

THE ONE HUNDRED AND SECOND DAY

CARSON CITY (Thursday), May 18, 2017

Senate called to order at 11:41 a.m.

President Hutchison presiding.

Roll called.

All present.

Prayer by the Chaplain, Pastor Brennan Wilson.

Heavenly Father, thank You for Your watch and care over all things. I thank You for Your establishment of the United States of America and the Nevada State Legislature. In Job 12:23, the Bible says, speaking of You, Lord, *"He makes the nations great, then destroys them; He enlarges the nations, then leads them away."*

I ask that You might show mercy and kindness to this Country and to the leaders in government. Give them prudence in their leadership and please bless the work they do. I thank You that You are a God with love for all people including each individual here today.

I pray this in the Name of Jesus Christ, my God and Savior.

AMEN.

Pledge of Allegiance to the Flag.

By previous order of the Senate, the reading of the Journal is dispensed with, and the President and Secretary are authorized to make the necessary corrections and additions.

REPORTS OF COMMITTEES

Mr. President:

Your Committee on Commerce, Labor and Energy, to which was referred Assembly Bill No. 223, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

KELVIN ATKINSON, *Chair**Mr. President:*

Your Committee on Finance, to which was re-referred Senate Bill No. 233, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

JOYCE WOODHOUSE, *Chair**Mr. President:*

Your Committee on Government Affairs, to which was referred Assembly Bill No. 36, has had the same under consideration, and begs leave to report the same back with the recommendation: Do pass.

Also, your Committee on Government Affairs, to which was referred Assembly Bill No. 169, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

DAVID R. PARKS, *Chair**Mr. President:*

Your Committee on Health and Human Services, to which was referred Assembly Bill No. 176, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

PAT SPEARMAN, *Chair*

Mr. President:

Your Committee on Legislative Operations and Elections, to which were referred Assembly Bills Nos. 192, 301, has had the same under consideration, and begs leave to report the same back with the recommendation: Do pass.

Also, your Committee on Legislative Operations and Elections, to which was referred Assembly Bill No. 272, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

NICOLE J. CANNIZZARO, *Chair*

Mr. President:

Your Committee on Senate Parliamentary Rules and Procedures has approved the consideration of: Amendment 809 to Senate Bill No. 233; Amendment No. 762 to Assembly Bill No. 105.

KELVIN ATKINSON, *Chair*

MESSAGES FROM THE ASSEMBLY

ASSEMBLY CHAMBER, Carson City, May 17, 2017

To the Honorable the Senate:

I have the honor to inform your honorable body that the Assembly on this day passed Senate Bills Nos. 43, 53, 160, 206, 491.

Also, I have the honor to inform your honorable body that the Assembly amended, and on this day passed, as amended, Senate Bill No. 31, Amendment No. 675; Senate Bill No. 108, Amendment No. 659; Senate Bill No. 122, Amendment No. 649; Senate Bill No. 123, Amendment No. 650, and respectfully requests your honorable body to concur in said amendments.

CAROL AIELLO-SALA
Assistant Chief Clerk of the Assembly

WAIVERS AND EXEMPTIONS

WAIVER OF JOINT STANDING RULE(S)

May 17, 2017

Pursuant to paragraph (a) of subsection 4 of Joint Standing Rule No. 14.6, Assembly Bill No. 396 is not subject to the provisions of subsection 1 of Joint Standing Rule No. 14, Joint Standing Rule No. 14.1, subsection 1 of Joint Standing Rule No. 14.2 and Joint Standing Rule No. 14.3.

RICHARD S. COMBS
Director

INTRODUCTION, FIRST READING AND REFERENCE

By Senators Ford, Denis, Parks, Spearman, Atkinson, Cancela, Cannizzaro, Farley, Manendo, Ratti, Segerblom, Woodhouse and Assemblyman Frierson (emergency request of Senate Majority Leader):

Senate Bill No. 540—AN ACT relating to firefighters; directing the Legislative Commission to authorize the construction or installation of a memorial to Nevada firefighters on the Capitol Complex; and providing other matters properly relating thereto.

Senator Ford moved that the bill be referred to the Committee on Legislative Operations and Elections.

Motion carried.

By Senators Ford, Denis, Parks, Spearman, Atkinson, Cancela, Cannizzaro, Farley, Manendo, Ratti, Segerblom, Woodhouse and Assemblyman Frierson (emergency request of Senate Majority Leader.):

Senate Bill No. 541—AN ACT relating to crimes; enhancing the criminal penalty for certain crimes committed against first responders; and providing other matters properly relating thereto.

Senator Ford moved that the bill be referred to the Committee on Judiciary.
Motion carried.

SECOND READING AND AMENDMENT

Senate Bill No. 488.

Bill read second time.

The following amendment was proposed by the Committee on Judiciary:

Amendment No. 778.

SUMMARY—Revises provisions relating to sexual offenses.
(BDR 15-1086)

AN ACT relating to sexual offenses; establishing additional acts that constitute the crime of sex trafficking; ~~increasing the number of years required to be served by a person who is guilty of sex trafficking a child less than 14 years of age before the person is eligible for parole;~~ requiring the Department of Health and Human Services to develop a Medicaid service package to assist victims of sexual trauma who are eligible for Medicaid; authorizing the Department to adopt regulations relating to the development of such a Medicaid service package; requiring the Department to hold certain periodic meetings relating to sex trafficking; providing a penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law establishes certain specific acts that constitute the crime of sex trafficking and sets forth the penalties imposed upon a person who is found guilty of sex trafficking. Such penalties vary depending on whether the victim of sex trafficking is an adult or a child and, if a child, the age of the child. (NRS 201.300) Section 1 of this bill provides that a person is ~~also~~ guilty of sex trafficking if he or she: (1) facilitates, arranges, provides or pays for the transportation of a person to or within this State for the purpose of causing that person to engage in unlawful sexual conduct or prostitution or, if that person is a child, certain acts relating to pornography involving minors; (2) advertises, sells or offers to sell travel services that ~~include or~~ facilitate the travel of another person to this State with the knowledge that the other person is traveling to this State for the purpose of engaging in sexual conduct with a victim of sex trafficking, soliciting a child who is a victim of sex trafficking or engaging in certain acts relating to pornography involving minors; or (3) travels ~~or attempts to travel or knowingly causes another person to travel or attempt to travel~~ to or within this State by any means for the purpose of engaging in sexual conduct with a victim of sex trafficking with the knowledge that the victim is compelled to engage in sexual conduct or prostitution or engaging in certain acts relating to pornography involving minors.

~~Existing law provides that a person who is found guilty of sex trafficking a child who is less than 14 years of age at the time of the offense is punished by~~

~~imprisonment in the state prison for life with the possibility of parole, with eligibility for parole beginning when a minimum of 15 years has been served. (NRS 201.300) Section 1 increases the number of years such a person must serve before he or she is eligible for parole to 20 years.]~~

Section 2 of this bill requires the Department of Health and Human Services to develop a Medicaid service package called the Sexual Trauma Services Guide for the purpose of assisting victims of sexual trauma who are eligible for Medicaid. Section 2 requires the Department to post information relating to the Sexual Trauma Services Guide on the Internet website of the Department and to make such information available to any person upon request at the office of the Department. Section 2 also authorizes the Department to adopt regulations relating to the development of the Sexual Trauma Services Guide.

In 2016, the Governor established by executive order the Nevada Coalition to Prevent the Commercial Sexual Exploitation of Children. (Executive Order 2016-14 (5-31-2016)) The Coalition is required to prepare a comprehensive statewide strategic plan and recommendations regarding how to address certain provisions of federal law relating to sex trafficking. Section 3 of this bill requires the Department to hold periodic informational meetings for the purpose of coordinating the efforts of various entities to improve services for victims of sex trafficking and achieve the goals set forth in the statewide strategic plan developed by the Coalition.

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

Section 1. NRS 201.300 is hereby amended to read as follows:

201.300 1. A person who without physical force or the immediate threat of physical force, induces an adult to unlawfully become a prostitute or to continue to engage in prostitution, or to enter any place within this State in which prostitution is practiced, encouraged or allowed for the purpose of sexual conduct or prostitution is guilty of pandering which is a category C felony and shall be punished as provided in NRS 193.130. This subsection does not apply to the customer of a prostitute.

2. A person:

(a) Is guilty of sex trafficking if the person:

(1) Induces, causes, recruits, harbors, transports, provides, obtains or maintains a child to engage in prostitution, or to enter any place within this State in which prostitution is practiced, encouraged or allowed for the purpose of sexual conduct or prostitution;

(2) Induces, recruits, harbors, transports, provides, obtains or maintains a person by any means, knowing, or in reckless disregard of the fact, that threats, violence, force, intimidation, fraud, duress or coercion will be used to cause the person to engage in prostitution, or to enter any place within this State in which prostitution is practiced, encouraged or allowed for the purpose of sexual conduct or prostitution;

(3) By threats, violence, force, intimidation, fraud, duress, coercion, by any device or scheme, or by abuse of any position of confidence or authority,

or having legal charge, takes, places, harbors, induces, causes, compels or procures a person to engage in prostitution, or to enter any place within this State in which prostitution is practiced, encouraged or allowed for the purpose of sexual conduct or prostitution; ~~for~~

(4) *Facilitates, arranges, provides or pays for the transportation of a person to or within this State for the purpose of:*

(I) *Causing the person to engage in prostitution ~~for~~ in violation of subparagraph (1), (2) or (3);*

(II) *Causing the person to enter any place within this State in which prostitution is practiced, encouraged or allowed for the purpose of sexual conduct or prostitution in violation of subparagraph (1), (2) or (3); or*

~~###~~ (III) *If the person is a child, using the person for any act that is prohibited by NRS 200.710 or 200.720;*

(5) *Advertises, sells or offers to sell travel services that ~~include or~~ facilitate the travel of another person to this State with the knowledge that the other person is traveling to this State for the purpose of ~~engaging~~ ;*

(I) *Engaging in ~~f~~*

~~###~~ (I) *~~Sexual~~ sexual conduct with a person who is ~~caused~~ compelled to engage in sexual conduct or prostitution in violation of subparagraph (1), (2) or (3); ~~for~~*

(II) ~~###~~ *Soliciting a child who is compelled to engage in sexual conduct or prostitution in violation of subparagraph (1), (2) or (3); or*

(III) *Engaging in any act involving a child that is prohibited by NRS 200.710 or 200.720;*

(6) *Travels ~~f~~, attempts to travel or knowingly causes another person to travel or attempt to travel to or within this State by any means for the purpose of engaging in:*

(I) *Sexual conduct with a person who is ~~caused~~ compelled to engage in sexual conduct or prostitution in violation of subparagraph (1), (2) or (3) ~~for~~, with the knowledge that such a person is compelled to engage in such sexual conduct or prostitution; or*

(II) *Any act involving a child that is prohibited by NRS 200.710 or 200.720; or*

(7) Takes or detains a person with the intent to compel the person by force, violence, threats or duress to marry him or her or any other person.

