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 at no additional cost to the covered person; requiring a pharmacist to dispense up to a 12-month supply of certain contraceptives in certain circumstances; 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, 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 10-57** of this bill require certain additional forms of contraceptive drugs, devices, supplies and services 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 men and 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 15, 16, 24, 25, 41, 42, 48 and 49** of this bill remove that authority to exclude such coverage. In addition, **sections 20, 27, 33, 38, 45 and 54** of this bill do not include such a religious exemption. Thus, all insurers are required to provide coverage for the contraceptive drugs, devices and services included in this bill.

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 10-57** 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 beneficiaries. (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 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 2-6** 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 10-57** without any copay, coinsurance or deductible.

Existing law authorizes a pharmacist to dispense up to a 90-day supply of a drug pursuant to a valid prescription in certain circumstances. (NRS 639.2396) **Section 9** of this bill requires a pharmacist to dispense up to a 12-month supply of contraceptives or their therapeutic equivalent upon the request of a patient who has a valid prescription.

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

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

Sec. 2. ***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) 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;

(e) Voluntary sterilization for men and women; and

(f) Hormone replacement therapy.

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

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

(b) Use a program of step therapy;

(c) Obtain prior authorization; or

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

Sec. 3. ***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) Counseling, support and supplies 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) Screening for cervical cancer at least once every 3 years;

(g) Screening for depression;

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

(i) Smoking cessation programs for persons 18 years of age or older;

(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. 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;

(b) Obtain prior authorization; or

(c) 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 18 years of age or older;

(b) A baseline mammogram for women between the ages of 35 and 40 years; and

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

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;

(b) Obtain prior authorization; or

(c) 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;

(b) Obtain prior authorization; or

(c) 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. 6. NRS 422.403 is hereby amended to read as follows:

422.403 1. ~~[The]~~ ***Except as otherwise provided in section 2 of this act, the*** Department shall, by regulation, establish and manage the use by the Medicaid program of step therapy and prior authorization for prescription drugs.

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

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

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

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

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

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

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

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

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

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

the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 10. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0413, ***689A.0415, 689A.0417,*** 689A.044, 689A.0445, 689B.031, 689B.0313, 689B.0317, 689B.0374, ***689B.0376, 689B.0377,*** 695B.1912, 695B.1914, ***695B.1916, 695B.1918,*** 695B.1925, 695B.1942, ***695C.1694, 695C.1695,*** 695C.1713, 695C.1735, 695C.1745, 695C.1751, 695G.170, 695G.171 and 695G.177, ***and sections 12, 13, 20, 21, 38, 39, 45, 46, 54, 55 and 56 of this act,*** any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:

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

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

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

Sec. 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. 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 men and women.

2. 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, including, without limitation, a program of step therapy or prior authorization.

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

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;

(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) Screening for cervical cancer at least once every 3 years;

(g) Screening for depression;

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

(i) Smoking cessation programs for persons 18 years of age or older;

(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. 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, including, without limitation, prior authorization.

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

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

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

(a) An annual cytologic screening test for women 18 years of age or older;

(b) A baseline mammogram for women between the ages of 35 and 40 ~~[,]~~ ***years;*** and

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

2. ~~[A policy of health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***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, including, without limitation, prior authorization.

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

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

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

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

~~(b) Any]~~ ***any*** type of hormone replacement therapy ~~[,~~ ~~"]~~ which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

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

(a) Require an insured to pay a higher deductible, ***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 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 ~~[.]~~ ***; or***

(f) Impose any other restrictions or delays on the access of an insured to hormone replacement therapy, including, without limitation, a program of step therapy or prior authorization.

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,]~~ ***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. The provisions of this section do not ~~[:~~

~~(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 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 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 ~~[.]~~ ***; or***

(f) Impose any other restrictions or delays on the access of an insured to hormone replacement therapy, including, without limitation, a program of step therapy or prior authorization.

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

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

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

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

689A.044 1. A policy of health insurance 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 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. ~~[A policy of health insurance must not require an insured to obtain prior authorization for any service provided pursuant to~~

~~subsection 1.~~] ***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, including, without limitation, a program of step therapy or prior authorization.

3. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***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. ~~[For the purposes of]~~ ***As used in*** this section ~~[, "human]~~ ***:***

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

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

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

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

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

Sec. 20. *1. An insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:*

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

(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 men and women.

