

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

MARCH 1, 2017

Referred to Committee on Health and Human Services

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

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

CONTAINS UNFUNDED MANDATE (§§ 7, 8)  
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

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

**Legislative Counsel's Digest:**

1 Existing law requires most health insurance plans which cover prescription  
2 drugs and outpatient care to also include coverage for contraceptive drugs and  
3 devices without an additional copay, coinsurance or a higher deductible than that  
4 which may be charged for other prescription drugs and outpatient care under the  
5 plan. (NRS 689A.0415, 689A.0417, 689B.0376, 689B.0377, 695B.1916,  
6 695B.1918, 695C.1694, 695C.1695) Existing law also requires most health  
7 insurance plans to include coverage for certain preventative services, including the  
8 human papillomavirus vaccine, cytological screenings and mammograms. (NRS  
9 287.0272, 689A.0405, 689A.044, 689B.0313, 689B.0374, 695B.1912, 695B.1925,  
10 695C.1735, 695C.1745, 695G.171) Certain plans, including small employer plans,  
11 benefit contracts provided by fraternal benefit societies, plans issued by a managed  
12 care organization and certain plans offered by governmental entities of this State  
13 are not currently subject to some of these requirements. (Chapters 287, 689C, 695A  
14 and 695G of NRS)



The federal Patient Protection and Affordable Care Act (Public Law 111-148, as amended) requires certain preventative services to be covered by every health insurance plan without any copay, coinsurance or higher deductible, including, without limitation, certain contraceptive drugs, devices and services, certain vaccinations, mammograms, counseling concerning interpersonal and domestic violence, screenings for certain diseases and well-woman preventative visits. (42 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130) This bill places those requirements in Nevada law, requiring all public and private health insurance plans made available in this State to provide coverage for certain preventative services without any copay, coinsurance or a higher deductible. **Sections 7, 8 and 11-57** of this bill allow an insurer to require an insured to pay a higher deductible, copayment or coinsurance for a drug or device for contraception if the insured refused to accept a therapeutic equivalent of the contraceptive drug or device. In addition, a health insurance plan must include for each method of contraception which is approved by the Food and Drug Administration at least one contraceptive drug or device for which no deductible, copayment or coinsurance may be charged to the insured. **Sections 7, 8 and 11-57** authorize an insurer to require a program of step therapy or prior authorization to obtain coverage for the preventative services required by this bill. **Sections 7, 8 and 11-57** also require all forms of contraceptive drugs, devices and services which are approved by the Food and Drug Administration to be covered by a health insurance plan, including up to a 12-month supply of contraceptives or a therapeutic equivalent, insertion or removal of a contraceptive device, education and counseling relating to contraception and voluntary sterilization for women.

Existing law authorizes an insurer which is affiliated with a religious organization and which objects on religious grounds to providing coverage for contraceptive drugs and devices to exclude coverage in its policies, plans or contracts for such drugs and devices. (NRS 689A.0415, 689A.0417, 689B.0376, 689B.0377, 695B.1916, 695B.1918, 695C.1694, 695C.1695) **Sections 20, 27, 33, 38, 45 and 54** of this bill move the religious exemption to the new provisions relating to coverage of contraception.

Existing law requires most health insurance plans which cover prescription drugs and outpatient care to also include coverage for hormone replacement therapy without an additional copay, coinsurance or a higher deductible than that which may be charged for other prescription drugs and outpatient care under the plan. (NRS 689A.0415, 689A.0417, 689B.0376, 689B.0377, 695B.1916, 695B.1918, 695C.1694, 695C.1695) **Sections 7, 8 and 11-57** of this bill expand this requirement to all public and private health insurance plans made available in this State and require health insurance plans to provide coverage for hormone replacement therapy without any copay, coinsurance or higher deductible.

Existing law requires this State to develop a State Plan for Medicaid which includes, without limitation, a list of the medical services provided to Medicaid recipients. (42 U.S.C. § 1396a; NRS 422.063) Existing federal law authorizes a state to charge a copay, coinsurance or deductible for most Medicaid services, but prohibits any copay, coinsurance or deductible for certain contraceptive drugs, devices and services. (42 U.S.C. § 1396o-1) Existing federal law also authorizes a state to define the parameters of contraceptive coverage provided under Medicaid. (42 U.S.C. § 1396u-7) Existing law requires a number of specific medical services to be covered under Medicaid. (NRS 422.2717-422.27241) **Sections 2-5.5** of this bill require the State Plan for Medicaid to include the preventative services currently required to be covered by private health insurance plans pursuant to existing Nevada law, the Patient Protection and Affordable Care Act (Public Law 111-148 as amended) as well as the additional drugs, devices, supplies and services required by **sections 7, 8 and 11-57** without any copay, coinsurance or deductible in most cases. The benefits relating to contraceptive drugs which are provided by



section 2 of this bill are subject to step therapy and prior authorization requirements pursuant to existing law.