(b) Who is found guilty of sex trafficking:

(1) An adult is guilty of a category B felony and shall be punished by imprisonment in the state prison for a minimum term of not less than 3 years and a maximum term of not more than 10 years, and may be further punished by a fine of not more than \$10,000.

(2) A child:

(I) If the child is less than 14 years of age when the offense is committed, is guilty of a category A felony and shall be punished by imprisonment in the state prison for life with the possibility of parole, with

eligibility for parole beginning when a minimum of 15 ~~20~~ years has been served, and may be further punished by a fine of not more than \$20,000.

(II) If the child is at least 14 years of age but less than 16 years of age when the offense is committed, is guilty of a category A felony and shall be punished by imprisonment in the state prison for life with the possibility of parole, with eligibility for parole beginning when a minimum of 10 years has been served, and may be further punished by a fine of not more than \$10,000.

(III) If the child is at least 16 years of age but less than 18 years of age when the offense is committed, is guilty of a category A felony and shall be punished by imprisonment in the state prison for life with the possibility of parole, with eligibility for parole beginning when a minimum of 5 years has been served, and may be further punished by a fine of not more than \$10,000.

3. A court shall not grant probation to or suspend the sentence of a person convicted of sex trafficking a child pursuant to subsection 2.

4. Consent of a victim of pandering or sex trafficking to an act of prostitution is not a defense to a prosecution for any of the acts prohibited by this section.

5. In a prosecution for sex trafficking a child pursuant to subsection 2, it is not a defense that the defendant did not have knowledge of the victim's age, nor is reasonable mistake of age a valid defense to a prosecution conducted pursuant to subsection 2.

Sec. 2. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

1. *To the extent authorized by federal law, the Department shall develop a Medicaid service package called the Sexual Trauma Services Guide for the purpose of assisting victims of sexual trauma who are eligible for Medicaid.*

2. *The Department shall post information relating to the Sexual Trauma Services Guide, including, without limitation, information concerning the available services to which victims of sexual trauma are entitled, on the Internet website maintained by the Department and shall make such information available to any person upon request at the office of the Department.*

3. *The Department may adopt any regulations necessary to carry out the provisions of this section.*

Sec. 3. Chapter 439 of NRS is hereby amended by adding thereto a new section to read as follows:

The Department shall periodically hold informational meetings, as deemed appropriate by the Director, for the purpose of coordinating the efforts of various entities associated with the provision of services for victims of sex trafficking to improve such services, including, without limitation, to ensure that any applicable funding received by such entities is used in the most effective and efficient way possible to assist victims of sex trafficking and to achieve the goals set forth in the statewide strategic plan developed by the Nevada Coalition to Prevent the Commercial Sexual Exploitation of Children,

established by the Governor pursuant to Executive Order 2016-14, issued on May 31, 2016.

Senator Segerblom moved the adoption of the amendment.

Remarks by Senator Segerblom.

Amendment No. 778 to Senate Bill No. 488 removes the term "knowingly" from portions of the bill in relation to whether a person is guilty of sex trafficking and includes the phrase "with the knowledge that." It also adds the term "compelled" in relation to whether a person is a victim of sex trafficking.

Amendment adopted.

Bill ordered reprinted, engrossed and to the third reading.

GENERAL FILE AND THIRD READING

Senate Bill No. 394.

Bill read third time.

Senator Spearman moved that the bill be taken from the General File and placed on the Secretary's desk.

Motion carried.

MOTIONS, RESOLUTIONS AND NOTICES

Senator Segerblom moved that Assembly Bill No. 319 be taken from the Secretary's desk and placed at the bottom of the General File, last Agenda.

Motion carried.

GENERAL FILE AND THIRD READING

Senate Bill No. 503.

Bill read third time.

Remarks by Senator Woodhouse.

Senate Bill No. 503 appropriates \$250,000 to replenish the balance in the Account for Channel Clearance, Maintenance, Restoration, Surveying and Monumenting Program established in NRS 532.230.

Roll call on Senate Bill No. 503:

YEAS—21.

NAYS—None.

Senate Bill No. 503 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 61.

Bill read third time.

Remarks by Senator Settelmeyer.

Assembly Bill No. 61 allows the Commissioner of Financial Institutions to authorize a foreign trust company licensed in another state and subject to federal regulation to act as a fiduciary, solicit business and engage in the business of a trust company in Nevada without first obtaining a license in Nevada under certain circumstances. The bill also allows the Commissioner to authorize a foreign independent trust company licensed in another state but not subject to federal regulation to solicit business in Nevada without first obtaining a license in Nevada under certain circumstances.

Roll call on Assembly Bill No. 61:

YEAS—21.

NAYS—None.

Assembly Bill No. 61 having received a two-thirds majority, Mr. President declared it passed.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 62.

Bill read third time.

Remarks by Senator Ratti.

Assembly Bill No. 62 revises existing procedures and adds additional requirements for wholesale and retail tobacco dealers to aid in the statutory enforcement of the Tobacco Master Settlement Agreement (MSA). The changes include the following extending the period by which certain records must be retained by retail and wholesale tobacco dealers from three to five years; requiring cigarette vending-machine operators to obtain a license from the Department of Taxation; specifying that manufacturer, wholesale and retail tobacco licenses authorize the holder of the license to sell cigarettes from the premises for which the license was issued; requiring importers of cigarettes, roll-your-own tobacco and smokeless tobacco to report to the Department of Taxation the amount of product sold, transferred or delivered into Nevada each month, and requiring manufacturers and importers who are nonparticipants in the MSA to submit additional reports to the Attorney General's Office.

Senator Ratti requested the following letter to be entered in the Journal.

May 17, 2017

THE HONORABLE JULIA RATTI, CHAIR

Senate Committee on Revenue and Economic Development

Dear Senator Ratti:

The Office of the Attorney General thanks the Senate Committee on Revenue and Economic Development for passing A.B. 62. To confirm our testimony at the May 16th hearing, the amendments to NRS 370A.153 in Section 9 of the bill only apply to monies in a qualified escrow fund. To the extent monies have been released under NRS 370A.150, or for any reason are no longer in the qualified escrow fund, these monies cannot be assigned to the State under NRS 370A.153.

Thank you for your consideration of this bill. If you have any questions, please do not hesitate to contact me at 684-1201 or bkandt@ag.nv.gov.

Sincerely,

ADAM PAUL LAXALT

Attorney General

BRETT KANDT

Chief Deputy Attorney General

Roll call on Assembly Bill No. 62:

YEAS—21.

NAYS—None.

Assembly Bill No. 62 having received a constitutional majority, Mr. President declared it passed.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 101.

Bill read third time.

Remarks by Senators Cancela and Goicoechea.

SENATOR CANCELA:

Assembly Bill No. 101 removes the requirement that 80 percent of the Wildlife Account be spent on lethal management and control of predatory wildlife and the mandate for consultation with the State Predatory Animal and Rodent Committee in the management of predatory wildlife. The measure expands the uses of the Wildlife Account to include activities related to the protection of wildlife habitat. The bill also adds establishment of policies for the conservation of wildlife to the list of policies to be developed by the Board of Wildlife Commissioners. Finally, the bill requires the Department of Wildlife to submit a report to the Legislature no later than December 31 of each year summarizing the effectiveness and outcomes of the programs and activities funded by the Account.

SENATOR GOICOECHEA:

Assembly Bill No. 101 removes the requirement to expend the amount of 80 percent of the \$3.00 Sportsman fee that is paid in this State by a sportsman for predator control. Because of that removal, I will have to oppose the bill.

Roll call on Assembly Bill No. 101:

YEAS—12.

NAYS—Gansert, Goicoechea, Gustavson, Hammond, Hardy, Harris, Kieckhefer, Roberson, Settlemeyer—9.

Assembly Bill No. 101 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 105.

Bill read third time.

The following amendment was proposed by Senator Atkinson:

Amendment No. 762.

SUMMARY—Revises continuing education requirements relating to suicide prevention and awareness for certain providers of health care. (BDR 54-32)

AN ACT relating to public health; revising continuing education requirements relating to suicide prevention and awareness for certain providers of health care; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires or encourages certain providers of health care, including physicians, physician assistants, advanced practice registered nurses, psychologists, behavior analysts, assistant behavior analysts, marriage and family therapists, clinical professional counselors, social workers, alcohol and drug abuse counselors and problem gambling counselors and certain interns related to these professions to receive at least 1 or 2 hours of continuing education in certain topics related to suicide prevention and awareness. (NRS 630.253, 632.343, 633.471, 641.220, 641A.260, 641B.280, 641C.450) Sections 1-6 of this bill make mandatory continuing education requirements relating to suicide prevention and awareness for each of these providers of health care and requires the completion of a course of instruction on suicide prevention and awareness ~~every 4 years.~~ at regular intervals.

~~[Section]~~ Sections 1 and 2.5 also ~~remove~~ remove the authority for certain persons who hold a license to practice medicine, including, without limitation,

physicians, osteopathic physicians and psychiatrists, to substitute not more than 2 hours of continuing education in certain topics related to suicide prevention for an equivalent continuing education requirement in ethics. (NRS 630.253, ~~633.471~~)

Section 9 of this bill repeals the prospective expiration of the existing requirement for a physician and osteopathic physician to complete a course of instruction on suicide prevention and awareness. Section 9 also repeals a provision to remove the prospective expiration of the requirement for psychologists, behavior analysts and assistant behavior analysts to complete a course of instruction on suicide prevention and awareness.

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

Section 1. NRS 630.253 is hereby amended to read as follows:

630.253 1. The Board shall, as a prerequisite for the:

- (a) Renewal of a license as a physician assistant; or
 - (b) Biennial registration of the holder of a license to practice medicine,
- ↪ require each holder to submit evidence of compliance with the requirements for continuing education as set forth in regulations adopted by the Board.

2. These requirements:

- (a) May provide for the completion of one or more courses of instruction relating to risk management in the performance of medical services.
- (b) Must provide for the completion of a course of instruction, within 2 years after initial licensure, relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. The course must provide at least 4 hours of instruction that includes instruction in the following subjects:

- (1) An overview of acts of terrorism and weapons of mass destruction;
- (2) Personal protective equipment required for acts of terrorism;
- (3) Common symptoms and methods of treatment associated with exposure to, or injuries caused by, chemical, biological, radioactive and nuclear agents;
- (4) Syndromic surveillance and reporting procedures for acts of terrorism that involve biological agents; and
- (5) An overview of the information available on, and the use of, the Health Alert Network.

(c) Must provide for the completion by a holder of a license to practice medicine ~~[who is a psychiatrist]~~ of a course of instruction *within 2 years after initial licensure* that provides at least 2 hours of instruction on ~~[clinically based]~~ *evidence-based* suicide prevention and awareness ~~[]~~ *as described in subsection 5.*

↪ The Board may thereafter determine whether to include in a program of continuing education additional courses of instruction relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction.