2. An insurer that offers or issues a policy of group health insurance shall not:

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

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

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

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement 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, including, without limitation, a program of step therapy or prior authorization.

3. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 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. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

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

(a) Counseling, support and supplies 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) Screening for cervical cancer at least once every 3 years;

(g) Screening for depression;

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

(i) Smoking cessation programs for persons 18 years of age or older;

(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. An insurer that offers or issues a policy of group health insurance shall not:

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

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

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

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

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

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

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

689B.0313 1. A policy of group health insurance 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 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. ~~[A policy of group health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***An insurer that offers or issues a policy of group health insurance shall not:***

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

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

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

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

3. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***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. ~~[For the purposes of]~~ ***As used in*** this section ~~[, "human]~~ ***:***

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

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

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

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

(a) An annual cytologic screening test for women 18 years of age or older;

(b) A baseline mammogram for women between the ages of 35 and 40 ~~[,]~~ ***years;*** and

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

2. ~~[A policy of group health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***An insurer that offers or issues a policy of group health insurance shall not:***

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

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

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

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

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. 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 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 ~~[.]~~ ***; or***

(f) Impose any other restrictions or delays on the access of an insured to hormone replacement therapy, including, without limitation, a program of step therapy or prior authorization.

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,]~~ ***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. The provisions of this section do not ~~[:~~

~~(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 policy.]~~

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

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

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

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

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

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

(a) Require an insured to pay a higher deductible, ***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 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 ~~[.]~~ ***; or***

(f) Impose any other restrictions or delays on the access of an insured to hormone replacement therapy, including, without limitation, a program of step therapy or prior authorization.

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

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

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

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

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

Sec. 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. 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 men and women.

2. 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, including, without limitation, a program of step therapy or prior authorization.

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

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

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

(a) Counseling, support and supplies 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) Screening for cervical cancer at least once every 3 years;

(h) Screening for depression;

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

(j) Smoking cessation programs for persons 18 years of age or older;

(k) 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

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

2. 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, including, without limitation, prior authorization.

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

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

(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 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. 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, including, without limitation, prior authorization.

3. A plan subject to the provisions of this chapter which 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 subsection 1 is void.

4. As used in this section:

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

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

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

(a) An annual cytologic screening test for women 18 years of age or older;

(b) A baseline mammogram for women between the ages of 35 and 40 years; and

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

2. 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, including, without limitation, prior authorization.

3. A plan subject to the provisions of this chapter which 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 subsection 1 is void.

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

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

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

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

Sec. 33. ***1. A society that offers or issues a benefit contract which provides coverage for prescription drugs or devices shall include in the contract coverage for:***

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

(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 men and women.

2. A society that offers or issues a benefit contract shall not:

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

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

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

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement 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, including, without limitation, a program of step therapy or prior authorization.

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

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;

(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) Screening for cervical cancer at least once every 3 years;

(h) Screening for depression;

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

(j) Smoking cessation programs for persons 18 years of age or older;

(k) 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

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

2. A society that offers or issues a benefit contract shall not:

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

other condition to obtain any benefit provided in the benefit contract pursuant to subsection 1;

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

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

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

3. 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 benefit contract or the renewal which is in conflict with this section is void.

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

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

(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 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. A society that offers or issues a benefit contract shall not:

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

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

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

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

3. A benefit contract subject to the provisions of this chapter which 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 benefit contract or the renewal which is in conflict with subsection 1 is void.

4. As used in this section:

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

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

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

(a) An annual cytologic screening test for women 18 years of age or older;

(b) A baseline mammogram for women between the ages of 35 and 40 years; and

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

2. A society that offers or issues a benefit contract shall not:

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

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

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

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

3. A benefit contract subject to the provisions of this chapter which 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 benefit contract or the renewal which is in conflict with subsection 1 is void.

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

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

Sec. 38. ***1. An insurer that offers or issues a contract for hospital or medical service shall include in the contract coverage for:***

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

(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 men and women.

2. 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 the contract for hospital or medical service pursuant to subsection 1;

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

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

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement 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, including, without limitation, a program of step therapy or prior authorization.