Existing law authorizes a pharmacist to dispense up to a 90-day supply of a drug pursuant to a valid prescription or order in certain circumstances. (NRS 639.2396) Section 8.5 of this bill requires a pharmacist to dispense up to a 12-month supply of contraceptives or their therapeutic equivalent pursuant to a valid prescription or order if: (1) the patient has previously received a 3-month supply of the same drug; (2) the patient has previously received a 9-month supply of the same drug or a supply of the same drug for the balance of the plan year in which the 3-month supply was prescribed or ordered, whichever is shorter; (3) the patient is insured by the same health insurance plan; and (4) a provider of health care has not specified in the prescription or order that a different supply of the drug is necessary.

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

**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 women pursuant to 42 C.F.R. §§ 441.250 to 441.259, inclusive; and*

*(f) Hormone replacement therapy.*

**2. *Except as otherwise provided in subsections 4 and 5, 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; or*

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

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

**4. *The Plan may require a person enrolled in Medicaid to pay a higher deductible, copayment or coinsurance for a drug or***



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

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

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

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

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

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

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

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

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

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

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

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

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

36 *(g) Screening for depression;*

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

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

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



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(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; or

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

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

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

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

(1) Every 3 years; or

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

(c) An annual mammogram for women.

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

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

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

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

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

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

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

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

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

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

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



1     **Sec. 5.5.** NRS 422.401 is hereby amended to read as follows:  
2     422.401 As used in NRS 422.401 to 422.406, inclusive, *and*  
3     *sections 2, 3 and 4 of this act*, unless the context otherwise requires,  
4     the words and terms defined in NRS 422.4015 and 422.402 have the  
5     meanings ascribed to them in those sections.

6     **Sec. 5.7.** NRS 422.406 is hereby amended to read as follows:  
7     422.406 1. The Department may, to carry out its duties set  
8     forth in NRS 422.401 to 422.406, inclusive, *and sections 2, 3 and 4*  
9     *of this act*, and to administer the provisions of NRS 422.401 to  
10    422.406, inclusive ~~14~~, *and sections 2, 3 and 4 of this act*:

11    (a) Adopt regulations; and

12    (b) Enter into contracts for any services.

13    2. Any regulations adopted by the Department pursuant to NRS  
14    422.401 to 422.406, inclusive, *and sections 2, 3 and 4 of this act*,  
15    must be adopted in accordance with the provisions of chapter 241 of  
16    NRS.

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

18    **Sec. 7.** NRS 287.010 is hereby amended to read as follows:

19    287.010 1. The governing body of any county, school  
20    district, municipal corporation, political subdivision, public  
21    corporation or other local governmental agency of the State of  
22    Nevada may:

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

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

38    (c) Provide group life, accident or health coverage through a  
39    self-insurance reserve fund and, where necessary, deduct  
40    contributions to the maintenance of the fund from the compensation  
41    of officers and employees and pay the deductions into the fund. The  
42    money accumulated for this purpose through deductions from the  
43    compensation of officers and employees and contributions of the  
44    governing body must be maintained as an internal service fund as  
45    defined by NRS 354.543. The money must be deposited in a state or



1 national bank or credit union authorized to transact business in the  
2 State of Nevada. Any independent administrator of a fund created  
3 under this section is subject to the licensing requirements of chapter  
4 683A of NRS, and must be a resident of this State. Any contract  
5 with an independent administrator must be approved by the  
6 Commissioner of Insurance as to the reasonableness of  
7 administrative charges in relation to contributions collected and  
8 benefits provided. The provisions of NRS 687B.408, 689B.030 to  
9 689B.050, inclusive, *and sections 20 and 21 of this act* and  
10 689B.287 apply to coverage provided pursuant to this paragraph.