3. The Board shall encourage each holder of a license who treats or cares for persons who are more than 60 years of age to receive, as a portion of their continuing education, education in geriatrics and gerontology, including such topics as:

- (a) The skills and knowledge that the licensee needs to address aging issues;
- (b) Approaches to providing health care to older persons, including both didactic and clinical approaches;
- (c) The biological, behavioral, social and emotional aspects of the aging process; and
- (d) The importance of maintenance of function and independence for older persons.

4. The Board shall encourage each holder of a license to practice medicine to receive, as a portion of his or her continuing education, training concerning methods for educating patients about how to effectively manage medications, including, without limitation, the ability of the patient to request to have the symptom or purpose for which a drug is prescribed included on the label attached to the container of the drug.

5. The Board shall ~~encourage~~ *require* each holder of a license to practice medicine ~~[, other than a psychiatrist,]~~ to receive as a portion of his or her continuing education ~~[training concerning suicide, including,]~~ *at least 2 hours of instruction every 4 years on evidence-based suicide prevention and awareness, which may include, without limitation, [such topics as:] instruction concerning:*

- (a) The skills and knowledge that the licensee needs to detect behaviors that may lead to suicide, including, without limitation, post-traumatic stress disorder;
- (b) Approaches to engaging other professionals in suicide intervention; and
- (c) The detection of suicidal thoughts and ideations and the prevention of suicide.

6. A holder of a license to practice medicine may *not* substitute ~~[not more than 2 hours of]~~ the continuing education credits ~~[in the detection of suicidal thoughts and ideations, and the intervention and prevention of suicide, pain management or addiction care]~~ *relating to suicide prevention and awareness required by this section* for the purposes of satisfying an equivalent requirement for continuing education in ethics.

7. *A holder of a license to practice medicine may substitute not more than 2 hours of continuing education credits in pain management or addiction care for the purposes of satisfying an equivalent requirement for continuing education in ethics.*

8. As used in this section:

- (a) "Act of terrorism" has the meaning ascribed to it in NRS 202.4415.
- (b) "Biological agent" has the meaning ascribed to it in NRS 202.442.
- (c) "Chemical agent" has the meaning ascribed to it in NRS 202.4425.
- (d) "Radioactive agent" has the meaning ascribed to it in NRS 202.4437.

(e) "Weapon of mass destruction" has the meaning ascribed to it in NRS 202.4445.

Sec. 2. NRS 632.343 is hereby amended to read as follows:

632.343 1. The Board shall not renew any license issued under this chapter until the licensee has submitted proof satisfactory to the Board of completion, during the 2-year period before renewal of the license, of 30 hours in a program of continuing education approved by the Board in accordance with regulations adopted by the Board. ~~[The]~~ *Except as otherwise provided in subsection 3, the licensee is exempt from this provision for the first biennial period after graduation from:*

- (a) An accredited school of professional nursing;
- (b) An accredited school of practical nursing;
- (c) An approved school of professional nursing in the process of obtaining accreditation; or
- (d) An approved school of practical nursing in the process of obtaining accreditation.

2. The Board shall review all courses offered to nurses for the completion of the requirement set forth in subsection 1. The Board may approve nursing and other courses which are directly related to the practice of nursing as well as others which bear a reasonable relationship to current developments in the field of nursing or any special area of practice in which a licensee engages. These may include academic studies, workshops, extension studies, home study and other courses.

3. The program of continuing education required by subsection 1 must include :

(a) For a person licensed as an advanced practice registered nurse, a course of instruction to be completed within 2 years after initial licensure that provides at least 2 hours of instruction on suicide prevention and awareness as described in subsection 5.

(b) For each person licensed pursuant to this chapter, a course of instruction, to be completed within 2 years after initial licensure, relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. The course must provide at least 4 hours of instruction that includes instruction in the following subjects:

- ~~[(a)]~~ (1) An overview of acts of terrorism and weapons of mass destruction;
- ~~[(b)]~~ (2) Personal protective equipment required for acts of terrorism;
- ~~[(c)]~~ (3) Common symptoms and methods of treatment associated with exposure to, or injuries caused by, chemical, biological, radioactive and nuclear agents;
- ~~[(d)]~~ (4) Syndromic surveillance and reporting procedures for acts of terrorism that involve biological agents; and
- ~~[(e)]~~ (5) An overview of the information available on, and the use of, the Health Alert Network.

➡ The Board may thereafter determine whether to include in a program of continuing education additional courses of instruction relating to the medical

consequences of an act of terrorism that involves the use of a weapon of mass destruction.

4. The Board shall encourage each licensee who treats or cares for persons who are more than 60 years of age to receive, as a portion of their continuing education, education in geriatrics and gerontology, including such topics as:

- (a) The skills and knowledge that the licensee needs to address aging issues;
- (b) Approaches to providing health care to older persons, including both didactic and clinical approaches;
- (c) The biological, behavioral, social and emotional aspects of the aging process; and
- (d) The importance of maintenance of function and independence for older persons.

5. The Board shall ~~encourage~~ *require* each person licensed as an advanced practice registered nurse to receive as a portion of his or her continuing education at least 2 hours of instruction *every 4 years* on ~~clinically based~~ *evidence-based* suicide prevention and awareness ~~or~~ *another course of instruction on suicide prevention and awareness that is approved by the Board which the Board has determined to be effective and appropriate.*

6. As used in this section:

- (a) "Act of terrorism" has the meaning ascribed to it in NRS 202.4415.
- (b) "Biological agent" has the meaning ascribed to it in NRS 202.442.
- (c) "Chemical agent" has the meaning ascribed to it in NRS 202.4425.
- (d) "Radioactive agent" has the meaning ascribed to it in NRS 202.4437.
- (e) "Weapon of mass destruction" has the meaning ascribed to it in NRS 202.4445.

Sec. 2.5. NRS 633.471 is hereby amended to read as follows:

633.471 1. Except as otherwise provided in subsection ~~8~~ 9 and NRS 633.491, every holder of a license issued under this chapter, except a temporary or a special license, may renew the license on or before January 1 of each calendar year after its issuance by:

- (a) Applying for renewal on forms provided by the Board;
- (b) Paying the annual license renewal fee specified in this chapter;
- (c) Submitting a list of all actions filed or claims submitted to arbitration or mediation for malpractice or negligence against the holder during the previous year;
- (d) Submitting evidence to the Board that in the year preceding the application for renewal the holder has attended courses or programs of continuing education approved by the Board in accordance with regulations adopted by the Board totaling a number of hours established by the Board which must not be less than 35 hours nor more than that set in the requirements for continuing medical education of the American Osteopathic Association; and
- (e) Submitting all information required to complete the renewal.

2. The Secretary of the Board shall notify each licensee of the requirements for renewal not less than 30 days before the date of renewal.

3. The Board shall request submission of verified evidence of completion of the required number of hours of continuing medical education annually from no fewer than one-third of the applicants for renewal of a license to practice osteopathic medicine or a license to practice as a physician assistant. Upon a request from the Board, an applicant for renewal of a license to practice osteopathic medicine or a license to practice as a physician assistant shall submit verified evidence satisfactory to the Board that in the year preceding the application for renewal the applicant attended courses or programs of continuing medical education approved by the Board totaling the number of hours established by the Board.

4. *The Board shall require each holder of a license to practice osteopathic medicine to complete a course of instruction within ~~1 year~~ 2 years after initial licensure that provides at least 2 hours of instruction on evidence-based suicide prevention and awareness as described in subsection 7.*

5. The Board shall encourage each holder of a license to practice osteopathic medicine to receive, as a portion of his or her continuing education, training concerning methods for educating patients about how to effectively manage medications, including, without limitation, the ability of the patient to request to have the symptom or purpose for which a drug is prescribed included on the label attached to the container of the drug.

~~{5.}~~ 6. The Board shall require, as part of the continuing education requirements approved by the Board, the biennial completion by a holder of a license to practice osteopathic medicine of ~~{~~:

~~—(a) At~~ at least 2 hours of continuing education credits in ethics, pain management or addiction care. ~~{; and~~

~~—(b) If the holder of a license to practice osteopathic medicine is a psychiatrist, at least 2 hours of continuing education credits on clinically based suicide prevention and awareness.~~

~~—6.}~~ 7. The Board shall ~~{encourage}~~ *require* each holder of a license to practice osteopathic medicine ~~{, other than a psychiatrist,}~~ to receive as a portion of his or her continuing education ~~{training concerning suicide, including,}~~ *at least 2 hours of instruction every 4 years on evidence-based suicide prevention and awareness which may include, without limitation, {such topics as:}* instruction concerning:

(a) The skills and knowledge that the licensee needs to detect behaviors that may lead to suicide, including, without limitation, post-traumatic stress disorder;

(b) Approaches to engaging other professionals in suicide intervention; and

(c) The detection of suicidal thoughts and ideations and the prevention of suicide.

~~{7.}~~ 8. A holder of a license to practice osteopathic medicine may *not* substitute ~~{not more than 2 hours of}~~ the continuing education credits ~~{in the detection of suicidal thoughts and ideations, and the intervention and~~

~~prevention of suicide~~ relating to suicide prevention and awareness required by this section for the purposes of satisfying an equivalent requirement for continuing education in ethics.

~~§~~ 9. Members of the Armed Forces of the United States and the United States Public Health Service are exempt from payment of the annual license renewal fee during their active duty status.

Sec. 3. NRS 641.220 is hereby amended to read as follows:

641.220 1. To renew a license issued pursuant to this chapter, each person must, on or before the first day of January of each odd-numbered year:

- (a) Apply to the Board for renewal;
- (b) Pay the biennial fee for the renewal of a license;
- (c) Submit evidence to the Board of completion of the requirements for continuing education as set forth in regulations adopted by the Board; and
- (d) Submit all information required to complete the renewal.

2. Upon renewing his or her license, a psychologist shall declare his or her areas of competence, as determined in accordance with NRS 641.112.

3. The Board shall, as a prerequisite for the renewal of a license, require each holder to comply with the requirements for continuing education adopted by the Board. ~~[-which]~~

4. *The requirements for continuing education adopted by the Board pursuant to subsection 3 must include, without limitation, a requirement that the holder of a license receive at least 2 hours of instruction on evidence-based suicide prevention and awareness ~~[-]~~ or another course of instruction on suicide prevention and awareness that is approved by the Board which the Board has determined to be effective and appropriate. The hours of instruction required by this subsection must be completed within 2 years after initial licensure and at least every 4 years thereafter.*

Sec. 4. NRS 641A.260 is hereby amended to read as follows:

641A.260 1. To renew a license issued pursuant to this chapter, each person must, on or before the date of expiration of the current license:

- (a) Apply to the Board for renewal;
- (b) Pay the fee for renewal set by the Board;
- (c) Submit evidence to the Board of completion of the requirements for continuing education as set forth in regulations adopted by the Board; and
- (d) Submit all information required to complete the renewal.

