provisions of this chapter that is  
49      delivered, issued for delivery or renewed on or after January 1, 2018, has the  
50      legal effect of including the coverage required by subsection 1, and any provision  
51      of the plan or the renewal which is in conflict with this section is void.

52      4. A managed care organization may require an insured to:



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

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

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

9 **Sec. 57.** NRS 695G.171 is hereby amended to read as follows:

10 695G.171 1. A health care plan issued by a managed care organization must  
11 provide coverage for benefits payable for expenses incurred for ~~administering~~ :

12 *(a) Deoxyribonucleic acid testing for high-risk strains of human*  
13 *papillomavirus; and*

14 *(b) Administering* the human papillomavirus vaccine as recommended for  
15 vaccination by a competent authority, including, without limitation, the Centers for  
16 Disease Control and Prevention of the United States Department of Health and  
17 Human Services, the Food and Drug Administration or the manufacturer of the  
18 vaccine.

19 2. ~~{A health care plan must not require an insured to obtain prior authorization~~  
20 ~~for any service provided pursuant to subsection 1.}~~ *Except as otherwise provided in*  
21 *subsection 4, a managed care organization that offers or issues a health care plan*  
22 *which provides coverage for prescription drugs shall not:*

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

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

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

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

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

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

39 3. An evidence of coverage for a health care plan subject to the provisions of  
40 this chapter which is delivered, issued for delivery or renewed on or after ~~{July 1,~~  
41 ~~2007.}~~ *January 1, 2018*, has the legal effect of including the coverage required by  
42 subsection 1, and any provision of the evidence of coverage or the renewal thereof  
43 which is in conflict with subsection 1 is void.

44 4. ~~{For the purposes of}~~ *A managed care organization may require an*  
45 *insured to:*

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

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

52 *5. As used in this section* ~~{,"human"}~~ :

1        *(a) "Human* papillomavirus vaccine" means the Quadrivalent Human  
2 Papillomavirus Recombinant Vaccine or its successor which is approved by the  
3 Food and Drug Administration for the prevention of human papillomavirus  
4 infection and cervical cancer.

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

6        **Sec. 58.** The provisions of NRS 354.599 do not apply to any additional  
7 expenses of a local government that are related to the provisions of this act.

8        **Sec. 59.** This act becomes effective on January 1, 2018.