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

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

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

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

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

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

45 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. 8.5.** Chapter 639 of NRS is hereby amended by adding thereto a new section to read as follows:

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

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

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

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

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

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

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



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

4. *As used in this section:*

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

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

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

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

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

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

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

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

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



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

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

**Sec. 10.** (Deleted by amendment.)

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

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

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

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

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

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

(e) *Voluntary sterilization for women.*

2. *Except as otherwise provided in subsections 5, 6 and 7, an insurer that offers or issues a policy of health insurance shall not:*

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

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

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

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

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

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



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

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

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

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

26       7. An insurer may require an insured to:

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

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

33       8. As used in this section:

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

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

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

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

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



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

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

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

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

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

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

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

15     **(g) Screening for depression;**

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

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

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

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

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

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

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

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

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

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



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

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. *An insurer may require an insured to:*

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

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

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

Sec. 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;~~ *between the ages of 21 and 29 years;*

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

*(1) Every 3 years; or*

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

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

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

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

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

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



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

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

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

10 3. A policy subject to the provisions of this chapter which is  
11 delivered, issued for delivery or renewed on or after ~~October 1,~~  
12 ~~1989,~~ January 1, 2018, has the legal effect of including the  
13 coverage required by subsection 1, and any provision of the policy  
14 or the renewal which is in conflict with subsection 1 is void.

15 4. An insurer may require an insured to:

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

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

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

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

26 689A.0415 1. ~~Except as otherwise provided in subsection 5,~~  
27 ~~an~~ An insurer that offers or issues a policy of health insurance  
28 which provides coverage for prescription drugs or devices shall  
29 include in the policy coverage for ~~the~~

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

31 ~~—(b) Any~~ any type of hormone replacement therapy ~~the~~

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

34 2. ~~An~~ Except as otherwise provided in subsection 4, an  
35 insurer that offers or issues a policy of health insurance that  
36 provides coverage for prescription drugs shall not:

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

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



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

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

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

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

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

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

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

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

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

~~(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.



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1     **Sec. 16.** NRS 689A.0417 is hereby amended to read as  
2 follows:

3     689A.0417 1. ~~{Except as otherwise provided in subsection 5,~~  
4 ~~an}~~ *An* insurer that offers or issues a policy of health insurance  
5 which provides coverage for outpatient care shall include in the  
6 policy coverage for any health care service related to ~~{contraceptives~~  
7 ~~or}~~ hormone replacement therapy.

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

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

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

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

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

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

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

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

43     ~~5. An insurer which offers or issues such a policy of health~~  
44 ~~insurance and which is affiliated with a religious organization is not~~  
45 ~~required to provide the coverage for health care service related to~~





~~contraceptives required by this section if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of health insurance and before the renewal of such a policy, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.~~

~~—6.† An insurer may require an insured to:~~

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

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

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

**Sec. 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.†~~ Except as otherwise provided in subsection 4, an insurer that offers or issues a policy of health insurance shall not:

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

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

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

~~(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,~~



1 *reduce, withhold, limit or delay access to any such benefit to an*  
2 *insured; or*

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

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

10 4. ~~For the purposes of~~ *An insurer may require an insured to:*  
11 *(a) Participate in a reasonable program of step therapy to*  
12 *obtain coverage for any benefit required by subsection 1.*

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

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

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

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

24 **Sec. 18.** NRS 689A.330 is hereby amended to read as follows:  
25 689A.330 If any policy is issued by a domestic insurer for  
26 delivery to a person residing in another state, and if the insurance  
27 commissioner or corresponding public officer of that other state has  
28 informed the Commissioner that the policy is not subject to approval  
29 or disapproval by that officer, the Commissioner may by ruling  
30 require that the policy meet the standards set forth in NRS 689A.030  
31 to 689A.320, inclusive ~~“H”,~~ *and sections 12 and 13 of this act.*

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

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

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

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

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

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



(e) *Voluntary sterilization for women.*

2. *Except as otherwise provided in subsections 6, 7 and 8, 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.*

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

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

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



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

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

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

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

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

17 9. *As used in this section:*

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

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

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

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

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

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

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

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

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

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

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

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

43 (g) *Screening for depression;*

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

3     689B.0313 1. A policy of group health insurance must  
4 provide coverage for benefits payable for expenses incurred for  
5 ~~administering~~ :

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

8     (b) *Administering* the human papillomavirus vaccine as  
9 recommended for vaccination by a competent authority, including,  
10 without limitation, the Centers for Disease Control and Prevention  
11 of the United States Department of Health and Human Services, the  
12 Food and Drug Administration or the manufacturer of the vaccine.