2. The Board shall, as a prerequisite for the renewal of a license, require each holder to comply with the requirements for continuing education adopted by the Board, which must include, without limitation, a requirement that the holder receive at least 2 hours of instruction on evidence-based suicide prevention and awareness ~~[-]~~ or another course of instruction on suicide prevention and awareness that is approved by the Board which the Board has determined to be effective and appropriate.

Sec. 5. NRS 641B.280 is hereby amended to read as follows:

641B.280 1. Every holder of a license issued pursuant to this chapter may renew his or her license annually by:

- (a) Applying to the Board for renewal;
- (b) Paying the annual renewal fee set by the Board;
- (c) Submitting evidence to the Board of completion of the required continuing education as set forth in regulations adopted by the Board; and
- (d) Submitting all information required to complete the renewal.

2. The Board shall, as a prerequisite for the renewal of a license, require the holder to comply with the requirements for continuing education adopted by the Board, which must include, without limitation, a requirement that the holder receive at least 2 hours of instruction on evidence-based suicide prevention and awareness ~~[+] or another course of instruction on suicide prevention and awareness that is approved by the Board which the Board has determined to be effective and appropriate.~~

Sec. 6. NRS 641C.450 is hereby amended to read as follows:

641C.450 Except as otherwise provided in NRS 641C.310, 641C.320, 641C.440 and 641C.530, a person may renew his or her license or certificate by submitting to the Board:

- 1. An application for the renewal of the license or certificate;
- 2. The fee for the renewal of a license or certificate prescribed in NRS 641C.470;
- 3. Evidence of completion of the continuing education required by the Board, which must include, without limitation, a requirement that the applicant receive at least 1 hour of instruction on evidence-based suicide prevention and awareness *or another course of instruction on suicide prevention and awareness that is approved by the Board which the Board has determined to be effective and appropriate* for each year of the term of the applicant's licensure or certification;
- 4. If the applicant is a certified intern, the name of the licensed or certified counselor who supervises the applicant; and
- 5. All information required to complete the renewal.

Sec. 7. Section 6 of chapter 403, Statutes of Nevada 2015, at page 2289, is hereby amended to read as follows:

Sec. 6. 1. This section and sections 1, 1.5, 2, 3, 4, 5, 5.3 and 5.7 of this act become effective on July 1, 2016.

2. Sections 5.3 and 5.7 of this act expire by limitation on June 30, 2026.

3. Sections ~~[1.3, 2.5, 3.5,]~~ 4.5 and 5.1 of this act become effective on July 1, 2026.

Sec. 8. A person who is:

- 1. Licensed to practice medicine pursuant to the provisions of chapter 630 of NRS;
- 2. Licensed as an advanced practice registered nurse pursuant to the provisions of chapter 632 of NRS;
- 3. Licensed to practice osteopathic medicine pursuant to the provisions of chapter 633 of NRS; or
- 4. Licensed pursuant to the provisions of chapter 641 of NRS,

↪ and who has previously renewed his or her license before July 1, 2017, shall complete a course of instruction on suicide prevention and awareness as required pursuant to NRS 630.253, 632.343, 633.471 or 641.220, as amended by sections 1, 2, 2.5 and 3 of this act, as applicable, by July 1, 2018, or before the date on which the license of the person must next be renewed, whichever is later.

Sec. 9. Sections 1.3, 2.5 and 3.5 of chapter 403, Statutes of Nevada 2015, at pages 2281, 2285 and 2287, respectively, are hereby repealed.

Sec. 10. This act becomes effective:

1. Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

2. On July 1, 2017, for all other purposes.

TEXT OF REPEALED SECTIONS

Section 1.3 of chapter 403, Statutes of Nevada 2015:

Sec. 1.3. NRS 630.253 is hereby amended to read as follows:

630.253 1. The Board shall, as a prerequisite for the:

(a) Renewal of a license as a physician assistant; or

(b) Biennial registration of the holder of a license to practice medicine,

↪ require each holder to submit evidence of compliance with the requirements for continuing education as set forth in regulations adopted by the Board.

2. These requirements:

(a) May provide for the completion of one or more courses of instruction relating to risk management in the performance of medical services.

(b) Must provide for the completion of a course of instruction, within 2 years after initial licensure, relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. The course must provide at least 4 hours of instruction that includes instruction in the following subjects:

(1) An overview of acts of terrorism and weapons of mass destruction;

(2) Personal protective equipment required for acts of terrorism;

(3) Common symptoms and methods of treatment associated with exposure to, or injuries caused by, chemical, biological, radioactive and nuclear agents;

(4) Syndromic surveillance and reporting procedures for acts of terrorism that involve biological agents; and

(5) An overview of the information available on, and the use of, the Health Alert Network.

↪ The Board may thereafter determine whether to include in a program of continuing education additional courses of instruction relating to the medical consequences of an act of terrorism that involves the use of a

weapon of mass destruction.

3. The Board shall encourage each holder of a license who treats or cares for persons who are more than 60 years of age to receive, as a portion of their continuing education, education in geriatrics and gerontology, including such topics as:

(a) The skills and knowledge that the licensee needs to address aging issues;

(b) Approaches to providing health care to older persons, including both didactic and clinical approaches;

(c) The biological, behavioral, social and emotional aspects of the aging process; and

(d) The importance of maintenance of function and independence for older persons.

4. The Board shall encourage each holder of a license to practice medicine to receive, as a portion of his or her continuing education, training concerning methods for educating patients about how to effectively manage medications, including, without limitation, the ability of the patient to request to have the symptom or purpose for which a drug is prescribed included on the label attached to the container of the drug.

5. The Board shall encourage each holder of a license to practice medicine to receive as a portion of his or her continuing education training concerning suicide, including, without limitation, such topics as:

(a) The skills and knowledge that the licensee needs to detect behaviors that may lead to suicide, including, without limitation, post-traumatic stress disorder;

(b) Approaches to engaging other professionals in suicide intervention; and

(c) The detection of suicidal thoughts and ideations and the prevention of suicide.

6. A holder of a license to practice medicine may substitute not more than 2 hours of continuing education credits in the detection of suicidal thoughts and ideations, and the intervention and prevention of suicide, pain management or addiction care for the purposes of satisfying an equivalent requirement for continuing education in ethics.

7. As used in this section:

(a) "Act of terrorism" has the meaning ascribed to it in NRS 202.4415.

(b) "Biological agent" has the meaning ascribed to it in NRS 202.442.

(c) "Chemical agent" has the meaning ascribed to it in NRS 202.4425.

(d) "Radioactive agent" has the meaning ascribed to it in NRS 202.4437.

(e) "Weapon of mass destruction" has the meaning ascribed to it in NRS 202.4445.

Section 2.5 of chapter 403, Statutes of Nevada 2015:

Sec. 2.5. NRS 633.471 is hereby amended to read as follows:

633.471 1. Except as otherwise provided in subsection 8 and NRS 633.491, every holder of a license issued under this chapter, except a temporary or a special license, may renew the license on or before January 1 of each calendar year after its issuance by:

- (a) Applying for renewal on forms provided by the Board;
- (b) Paying the annual license renewal fee specified in this chapter;
- (c) Submitting a list of all actions filed or claims submitted to arbitration or mediation for malpractice or negligence against the holder during the previous year;

- (d) Submitting evidence to the Board that in the year preceding the application for renewal the holder has attended courses or programs of continuing education approved by the Board in accordance with regulations adopted by the Board totaling a number of hours established by the Board which must not be less than 35 hours nor more than that set in the requirements for continuing medical education of the American Osteopathic Association; and

- (e) Submitting all information required to complete the renewal.

2. The Secretary of the Board shall notify each licensee of the requirements for renewal not less than 30 days before the date of renewal.

3. The Board shall request submission of verified evidence of completion of the required number of hours of continuing medical education annually from no fewer than one-third of the applicants for renewal of a license to practice osteopathic medicine or a license to practice as a physician assistant. Upon a request from the Board, an applicant for renewal of a license to practice osteopathic medicine or a license to practice as a physician assistant shall submit verified evidence satisfactory to the Board that in the year preceding the application for renewal the applicant attended courses or programs of continuing medical education approved by the Board totaling the number of hours established by the Board.

4. The Board shall encourage each holder of a license to practice osteopathic medicine to receive, as a portion of his or her continuing education, training concerning methods for educating patients about how to effectively manage medications, including, without limitation, the ability of the patient to request to have the symptom or purpose for which a drug is prescribed included on the label attached to the container of the drug.

5. The Board shall require, as part of the continuing education requirements approved by the Board, the biennial completion by a holder of a license to practice osteopathic medicine of at least 2 hours

of continuing education credits in ethics, pain management or addiction care.

6. The Board shall encourage each holder of a license to practice osteopathic medicine to receive as a portion of his or her continuing education training concerning suicide, including, without limitation, such topics as:

(a) The skills and knowledge that the licensee needs to detect behaviors that may lead to suicide, including, without limitation, post-traumatic stress disorder;

(b) Approaches to engaging other professionals in suicide intervention; and

(c) The detection of suicidal thoughts and ideations and the prevention of suicide.

7. A holder of a license to practice osteopathic medicine may substitute not more than 2 hours of continuing education credits in the detection of suicidal thoughts and ideations, and the intervention and prevention of suicide for the purposes of satisfying an equivalent requirement for continuing education in ethics.

8. Members of the Armed Forces of the United States and the United States Public Health Service are exempt from payment of the annual license renewal fee during their active duty status.

Section 3.5 of chapter 403, Statutes of Nevada 2015:

Sec. 3.5. NRS 641.220 is hereby amended to read as follows:

641.220 1. To renew a license or certificate issued pursuant to this chapter, each person must, on or before the first day of January of each odd-numbered year:

(a) Apply to the Board for renewal;

(b) Pay the biennial fee for the renewal of a license or certificate;

(c) Submit evidence to the Board of completion of the requirements for continuing education as set forth in regulations adopted by the Board; and

(d) Submit all information required to complete the renewal.

2. Upon renewing his or her license, a psychologist shall declare his or her areas of competence, as determined in accordance with NRS 641.112.

3. The Board shall, as a prerequisite for the renewal of a license or certificate, require each holder to comply with the requirements for continuing education adopted by the Board.

Senator Atkinson moved the adoption of the amendment.

Remarks by Senator Atkinson.

Amendment No. 762 to Assembly Bill No. 105 requires osteopathic physicians to complete a course of instruction on evidence-based suicide prevention and awareness within two years after initial licensure.

Amendment adopted.

Bill read third time.

Remarks by Senator Atkinson.

Assembly Bill No. 105 requires certain health-care providers to obtain continuing education in suicide prevention and awareness every four years. It also removes a provision that allows some providers to substitute courses in ethics to meet the requirements and further repeals the prospective expiration of existing requirements that certain health-care providers complete a course of instruction on suicide prevention and awareness.

Roll call on Assembly Bill No. 105:

YEAS—21.

NAYS—None.