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

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

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

(a) Counseling, support and supplies 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) Screening for cervical cancer at least once every 3 years;

(g) Screening for depression;

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

(i) Smoking cessation programs for persons 18 years of age or older;

(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. 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 the contract for hospital or medical service pursuant to subsection 1;

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

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

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

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

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

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

695B.1912 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:

(a) An annual cytologic screening test for women 18 years of age or older;

(b) A baseline mammogram for women between the ages of 35 and 40 ~~[.]~~ ***years;*** and

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

2. ~~[A policy of health insurance issued by a hospital or medical service corporation must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***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, including, without limitation, prior authorization.

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. 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. 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 ~~[.]~~ ***; or***

(f) Impose any other restrictions or delays on the access of an insured to hormone replacement therapy, including, without limitation, a program of step therapy or prior authorization.

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,]~~ ***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. The provisions of this section do not ~~[:~~

~~(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.~~ 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 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 ~~[.]~~ ***; or***

(f) Impose any other restrictions or delays on the access of an insured to hormone replacement therapy, including, without limitation, a program of step therapy or prior authorization.

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

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

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

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

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

2. ~~[A policy of health insurance issued by a hospital or medical service corporation must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***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 the contract for hospital or medical service pursuant to subsection 1;

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

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

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

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 ~~[July 1, 2007,]~~ ***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. ~~[For the purposes of]~~ ***As used in*** this section ~~[, "human]~~ ***:***

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

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

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

Sec. 45. ***1. A health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:***

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

(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 men and women.

2. 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, including, without limitation, a program of step therapy or prior authorization.

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

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;

(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) Screening for cervical cancer at least once every 3 years;

(g) Screening for depression;

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

(i) Smoking cessation programs for persons 18 years of age or older;

(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. 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, including, without limitation, a program of step therapy or prior authorization.

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Require an enrollee to pay a higher deductible, ***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 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 ~~[.]~~ ***; or***

(f) Impose any other restrictions or delays on the access of an enrollee to hormone replacement therapy, including, without limitation, a program of step therapy or prior authorization.

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,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

4. The provisions of this section do not ~~[:~~

~~(a) Require]~~ ***require*** a health maintenance organization to provide coverage for fertility drugs.

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

5. ~~[A health maintenance organization which offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of~~

~~subsection 1 if the health maintenance organization objects on religious grounds. The health maintenance organization shall, before the issuance of a health care plan and before renewal of enrollment in such a plan, provide to the group policyholder or prospective enrollee, as applicable, written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection. The health maintenance organization shall provide notice to each enrollee, at the time the enrollee receives his or her evidence of coverage, that the health maintenance organization refused to provide coverage pursuant to this subsection.~~

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

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

Sec. 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 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 ~~[.]~~ ***; or***

(f) Impose any other restrictions or delays on the access of an enrollee to hormone replacement therapy, including, without limitation, a program of step therapy or prior authorization.

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,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

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

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

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

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

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

695C.1735 1. A 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;

(b) A baseline mammogram for women between the ages of 35 and 40 ~~[,]~~ ***years;*** 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.]~~ ***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, including, without limitation, prior authorization.

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. 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 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. ~~[A health care plan of a health maintenance organization must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***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, including, without limitation, prior authorization.

3. Any evidence of coverage subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***January 1, 2018,*** 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 subsection 1 is void.

4. ~~[For the purposes of]~~ ***As used in*** this section ~~[, "human]~~ ***:***

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

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

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

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

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

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, ***and sections 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. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:***

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

(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;

(e) Voluntary sterilization for men and women; and

(f) Hormone replacement therapy.

2. A managed care organization that offers or issues a health care plan which 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 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 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, including, without limitation, a program of step therapy or prior authorization.

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

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

(a) Counseling, support and supplies 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) Screening for cervical cancer at least once every 3 years;

(h) Screening for depression;

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

(j) Smoking cessation programs for adults;

(k) 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

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

2. A managed care organization that offers or issues a health care plan shall not:

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

other condition to obtain any benefit 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 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, including, without limitation, prior authorization.

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

Sec. 56. *1. A health care plan issued by a managed care 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;

(b) A baseline mammogram for women between the ages of 35 and 40 years; and

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

2. A managed care organization that offers or issues a health care plan which 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 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 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, including, without limitation, prior authorization.

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

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

695G.171 1. A health care plan issued by a managed care 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 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. ~~[A health care plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***A managed care organization that offers or issues a health care plan which 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 to obtain any benefit provided in a 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 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, including, without limitation, prior authorization.

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

4. ~~[For the purposes of]~~ ***As used in*** this section ~~[, "human]~~ ***:***

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

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

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

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

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