13     2. ~~{A policy of group health insurance must not require an~~  
14 ~~insured to obtain prior authorization for any service provided~~  
15 ~~pursuant to subsection 1.}~~ *Except as otherwise provided in*  
16 *subsection 4, an insurer that offers or issues a policy of group*  
17 *health insurance shall not:*

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

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

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

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

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

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

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

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

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



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

5. 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;~~ between the ages of 21 and 29 years;

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

(1) Every 3 years; or

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

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

2. ~~A policy of group health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.~~ Except as otherwise provided in subsection 4, 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;





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

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

7 3. A policy subject to the provisions of this chapter which is  
8 delivered, issued for delivery or renewed on or after ~~October 1,~~  
9 ~~1989,~~ January 1, 2018, has the legal effect of including the  
10 coverage required by subsection 1, and any provision of the policy  
11 or the renewal which is in conflict with subsection 1 is void.

12 4. An insurer may require an insured to:

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

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

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

21 Sec. 24. NRS 689B.0376 is hereby amended to read as  
22 follows:

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

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

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

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

31 2. ~~[An]~~ Except as otherwise provided in subsection 4, an  
32 insurer that offers or issues a policy of group health insurance that  
33 provides coverage for prescription drugs shall not:

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

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

43 (c) Offer or pay any type of material inducement or financial  
44 incentive to an insured to discourage the insured from accessing



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

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

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

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

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

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

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

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

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

~~{(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~~



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

3 ~~—7.1~~ 6. As used in this section, “provider of health care” has the  
4 meaning ascribed to it in NRS 629.031.

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

7 689B.0377 1. ~~{Except as otherwise provided in subsection 5,~~  
8 ~~an}~~ An insurer that offers or issues a policy of group health  
9 insurance which provides coverage for outpatient care shall include  
10 in the policy coverage for any health care service related to  
11 ~~{contraceptives or}~~ hormone replacement therapy.

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

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

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

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

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

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

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

42 4. ~~{The provisions of this section do not prohibit an insurer~~  
43 ~~from requiring an insured to pay a deductible, copayment or~~  
44 ~~coinsurance for the coverage required by subsection 1 that is the~~



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~~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.† An insurer may require an insured to:~~

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

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

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

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

**Sec. 27. 1.** *Except as otherwise provided in subsection 4, a carrier that offers or issues a health benefit plan shall include in the plan coverage for:*

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

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

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

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

*(e) Voluntary sterilization for women.*

**2.** *Except as otherwise provided in subsections 5, 6 and 7, a carrier that offers or issues a health benefit plan shall not:*



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

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

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

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

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

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

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

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

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

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

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



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

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

7 8. As used in this section:

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

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

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

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

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

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

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

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

26 (c) Counseling for sexually transmitted diseases;

27 (d) Hormone replacement therapy;

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

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

33 (g) An annual screening for cervical cancer;

34 (h) Screening for depression;

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

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

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

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



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

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. *A carrier may require an insured to:*

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

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

5. *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. Except as otherwise provided in subsection 4, 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.

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. A carrier may require an insured to:

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

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

5. 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 between the ages of 21 and 29 years;





1       (b) *A cytologic screening test for women between the ages of*  
2 *30 and 65 years:*

3           (1) *Every 3 years; or*

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

6       (c) *An annual mammogram for women.*

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

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

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

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

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

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

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

28       3. *A plan subject to the provisions of this chapter which is*  
29 *delivered, issued for delivery or renewed on or after January 1,*  
30 *2018, has the legal effect of including the coverage required by*  
31 *subsection 1, and any provision of the plan or the renewal which*  
32 *is in conflict with subsection 1 is void.*

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

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

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

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

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

43       689C.425 A voluntary purchasing group and any contract  
44 issued to such a group pursuant to NRS 689C.360 to 689C.600,  
45 inclusive, are subject to the provisions of NRS 689C.015 to



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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.** *Except as otherwise provided in subsection 4, 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 women.*

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

**3.** *Except as otherwise provided in subsection 4, a benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1,*



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

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

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

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

21 7. *A society may require an insured to:*

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

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

28 8. *As used in this section:*

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

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

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

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

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

40 **Sec. 34.** 1. *A society that offers or issues a benefit contract*  
41 *shall include in the contract coverage for:*

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



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

3       (c) Counseling for sexually transmitted diseases;

4       (d) Hormone replacement therapy;

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

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

10      (g) An annual screening for cervical cancer;

11      (h) Screening for depression;

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

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

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

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

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

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

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

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

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

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

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

44       3. A benefit contract subject to the provisions of this chapter  
45 that is delivered, issued for delivery or renewed on or after



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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. A society may require an insured to:

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

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

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

3. A benefit contract subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after



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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. A society may require an insured to:

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

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

5. 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 between the ages of 21 and 29 years;

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

(1) Every 3 years; or

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

(c) An annual mammogram for women.