Assembly Bill No. 105 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 145.

Bill read third time.

Remarks by Senator Cannizzaro.

Assembly Bill No. 145 extends the statute of limitations for filing a civil action to recover damages arising out of sexual abuse committed against a person under 18 years of age. The time is extended from 10 years to 20 years after the person reaches 18 years of age or discovers or should have discovered that an injury was caused by the sexual abuse, whichever is later.

In addition, the bill extends the statute of limitations for filing a civil action to recover damages arising out of the appearance in pornographic material before 16 years of age. The time is extended from 3 years to 20 years after the person reaches 18 years of age or after a court enters a verdict in a related criminal case, whichever is later. Lastly, if the cause of action has not yet expired, then the statute of limitations is extended, but if the cause of action has expired, then it cannot be revived.

Roll call on Assembly Bill No. 145:

YEAS—21.

NAYS—None.

Assembly Bill No. 145 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 146.

Bill read third time.

Remarks by Senator Harris.

Assembly Bill No. 146 enacts the Uniform Recognition and Enforcement of Canadian Domestic-Violence Protection Orders Act. The measure provides for the enforcement and registration of domestic-violence protection orders issued by Canadian courts. A law enforcement officer must, subject to certain exceptions, enforce a Canadian Domestic-Violence Protection Order in the same way that he or she would enforce a similar order that was issued by a court of this State. A person who enforces such an order based upon a reasonable belief that the order is valid, or who refuses to enforce such an order based upon a reasonable belief that the order is not valid, is provided immunity from civil or criminal liability.

Roll call on Assembly Bill No. 146:

YEAS—21.

NAYS—None.

Assembly Bill No. 146 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 154.

Bill read third time.

Remarks by Senators Ratti and Roberson.

SENATOR RATTI:

Assembly Bill No. 154 removes the 90 percent prevailing-wage rate exception for public works constructed by school districts and the Nevada System of Higher Education. They are required to pay the same prevailing-wage on their public works projects as other public bodies effective July 1, 2017.

SENATOR ROBERSON:

This is another futile attempt to repeal common-sense, bipartisan reforms from last Session. I encourage all my colleagues to vote "no".

Roll call on Assembly Bill No. 154:

YEAS—12.

NAYS—Gansert, Goicoechea, Gustavson, Hammond, Hardy, Harris, Kieckhefer, Roberson, Settelmeyer—9.

Assembly Bill No. 154 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 202.

Bill read third time.

Remarks by Senator Segerblom.

Assembly Bill No. 202 requires the Legislative Commission to appoint a committee to conduct an interim study concerning the cost and affordability of higher education in Nevada. The bill requires the committee to consider certain topics and perform certain duties, including preparing a report for submission to the Legislature and making recommendations to the Legislature and the Board of Regents concerning findings related to the affordability and programs of higher education, including, without limitation, where long-term investments should be made to improve affordability and address workforce needs, and actions needed for the efficient and effective operation of higher education if the State is to progress economically and socially.

Roll call on Assembly Bill No. 202:

YEAS—20.

NAYS—Gustavson.

Assembly Bill No. 202 having received a constitutional majority, Mr. President declared it passed.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 209.

Bill read third time.

Remarks by Senator Settelmeyer.

Assembly Bill No. 209 revises the criteria considered by the State Engineer for an extension of time to work a forfeiture of groundwater rights. In certain groundwater basins, the State Engineer may grant an extension of up to three years and may grant multiple extensions.

Roll call on Assembly Bill No. 209:

YEAS—21.

NAYS—None.

Assembly Bill No. 209 having received a constitutional majority, Mr. President declared it passed.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 262.

Bill read third time.

Remarks by Senator Hardy.

Assembly Bill No. 262 provides that a person who repossesses a vehicle before default or commits any act against a consumer in violation of the Uniform Commercial Code has committed a deceptive trade practice. The bill also makes changes to provisions related to surety bonds for vehicle and off-highway vehicle sellers and manufacturers. It requires the surety to appoint the Commissioner of Insurance as its agent. Additionally, the bill expands the uses for which a consumer may make a claim against a surety bond of a motor-vehicle broker.

Roll call on Assembly Bill No. 262:

YEAS—21.

NAYS—None.

Assembly Bill No. 262 having received a constitutional majority, Mr. President declared it passed.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 341.

Bill read third time.

Remarks by Senator Cannizzaro.

Assembly Bill No. 341 authorizes an attorney who represents a child in a juvenile proceeding to consult and seek appointment from a social worker, a mental-health professional, an educator or other expert the attorney deems appropriate.

In addition, this measure urges the Nevada Supreme Court to adopt rules for attorneys who represent juveniles to ensure effective assistance of counsel in proceedings. Rules may include minimum requirements for courses, programs and continuing legal education in order to provide effective representation of juveniles; standards for professional conduct specific to juvenile justice, and minimum requirements for attorneys who represent juveniles and are employed by the Office of the State Public Defender.

Roll call on Assembly Bill No. 341:

YEAS—21.

NAYS—None.

Assembly Bill No. 341 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 365.

Bill read third time.

Remarks by Senator Segerblom.

Assembly Bill No. 365 grants marriage officiants the authorization and responsibility to perform a marriage. A marriage officiant is defined as a person, other than a minister, other church or religious official authorized to solemnize a marriage or notary public who obtains a certificate

of permission to perform marriages. A county clerk is prohibited from authorizing a marriage officiant to solemnize a marriage until the applicant who desires to be a marriage officiant successfully completes a course established by the clerk as provided for in this bill. The county clerk may establish a policy providing that a certificate of permission to perform marriages expires five years after the date it was issued or renewed. A county clerk is also authorized to revoke a certificate of permission to perform marriages if a minister, other church or religious official authorized to solemnize a marriage, or marriage officiant who fails to notify the county clerk within 30 days of changing his or her address.

A county clerk is authorized to establish a program to provide a couple who renews their marriage vows a certificate of vow renewal. The measure sets forth the requirements for the contents of a vow-renewal certificate and further exempts the certificate from any requirement for the retention of records. The county clerk may charge and collect a fee to cover the cost of preparing the certificate.

The civil penalty is revised for performing marriages that are not authorized by law. A board of county commissioners is authorized to enact an ordinance delegating to a hearing officer the authority to determine such violations and levy civil penalties for violations. In addition, the measure requires the county clerk to include on marriage forms language that specifies the marriage certificate is not a certified copy. Finally, in Clark County, the county clerk is required to report, rather than submit a report, to the Board of County Commissioners regarding the special revenue fund for the promotion of marriage tourism.

Roll call on Assembly Bill No. 365:

YEAS—21.

NAYS—None.

Assembly Bill No. 365 having received a two-thirds majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 425.

Bill read third time.

Remarks by Senator Cancela.

Assembly Bill No. 425 makes various changes to the regulation of alcohol, drug and gambling counselors. The bill authorizes the Board of Examiners for Alcohol, Drug and Gambling Counselors to place licensees on inactive status in certain circumstances, while prohibiting a licensee who has requested inactive status from practicing and providing a penalty for failure to comply. Additionally, Assembly Bill No. 425 authorizes the Board to impose certain sanctions or penalties for providing services while not holding a license or certificate or falsely claiming to hold a license or certificate. Finally, the bill allows a certified alcohol and drug abuse counselor who meets certain requirements to supervise a certified intern.

Roll call on Assembly Bill No. 425:

YEAS—21.

NAYS—None.

Assembly Bill No. 425 having received a two-thirds majority, Mr. President declared it passed.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 429.

Bill read third time.

Remarks by Senator Hardy.

Assembly Bill No. 429 enacts the Psychology Interjurisdictional Compact of the Association of State and Provincial Psychology Boards. The interstate compact allows a person who is licensed

as a psychologist in a state that is a member of the Compact to provide services to patients in other states that are members of the Compact through telehealth or in person under certain conditions. Before providing such services, the Compact requires a psychologist to meet certain specified requirements.

The governing body of the Compact, the Psychology Interjurisdictional Compact Commission is authorized to access certain information and make certain determinations regarding the provision of services by a psychologist in a state that is a member of the Compact, under certain circumstances. Psychologists who provide services in states other than those in which they are licensed under the Compact are subject to the jurisdiction of the state in which they provide services, and such a state can revoke the authorization to practice in that state. The Commission is authorized to collect an annual assessment from each state that is a member of the Compact to fund the operations of the Commission; make rules concerning the administration of the Compact and the practice of psychology across state lines under the Compact; and resolve disputes among states that are members of the Compact related to the Compact.

Finally, the measure clarifies that a psychologist who is authorized to practice in this State pursuant to the Compact is authorized to engage in the same activities as a psychologist who is licensed in this State.

Roll call on Assembly Bill No. 429:

YEAS—21.

NAYS—None.

Assembly Bill No. 429 having received a constitutional majority, Mr. President declared it passed.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 439.

Bill read third time.

Remarks by Senator Gansert.

Assembly Bill No. 439, provides that for the purposes of state and local sales and use taxes, the Department of Taxation shall consider a licensed veterinarian to be a consumer, rather than a retailer of tangible personal property that is used furnished or dispensed by him or her in providing medical care or treatment, to animals as part of the performance of his or her professional service in the practice of veterinary medicine.

Roll call on Assembly Bill No. 439:

YEAS—21.

NAYS—None.

Assembly Bill No. 439 having received a constitutional majority, Mr. President declared it passed.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 455.

Bill read third time.

Remarks by Senator Gansert.

Assembly Bill No. 455 allows a notice or other document required by law to be provided as part of an insurance transaction or which serves as evidence of insurance to be delivered by electronic means in certain circumstances. The bill requires insurers to deliver notices or other documents in physical form to insured persons if the insurers do not receive verification or acknowledgment of receipt of electronic notice within three days of delivery. The bill also allows an insurer to post a standard policy of property or casualty insurance or a standard endorsement of such a policy on its Internet website rather than mailing or delivering it if the policy or

endorsement does not contain personally identifiable information and the insurer satisfies certain conditions.

Roll call on Assembly Bill No. 455:

YEAS—21.

NAYS—None.

Assembly Bill No. 455 having received a constitutional majority, Mr. President declared it passed.

Bill ordered transmitted to the Assembly.

Assembly Bill No. 464.

Bill read third time.

Remarks by Senator Ratti.

Assembly Bill No. 464 repeals a number of provisions relating to obsolete or redundant reports mandated by the Legislature but ensures that the information provided by certain reports will remain publicly available on pertinent websites. It also revises the frequency with which some reports are to be submitted to the Legislature.

Roll call on Assembly Bill No. 464:

YEAS—21.

NAYS—None.

Assembly Bill No. 464 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

UNFINISHED BUSINESS

CONSIDERATION OF ASSEMBLY AMENDMENTS

Senate Bill No. 267.

The following Assembly Amendment was read:

Amendment No. 662.