2. Except as otherwise provided in subsection 4, 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,



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1 *reduce, withhold, limit or delay access to any such benefit to an*  
2 *insured; or*

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

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

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

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

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

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

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

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

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

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

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

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

33 *(e) Voluntary sterilization for women.*

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

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

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



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

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

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

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

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

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

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

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

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

41      8. An insurer may require an insured to:

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

44      (b) Obtain prior authorization before obtaining coverage for  
45      any benefit required by subsection 1 as part of a determination by





1 *the insurer that the benefit is medically necessary or appropriate*  
2 *for the insured.*

3 *9. As used in this section:*

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

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

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

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

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

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

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

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

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

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

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

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

30 *(g) Screening for depression;*

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

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

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

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

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



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

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

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

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

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

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

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

27      4. An insurer may require an insured to:

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

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

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

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

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

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



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

*(1) Every 3 years; or*

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

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

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

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

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

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

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

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

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

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

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

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

*(b) Obtain prior authorization before obtaining coverage for any benefit required by subsection 1 as part of a determination by*



1 *the insurer that the benefit is medically necessary or appropriate*  
2 *for the insured.*

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

5 Sec. 41. NRS 695B.1916 is hereby amended to read as  
6 follows:

7 695B.1916 1. ~~{Except as otherwise provided in subsection 5,~~  
8 ~~an}~~ *An* insurer that offers or issues a contract for hospital or medical  
9 service which provides coverage for prescription drugs or devices  
10 shall include in the contract coverage for ~~{~~

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

12 ~~—(b) Any}~~ *any* type of hormone replacement therapy ~~{~~

13 ~~—}~~ which is lawfully prescribed or ordered and which has been  
14 approved by the Food and Drug Administration.

15 2. ~~{An}~~ *Except as otherwise provided in subsection 4, an*  
16 insurer that offers or issues a contract for hospital or medical service  
17 that provides coverage for prescription drugs shall not:

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

Sec. 42. NRS 695B.1918 is hereby amended to read as follows:

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

2. ~~[An]~~ *Except as otherwise provided in subsection 4, an* insurer that offers or issues a contract for hospital or medical service that provides coverage for outpatient care shall not:

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



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1 other condition for coverage for outpatient care related to  
2 ~~{contraceptives or}~~ hormone replacement therapy ; ~~{than is required~~  
3 ~~for other outpatient care covered by the contract;}~~

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

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

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

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

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

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

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

44 ~~—6.— If an insurer refuses, pursuant to subsection 5, to provide the~~  
45 ~~coverage required by paragraph (a) of subsection 1, an employer~~



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

3 ~~—7.1~~ *An insurer may require an insured to:*

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

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

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

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

14 695B.1925 1. ~~{A policy of health insurance issued by a~~  
15 ~~hospital or medical service corporation}~~ *An insurer that offers or*  
16 *issues a contract for hospital or medical service* must provide  
17 coverage for benefits payable for expenses incurred for  
18 ~~{administering}~~ :

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

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

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

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

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

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

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



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

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

3. A ~~policy~~ contract for hospital or medical service subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~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~~ An insurer may require an insured to:

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

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

5. As used in this section ~~;~~ "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. Except as otherwise provided in subsection 4, 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 women.

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





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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

9. As used in this section:

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

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

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

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

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

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

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

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

(c) Counseling for sexually transmitted diseases;

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

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

(f) An annual screening for cervical cancer;

(g) Screening for depression;

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

42      5. As used in this section, "provider of health care" has the  
43      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 ~~the~~

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

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

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



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2. ~~[A]~~ *Except as otherwise provided in subsection 4, a health maintenance organization that offers or issues a health care plan that provides coverage for 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.

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

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

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

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

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

~~(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~~



1 ~~the same as the enrollee is required to pay for other prescription~~  
2 ~~drugs covered by the plan.~~

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

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

20 ~~—7.†~~ 6. As used in this section, “provider of health care” has the  
21 meaning ascribed to it in NRS 629.031.

22 **Sec. 49.** NRS 695C.1695 is hereby amended to read as  
23 follows:

24 695C.1695 1. ~~{Except as otherwise provided in subsection 5,~~  
25 ~~a} A health maintenance organization that offers or issues a health~~  
26 ~~care plan which provides coverage for outpatient care shall include~~  
27 ~~in the plan coverage for any health care service related to~~  
28 ~~{contraceptives or} hormone replacement therapy.~~

29 2. ~~{A}~~ *Except as otherwise provided in subsection 4, a* health  
30 maintenance organization that offers or issues a health care plan that  
31 provides coverage for outpatient care shall not:

32 (a) Require an enrollee to pay a higher deductible, *any*  
33 copayment or coinsurance or require a longer waiting period or  
34 other condition for coverage for outpatient care related to  
35 ~~{contraceptives or} hormone replacement therapy ; {than is required~~  
36 ~~for other outpatient care covered by the plan;}~~

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

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



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

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

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

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

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

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

~~7.~~ *A health maintenance organization may require an enrollee to:*

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

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





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

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

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

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

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

*(1) Every 3 years; or*

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

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

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

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

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

*(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any benefit provided in the health care plan pursuant to subsection 1;*

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

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

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

3. A ~~policy~~ *health care plan* subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~October 1, 1989;~~ *January 1, 2018,* has the legal effect of



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

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

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

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

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

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

16 695C.1745 1. A health care plan of a health maintenance  
17 organization must provide coverage for benefits payable for  
18 expenses incurred for ~~administering~~:

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

21 *(b) Administering the human papillomavirus vaccine as*  
22 *recommended for vaccination by a competent authority, including,*  
23 *without limitation, the Centers for Disease Control and Prevention*  
24 *of the United States Department of Health and Human Services, the*  
25 *Food and Drug Administration or the manufacturer of the vaccine.*

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

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

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

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

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

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



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1 *reduce, withhold, limit or delay access to any such benefit to an*  
2 *enrollee; or*

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

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

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

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

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

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

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

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

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

27 695C.330 1. The Commissioner may suspend or revoke any  
28 certificate of authority issued to a health maintenance organization  
29 pursuant to the provisions of this chapter if the Commissioner finds  
30 that any of the following conditions exist:

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

38 (b) The health maintenance organization issues evidence of  
39 coverage or uses a schedule of charges for health care services  
40 which do not comply with the requirements of NRS 695C.1691 to  
41 695C.200, inclusive, *and sections 45 and 46 of this act* or  
42 695C.207;

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



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(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



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1 the greatest practical opportunity to obtain continuing coverage for  
2 health care.

3 **Sec. 53.** Chapter 695G of NRS is hereby amended by adding  
4 thereto the provisions set forth as sections 54, 55 and 56 of this act.

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

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

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

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

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

17 (e) *Voluntary sterilization for women; and*

18 (f) *Hormone replacement therapy.*

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

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

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

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

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

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

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

41 3. *Except as otherwise provided in subsection 4, a health care*  
42 *plan subject to the provisions of this chapter that is delivered,*  
43 *issued for delivery or renewed on or after January 1, 2018, has the*  
44 *legal effect of including the coverage required by subsection 1,*



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

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

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

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

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

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

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

29 8. *As used in this section:*

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

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

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

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

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

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

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



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

3       (c) Counseling for sexually transmitted diseases;

4       (d) Hormone replacement therapy;

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

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

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

11      (h) Screening for depression;

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

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

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

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

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

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

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

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

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

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

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

44       3. A health care plan subject to the provisions of this chapter  
45 that is delivered, issued for delivery or renewed on or after





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

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

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

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

5. 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 between the ages of 21 and 29 years;

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

(1) Every three years; or

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

(c) An annual mammogram for women.

2. Except as otherwise provided in subsection 4, 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.



\* S B 2 3 3 R 1 \*

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

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

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

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

5. *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.~~ Except as otherwise provided in subsection 4, 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,*



1 *reduce, withhold, limit or delay access to any such benefit to an*  
2 *insured; or*

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

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

11 4. ~~For the purposes of~~ *A managed care organization may*  
12 *require an insured to:*

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

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

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

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

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

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

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