SUMMARY—Revises provisions governing real property. (BDR 9-822)

AN ACT relating to real property; revising provisions governing the auction of property pursuant to the power of sale under a deed of trust; revising provisions requiring certain mortgagees and beneficiaries of a deed of trust to provide certain contact information to the Division of Financial Institutions of the Department of Business and Industry; providing for the continuation of certain provisions relating to an expedited process for the foreclosure of abandoned residential property; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Under existing law, the trustee under a deed of trust concerning owner-occupied housing has the power to sell the property to which the deed of trust applies, subject to certain restrictions. (NRS 107.080, 107.085, 107.086) Existing law requires such a sale to be made: (1) in a county whose population is less than 100,000 (currently all counties other than Clark and Washoe Counties), at the courthouse in the county in which the property or some part thereof is situated; or (2) in a county whose population is 100,000 or more (currently Clark and Washoe Counties), at the public location in the

county designated by the governing body of the county for that purpose. (NRS 107.081) Section 1 of this bill removes the population cap to require any such sale to be made at a public location in the county designated by the governing body of the county for that purpose.

Existing law requires a financial institution that is a mortgagee or beneficiary of a deed of trust under certain residential mortgage loans to provide to the Division of Financial Institutions of the Department of Business and Industry the name and certain contact information of a person to whom: (1) a borrower or a representative of a borrower must send information and notices to facilitate a mediation under the Foreclosure Mediation Program; and (2) a unit-owners' association must mail notices concerning the foreclosure of the association's lien on a unit. Existing law further requires the Division to maintain this information on its Internet website and provide a prominent display of, or a link to, this information on the home page of its Internet website. (NRS 657.110) Section 1.5 of this bill requires any mortgagee or beneficiary of a deed of trust under a residential mortgage loan to provide the Division with such contact information.

Senate Bill No. 278 of the 2013 Legislative Session (S.B. 278): (1) established an expedited process for the foreclosure of abandoned residential property; and (2) authorized a board of county commissioners or the governing body of an incorporated city to establish by ordinance a registry of abandoned residential real property and a registry of real property in danger of becoming abandoned. (Chapter 330, Statutes of Nevada 2013, p. 1543) The provisions of S.B. 278 expire by limitation on June 30, 2017. Section 2 of this bill extends the prospective expiration of the provisions of S.B. 278 to June 30, 2021.

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

Section 1. NRS 107.081 is hereby amended to read as follows:

107.081 1. All sales of property pursuant to NRS 107.080 must be made at auction to the highest bidder and must be made between the hours of 9 a.m. and 5 p.m. The agent holding the sale must not become a purchaser at the sale or be interested in any purchase at such a sale.

2. All sales of real property must be made ~~at~~:

~~—(a) In a county with a population of less than 100,000, at the courthouse in the county in which the property or some part thereof is situated.~~

~~—(b) In a county with a population of 100,000 or more,] at the public location in the county designated by the governing body of the county for that purpose.~~

Sec. 1.5. NRS 657.110 is hereby amended to read as follows:

657.110 1. ~~Each mortgagee or beneficiary of a deed of trust under a residential mortgage loan, including, without limitation, a bank, credit union, savings bank, savings and loan association, thrift company or other financial institution which is licensed, registered or otherwise authorized to do business in this State, [and which is the mortgagee or beneficiary of a deed of trust under a residential mortgage loan]~~ shall provide to the Division of

Financial Institutions the name, street address and any other contact information of a person to whom:

(a) A borrower or a representative of a borrower must send any document, record or notification necessary to facilitate a mediation conducted pursuant to NRS 40.437 or 107.086.

(b) A unit-owners' association must send any notice required to be given pursuant to NRS 116.3116 to 116.31168, inclusive.

2. The Division of Financial Institutions shall maintain on its Internet website the information provided to the Division pursuant to subsection 1 and provide a prominent display of, or a link to, the information described in subsection 1, on the home page of its Internet website.

3. As used in this section:

(a) "Borrower" means a person who is a mortgagor or grantor of a deed of trust under a residential mortgage loan.

(b) "Residential mortgage loan" means a loan which is primarily for personal, family or household use and which is secured by a mortgage or deed of trust on owner-occupied housing as defined in NRS 107.086.

Sec. 2. Section 7 of chapter 330, Statutes of Nevada 2013, at page 1555, is hereby amended to read as follows:

Sec. 7. This act becomes effective on July 1, 2013, and expires by limitation on June 30, ~~{2017}~~ 2021.

Sec. 3. This act becomes effective upon passage and approval.

Senator Segerblom moved that the Senate concur in Assembly Amendment No. 662 to Senate Bill No. 267.

Motion carried by a constitutional majority.

Bill ordered enrolled.

Senator Ford moved that the Senate recess until 12:45 p.m.

Motion carried.

Senate in recess at 12:18 p.m.

SENATE IN SESSION

At 12:50 p.m.

Mr. President Hutchison presiding.

Quorum present.

REPORTS OF COMMITTEES

Mr. President:

Your Committee on Finance, to which was re-referred Senate Bill No. 265, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

JOYCE WOODHOUSE, *Chair*

Mr. President:

Your Committee on Judiciary, to which was referred Senate Bill No. 203, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

TICK SEGERBLOM, *Chair*

SECOND READING AND AMENDMENT

Assembly Bill No. 36.

Bill read second time and ordered to third reading.

Assembly Bill No. 169.

Bill read second time.

The following amendment was proposed by the Committee on Government Affairs:

Amendment No. 742.

SUMMARY—Revises provisions governing certain fees collected by county recorders. (BDR 20-832)

AN ACT relating to county recorders; providing that a county recorder has discretion to accept and record a document that does not meet certain formatting requirements; revising certain fees collected by a county recorder; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Under existing law, certain documents submitted to a county recorder must meet certain formatting requirements and the county recorder is authorized to charge and collect a fee for documents which do not meet those formatting requirements. (NRS 247.110, 247.305) Section 1 of this bill provides that a county recorder has the discretion to accept and record a document that does not meet formatting requirements. Section 2 of this bill removes the fee charged for documents which do not comply with the formatting requirements.

Existing law requires the county recorder to charge and collect certain other fees for recording a document, including fees based on the number of pages in the document, certain indexing fees and an additional fee. (NRS 247.305) Section 2 revises the fees collected for recording certain documents ~~and~~ eliminates the additional fee for recording documents that are more than one page. Section 2 also increases the additional fee collected for recording certain documents from \$3 to \$5.

Existing law requires the county recorder to charge certain fees for recording certain documents relating to a mining claim. (NRS 247.310) Section 2.5 of this bill provides that the fee for recording a notice or certificate of location of a mining claim, or an amended notice or certificate of the location of a mining claim is \$10 and eliminates the additional fee for recording such documents that are more than one page.

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

Section 1. NRS 247.110 is hereby amended to read as follows:

247.110 1. When a document authorized, entitled or required by law to be recorded is deposited in the county recorder's office for recording, the county recorder shall:

- (a) Endorse upon it the time when it was received, noting:
 - (1) The year, month, day, hour and minute of its reception;
 - (2) The document number; and

(3) The amount of fees collected for recording the document.

(b) Record the document without delay, together with the acknowledgments, proofs and certificates, written upon or annexed to it, with the plats, surveys, schedules and other papers thereto annexed, in the order in which the papers are received for recording.

(c) Note at the upper right corner of the record and upon the document, except a map, so recorded the exact time of its reception and the name of the person at whose request it was recorded.

(d) Upon request, place a stamp or other notation upon one copy of the document presented at the time of recording to reflect the information endorsed upon the original pursuant to subparagraphs (1) and (2) of paragraph (a) and as evidence that the county recorder received the original, and return the copy to the person who presented it.

2. In addition to the information described in paragraph (a) of subsection 1, a county recorder may endorse upon a document the book and page where the document is recorded.

3. Except as otherwise provided in this section ~~[, subsection 5 of NRS 247.305]~~ and NRS 111.366 to 111.3697, inclusive, a document, except a map, certificate or affidavit of death, military discharge or document regarding taxes that is issued by the Internal Revenue Service of the United States Department of the Treasury, that is submitted for recording must be on a form authorized by NRS 104.9521 for the type of filing or , *except as otherwise provided in subsection 5*, must:

(a) Be on white, 20-pound paper that is 8 1/2 inches by 11 inches in size.

(b) Have a margin of 1 inch on the left and right sides and at the bottom of each page.

(c) Have a space of 3 inches by 3 inches at the upper right corner of the first page and have a margin of 1 inch at the top of each succeeding page.

(d) Not be on sheets of paper that are bound together at the side, top or bottom.

(e) Not contain printed material on more than one side of each page.

(f) Not have any documents or other materials physically attached to the paper.

(g) Not contain:

(1) Colored markings to highlight text or any other part of the document;

(2) A stamp or seal that overlaps with text or a signature on the document, except in the case of a validated stamp or seal of a professional engineer or land surveyor who is licensed pursuant to chapter 625 of NRS;

(3) Text that is smaller than a 10-point Times New Roman font and is printed in any ink other than black; or

(4) More than nine lines of text per vertical inch.

4. The provisions of subsection 3 do not apply to a document submitted for recording that has been filed with a court and which conforms to the formatting requirements established by the court.

5. A county recorder has the discretion to accept and record a document that does not meet the formatting requirements set forth in paragraphs (a) to (g), inclusive, of subsection 3.

6. A document is recorded when the information required pursuant to this section is placed on the document and is entered in the record of the county recorder.

Sec. 2. NRS 247.305 is hereby amended to read as follows:

247.305 1. If another statute specifies the fee to be charged for a service, county recorders shall charge and collect only the fee specified. Otherwise, unless prohibited by NRS 375.060, county recorders shall charge and collect the following fees:

(a) ~~For any document specified in paragraphs (k), (l) and (m) of section 1 of NRS 247.120, or any amendments thereto:~~

~~(1) For recording any a document, for the first page \$10~~

~~(b) (2) For each additional page \$1~~

~~(c) For recording each portion of a document which must be separately indexed, after the first indexing \$3~~

~~(d) (3) For copying any a record, for each page \$1~~

~~(b) For any other document:~~

~~(1) For recording a document \$25~~

~~(2) (b) For copying a record, for each page \$1~~

~~(e) (3) (c) For certifying, including certificate and seal \$4~~

~~(f) (4) (d) For a certified copy of a certificate of marriage \$10~~

~~(g) (5) (e) For a certified abstract of a certificate of marriage \$10~~

~~(h) (6) (f) For a certified copy of a certificate of marriage or for a~~

certified abstract of a certificate of marriage, the additional sum of \$5 for the Account for Aid for Victims of Domestic Violence in the State General Fund.

The fees collected for this purpose must be paid over to the county treasurer by the county recorder on or before the fifth day of each month for the preceding calendar month, and must be credited to that Account. The county treasurer shall, on or before the 15th day of each month, remit those fees deposited by the recorder to the State Controller for credit to that Account.

2. Except as otherwise provided in this subsection and NRS 375.060, a county recorder may charge and collect, in addition to any fee that a county recorder is otherwise authorized to charge and collect, an additional fee not to exceed ~~the~~ \$5 for recording a document, instrument, paper, notice, deed, conveyance, map, chart, survey or any other writing. A county recorder may not charge the additional fee authorized in this subsection for recording an originally signed certificate of marriage described in NRS 122.120. On or before the fifth day of each month, the county recorder shall pay the amount of fees collected by him or her pursuant to this subsection to the county treasurer for credit to the account established pursuant to NRS 247.306.

3. Except as otherwise provided in this subsection and NRS 375.060, a county recorder shall charge and collect, in addition to any fee that a county recorder is otherwise authorized to charge and collect, an additional fee of \$1

for recording a document, instrument, paper, notice, deed, conveyance, map, chart, survey or any other writing. A county recorder shall not charge the additional fee authorized in this subsection for recording an originally signed certificate of marriage described in NRS 122.120. On or before the fifth day of each month, the county recorder shall pay the amount of fees collected by him or her pursuant to this subsection to the county treasurer. On or before the 15th day of each month, the county treasurer shall remit the money received by him or her pursuant to this subsection to the State Treasurer for credit to the Account to Assist Persons Formerly in Foster Care established pursuant to NRS 432.017.

4. Except as otherwise provided in this subsection and NRS 375.060, a board of county commissioners may, in addition to any fee that a county recorder is otherwise authorized to charge and collect, impose by ordinance a fee of not more than \$3 for recording a document, instrument, paper, notice, deed, conveyance, map, chart, survey or any other writing. A county recorder shall not charge the additional fee authorized by this subsection for recording an originally signed certificate of marriage described in NRS 122.120. On or before the fifth day of each month, the county recorder shall pay the amount of fees collected by him or her pursuant to this subsection to the county treasurer. On or before the 15th day of each month, the county treasurer shall remit the money received by him or her pursuant to this subsection to the organization operating the program for legal services for the indigent that receives the fees charged pursuant to NRS 19.031 to be used to provide legal services for abused and neglected children.

5. ~~Except as otherwise provided in this subsection or subsection 6 or by specific statute, a county recorder may charge and collect, in addition to any fee that a county recorder is otherwise authorized to charge and collect, an additional fee not to exceed \$25 for recording any document that does not meet the standards set forth in subsection 3 of NRS 247.110. A county recorder shall not charge the additional fee authorized by this subsection for recording a document that is exempt from the provisions of subsection 3 of NRS 247.110.~~
~~—6.~~ Except as otherwise provided in subsection ~~{7.}~~ 6, a county recorder shall not charge or collect any fees for any of the services specified in this section when rendered by the county recorder to:

- (a) The county in which the county recorder's office is located.
- (b) The State of Nevada or any city or town within the county in which the county recorder's office is located, if the document being recorded:
 - (1) Conveys to the State, or to that city or town, an interest in land;
 - (2) Is a mortgage or deed of trust upon lands within the county which names the State or that city or town as beneficiary;
 - (3) Imposes a lien in favor of the State or that city or town; or
 - (4) Is a notice of the pendency of an action by the State or that city or town.

~~{7.}~~ 6. A county recorder shall charge and collect the fees specified in this section for copying any document at the request of the State of Nevada, and

any city or town within the county. For copying, and for his or her certificate and seal upon the copy, the county recorder shall charge the regular fee.

~~{8-}~~ 7. If the amount of money collected by a county recorder for a fee pursuant to this section:

(a) Exceeds by \$5 or less the amount required by law to be paid, the county recorder shall deposit the excess payment with the county treasurer for credit to the county general fund.

(b) Exceeds by more than \$5 the amount required by law to be paid, the county recorder shall refund the entire amount of the excess payment.

~~{9-}~~ 8. Except as otherwise provided in subsection 2, 3, 4 or ~~{8}~~ 7 or by an ordinance adopted pursuant to the provisions of NRS 244.207, county recorders shall, on or before the fifth working day of each month, account for and pay to the county treasurer all such fees collected during the preceding month.

~~{10-}~~ 9. For the purposes of this section, "State of Nevada," "county," "city" and "town" include any department or agency thereof and any officer thereof in his or her official capacity.

Sec. 2.5. NRS 247.310 is hereby amended to read as follows:

247.310 1. Except as otherwise provided by law, county recorders shall charge the following fees for recording affidavits of proof of labor on mining claims and for recording, pursuant to subsection 3 of NRS 517.230, affidavits of intent to hold mining claims:

For recording any such affidavits that embrace therein one claim \$2

For each additional mining claim embraced in the affidavit 2

2. Except as otherwise provided by law, county recorders shall charge \$10 for recording:

(a) A notice or certificate of location of a mining claim; or

(b) An amended notice or certificate of location of a mining claim.

3. Except as otherwise provided by an ordinance adopted pursuant to the provisions of NRS 244.207, county recorders shall, on or before the 5th working day of each month, account for and pay to the county treasurer all such fees collected during the preceding month.

Sec. 3. (Deleted by amendment.)

Senator Parks moved the adoption of the amendment.

Remarks by Senator Parks.

Amendment No. 742 to Assembly Bill No. 169 eliminates the additional fee for recording documents that are more than one page to allow for a "flat" recording fee. The amendment further clarifies that the fee for recording a notice or certificate of the location of a mining claim is \$10, as existing law requires.

Amendment adopted.

Bill ordered reprinted, re-engrossed and to third reading.

Assembly Bill No. 176.

Bill read second time.

The following amendment was proposed by the Committee on Health and Human Services:

Amendment No. 750.

SUMMARY—Establishes certain requirements for the operation of seasonal or temporary recreation programs. (BDR 38-702)

AN ACT relating to care of children; establishing certain requirements for the operation of ~~for~~ certain seasonal or temporary recreation ~~program;~~ programs; requiring the termination of certain staff members of such a program who have been convicted of certain crimes or who have had a substantiated report of child abuse or neglect made against them; providing a civil penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires a local government that operates an out-of-school recreation program to comply with certain health and safety standards and to comply with other requirements relating to the safety of participants in the program. (NRS 432A.610) Certain requirements for the staff of an out-of-school recreation program are set forth in existing law. (NRS 432A.620) Existing law further requires an out-of-school recreation program to maintain certain records regarding participants in the program. (NRS 432A.630) Sections 2-4 of this bill make certain requirements imposed on an out-of-school recreation program applicable to a nongovernmental person or entity that operates a program that primarily functions as a seasonal or temporary recreation program. Section 3.5 further requires a person or entity that operates such a program to terminate the employment of a staff member who has been convicted of certain crimes or has had a substantiated report of child abuse or neglect filed against him or her, after affording the staff member an opportunity to correct the information. Section 5 of this bill subjects a person who operates such a seasonal or temporary recreation program to a civil penalty not to exceed \$500 for failure to comply with ~~such~~ the requirements ~~of~~ of this bill.

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

Section 1. Chapter 432A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 5, inclusive, of this act.

Sec. 2. *A person who operates a program that primarily functions as a seasonal or temporary recreation program shall ensure that each site upon which the program is conducted:*

1. *Has a complete first-aid kit accessible on-site that complies with the requirements of the Occupational Safety and Health Administration of the United States Department of Labor;*

2. *Has an emergency exit plan posted on-site in a conspicuous place; and*

3. *Has at least one staff member or volunteer on-site and available during the hours of operation who is certified and receives annual training in the use and administration of first aid, including, without limitation, cardiopulmonary resuscitation.*

Sec. 3. A person who operates a program that primarily functions as a seasonal or temporary recreation program shall complete, for each member of the staff of the program:

1. A background and personal history check ~~for~~ not later than 3 days after the staff member is hired and once every 5 years thereafter; and

2. A child abuse and neglect screening through the Statewide Central Registry for the Collection of Information Concerning the Abuse or Neglect of a Child established by NRS 432.100 to determine whether there has been a substantiated report of child abuse or neglect made against the staff member.

Sec. 3.5. 1. Upon receiving the results of the background and personal history check performed pursuant to subsection 1 of section 3 of this act, the results of the child abuse and neglect screening pursuant to subsection 2 of section 3 of this act or evidence from any other source that a staff member of a person who operates a program that primarily functions as a seasonal or temporary recreation program has been convicted of a crime listed in subsection 2 of NRS 432A.170 or has had a substantiated report of child abuse or neglect made against him or her, the person shall terminate the employment of the staff member after allowing the staff member time to correct the information as required pursuant to subsection 2.

2. If a staff member believes that the information provided to the person who operates a program that primarily functions as a seasonal or temporary recreation program pursuant to subsection 1 is incorrect, the staff member must inform the person immediately. The person shall give any such staff member 30 days to correct the information.

3. During any period in which a staff member seeks to correct information pursuant to subsection 2, it is within the discretion of the person who operates a program that primarily functions as a seasonal or temporary recreation program whether to allow the staff member to continue to work for the program, except that the staff member shall not have contact with a child without supervision during such a period.

Sec. 4. 1. A person who operates a program that primarily functions as a seasonal or temporary recreation program shall maintain records containing pertinent information regarding each staff member of the program.

2. The distribution of any information maintained pursuant to this section is subject to the limitations set forth in NRS 239.0105.

Sec. 5. A person who operates a program that primarily functions as a seasonal or temporary recreation program and who fails to comply with any provision of section 2, 3, 3.5 or 4 of this act is subject to a civil penalty not to exceed \$500 for each failure to comply. The Attorney General or any district attorney of this State may recover the penalty in a civil action brought in the name of the State of Nevada in any court of competent jurisdiction.

Senator Ratti moved the adoption of the amendment.

Remarks by Senator Ratti.

Amendment No. 750 revises Assembly Bill No. 176 to require a person who operates a seasonal or temporary recreation program to ensure each program has at least one staff member or volunteer on site and available who is trained in first aid and CPR. In addition, the amendment requires the termination of a staff member who has been convicted of certain crimes or has had a substantiated report of child abuse or neglect filed against him or her, after affording the staff member an opportunity to correct the information.

Amendment adopted.

Bill ordered reprinted, re-engrossed and to third reading.

Assembly Bill No. 192.

Bill read second time and ordered to third reading.

Assembly Bill No. 223.

Bill read second time.

The following amendment was proposed by the Committee on Commerce, Labor and Energy:

Amendment No. 696.

SUMMARY—Revises provisions relating to energy efficiency programs.
(BDR 58-660)

AN ACT relating to energy efficiency programs; requiring an integrated resource plan filed by an electric utility (to submit to) with the Public Utilities Commission of Nevada ~~an energy efficiency plan designed to be cost effective; prescribing the contents of such a plan; requiring the Commission to determine the cost effectiveness of an energy efficiency plan or energy efficiency program through application of a test of the cost effectiveness of the plan or program that is selected by the Commission;~~ to include a proposal for the expenditure of certain amounts on energy efficiency and conservation programs directed to low-income customers of the electric utility; revising provisions relating to the approval by the Commission of certain energy efficiency and conservation programs; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires each electric utility to submit to the Public Utilities Commission of Nevada every 3 years ~~to~~ an integrated resource plan to increase the utility's supply of electricity or decrease the demands made on its system by its customers. Existing law provides that the integrated resource plan must include certain components, including, without limitation, an energy efficiency program for residential customers. (NRS 704.741) Section 7 of this bill revises this requirement to require an electric utility to include in its integrated resource plan ~~an energy efficiency plan for residential customers which reduces the consumption of electricity through~~ a proposal for the expenditure of not less than 5 percent of the total expenditures related to energy efficiency and conservation programs (and which is designed to be cost effective) on programs directed to low-income customers of the electric utility. Section 8 of this bill authorizes the Commission to accept an energy

efficiency plan that consists of energy efficiency programs and energy efficiency and conservation programs that are not cost effective if the energy efficiency plan as a whole is cost effective ~~for~~ according to the definition of "cost effective" set forth in section 3 of this bill. Section 8 further requires, as long as an energy efficiency plan remains cost effective, that any order of the Commission accepting or modifying an energy efficiency plan or an amendment to such a plan to require that at least 5 percent of the expenditures of the utility on approved energy efficiency and conservation programs in the energy efficiency plan be specifically directed toward energy efficiency programs for low-income customers.

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

Section 1. Chapter 704 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 5, inclusive, of this act.

Sec. 2. *As used in NRS 704.736 to 704.754, inclusive, and sections 2 to 5, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3, 4 and 5 of this act have the meanings ascribed to them in those sections.*

Sec. 3. *"Cost effective" means an energy efficiency plan or energy efficiency program has a benefit-cost ratio of 1.0 or greater as determined by the Commission, using a test of the cost effectiveness of the plan or program that:*

- 1. Is selected by the Commission; and*
- 2. Accounts for any non-energy benefits of the plan or program.*

Sec. 4. 1. *"Energy efficiency and conservation program" means a program designed, intended or used to improve energy efficiency by reducing the energy consumption by a ~~residential~~ retail customer of a utility which supplies electricity in this State.*

2. The term includes, without limitation, a demand-side response program or load-limiting program that shifts the consumption of energy by a ~~residential~~ retail customer from one period to another period.

3. The term does not include the implementation or assessment of any rate which is based on the time of day, day of the week or time of year during which electricity is used or which otherwise varies based upon the time during which the electricity is used.

Sec. 5. (Deleted by amendment.)

Sec. 6. NRS 704.736 is hereby amended to read as follows:

704.736 The application of NRS 704.736 to 704.754, inclusive, and sections 2 to 5, inclusive, of this act is limited to any public utility in the business of supplying electricity which has an annual operating revenue in this state of \$2,500,000 or more.

Sec. 7. NRS 704.741 is hereby amended to read as follows:

704.741 1. A utility which supplies electricity in this State shall, on or before July 1 of every third year, in the manner specified by the Commission,

submit a plan to increase its supply of electricity or decrease the demands made on its system by its customers to the Commission.

2. The Commission shall, by regulation:

(a) Prescribe the contents of such a plan, including, but not limited to, the methods or formulas which are used by the utility to:

(1) Forecast the future demands; and

(2) Determine the best combination of sources of supply to meet the demands or the best method to reduce them; and

(b) Designate renewable energy zones and revise the designated renewable energy zones as the Commission deems necessary.

3. The Commission shall require the utility to include in its plan:

(a) An energy efficiency program ~~plan~~ for residential customers ~~which is cost effective and~~ which reduces the consumption of electricity or any fossil fuel ~~through the implementation of energy efficiency and conservation programs. The energy efficiency plan must include, without limitation~~

~~(1) An energy efficiency and conservation program for residential customers which reduces the consumption of electricity or any fossil fuel~~ and which includes, without limitation, the use of new solar thermal energy sources

~~and~~

~~(2)~~

~~(b)~~ *A proposal for the expenditure of not less than 5 percent of the total expenditures related to energy efficiency and conservation programs on energy efficiency and conservation programs directed to low-income customers of the electric utility.*

~~(b)~~ *(c)* A comparison of a diverse set of scenarios of the best combination of sources of supply to meet the demands or the best methods to reduce the demands, which must include at least one scenario of low carbon intensity that includes the deployment of distributed generation.

~~(c)~~ *(d)* An analysis of the effects of the requirements of NRS 704.766 to 704.775, inclusive, on the reliability of the distribution system of the utility and the costs to the utility to provide electric service to all customers. The analysis must include an evaluation of the costs and benefits of addressing issues of reliability through investment in the distribution system.

~~(d)~~ *(e)* A list of the utility's assets described in NRS 704.7338.

~~(e)~~ *(f)* A surplus asset retirement plan as required by NRS 704.734.

4. The Commission shall require the utility to include in its plan a plan for construction or expansion of transmission facilities to serve renewable energy zones and to facilitate the utility in meeting the portfolio standard established by NRS 704.7821.

5. As used in this section:

(a) "Carbon intensity" means the amount of carbon by weight emitted per unit of energy consumed.

(b) "Renewable energy zones" means specific geographic zones where renewable energy resources are sufficient to develop generation capacity and

where transmission constrains the delivery of electricity from those resources to customers.

Sec. 8. NRS 704.751 is hereby amended to read as follows:

704.751 1. After a utility has filed the plan required pursuant to NRS 704.741, the Commission shall issue an order accepting or modifying the plan or specifying any portions of the plan it deems to be inadequate:

(a) Within 135 days for any portion of the plan relating to the energy supply plan for the utility for the 3 years covered by the plan; and

(b) Within 180 days for all portions of the plan not described in paragraph (a).

➡ If the Commission issues an order modifying the plan, the utility may consent to or reject some or all of the modifications by filing with the Commission a notice to that effect. Any such notice must be filed not later than 30 days after the date of issuance of the order. If such a notice is filed, any petition for reconsideration or rehearing of the order must be filed with the Commission not later than 10 business days after the date the notice is filed.

2. If a utility files an amendment to a plan, the Commission shall issue an order accepting or modifying the amendment or specifying any portions of the amendment it deems to be inadequate:

(a) Within 135 days after the filing of the amendment; or

(b) Within 180 days after the filing of the amendment for all portions of the amendment which contain an element of the emissions reduction and capacity replacement plan.

➡ If the Commission issues an order modifying the amendment, the utility may consent to or reject some or all of the modifications by filing with the Commission a notice to that effect. Any such notice must be filed not later than 30 days after the date of issuance of the order. If such a notice is filed, any petition for reconsideration or rehearing of the order must be filed with the Commission not later than 10 business days after the date the notice is filed.

3. All prudent and reasonable expenditures made to develop the utility's plan, including environmental, engineering and other studies, must be recovered from the rates charged to the utility's customers.

4. *The Commission may accept an energy efficiency plan containing an energy efficiency program submitted pursuant to paragraph (a) of subsection 3 of NRS 704.741 ~~(that consists of)~~ and energy efficiency and conservation programs submitted pursuant to paragraph (b) of subsection 3 of NRS 704.741 that are not cost effective if the energy efficiency plan as a whole is cost effective. Any order issued by the Commission accepting or modifying an energy efficiency plan or an amendment to such a plan must, if the energy efficiency plan remains cost effective, require that not less than 5 percent of the total expenditures of the utility on approved energy efficiency and conservation programs in the energy efficiency plan must be specifically directed to energy efficiency and conservation programs for low-income customers of the utility.*

5. The Commission may accept a transmission plan submitted pursuant to subsection 4 of NRS 704.741 for a renewable energy zone if the Commission determines that the construction or expansion of transmission facilities would facilitate the utility meeting the portfolio standard, as defined in NRS 704.7805.

~~{5.}~~ 6. The Commission shall adopt regulations establishing the criteria for determining the adequacy of a transmission plan submitted pursuant to subsection 4 of NRS 704.741.

~~{6.}~~ 7. Any order issued by the Commission accepting or modifying an element of an emissions reduction and capacity replacement plan must include provisions authorizing the electric utility to construct or acquire and own electric generating plants necessary to meet the capacity amounts approved in, and carry out the provisions of, the plan. As used in this subsection, "capacity" means an amount of firm electric generating capacity used by the electric utility for the purpose of preparing a plan filed with the Commission pursuant to NRS 704.736 to 704.754, inclusive ~~{7.}~~, *and sections 2 to 5, inclusive, of this act.*

Sec. 9. This act becomes effective:

1. Upon passage and approval for the purpose of adopting regulations and performing any other preparatory administrative tasks necessary to carry out the provisions of this act; and

2. On July 1, 2017, for all other purposes.

Senator Atkinson moved the adoption of the amendment.

Remarks by Senator Atkinson.

Amendment No. 696 makes four changes to Assembly Bill No. 223. The amendment adds Assemblywoman Tolles as a co-sponsor of the bill. It also amends section 4 of the bill to change residential customer to retail customer. It amends subsection 3(a) of section 7 to retain the existing energy-efficiency program for residential customers. Finally, it amends section 8 of the bill to update references to the energy-efficiency programs for residential customers as they now appear in subsection 3(a) and subsection 3(b) of section 7 of the bill.

Amendment adopted.

Bill ordered reprinted, re-engrossed and to third reading.

Assembly Bill No. 272.

Bill read second time.

The following amendment was proposed by the Committee on Legislative Operations and Elections:

Amendment No. 773.

SUMMARY—Revises provisions relating to elections. (BDR 24-851)

AN ACT relating to elections; authorizing each county and city clerk to establish polling places where any registered voter of the county or city, respectively, may vote in person on the day of certain elections; requiring, under certain circumstances, county and city clerks to establish polling places within the boundaries of Indian reservations and colonies; ~~requiring the preparation and use of electronic rosters;~~ authorizing voting materials to be

provided in certain languages; authorizing county and city clerks to extend the period for early voting; and providing other matters properly relating thereto. Legislative Counsel's Digest:

Existing law requires a county clerk to establish the boundaries of election precincts and authorizes election precincts to be combined into election districts. (NRS 293.205-293.209) Existing law prohibits a person from applying for or receiving a ballot at any election precinct or district other than the one at which the person is entitled to vote. (NRS 293.730) Section 2 of this bill authorizes a county clerk to establish one or more polling places in the county where any person entitled to vote in the county by personal appearance may do so on the day of a primary or general election. If any such polling place is established: (1) section 3 of this bill requires, with limited exception, the county clerk to publicize the location of such polling places; and (2) section 4 of this bill requires the county clerk to prepare a roster of eligible voters in the county for any such polling place. Section 5 of this bill sets forth the procedure for a person to vote in person at any such polling place. Sections 27-30 of this bill set forth corresponding provisions authorizing city clerks to establish polling places where any person who is entitled to vote in the city by personal appearance may do so on the day of the primary city or general city election. Sections 8, 10-15, 18, 22-25, 33-37 and 40-42 of this bill make conforming changes.

Sections 6 and 31 of this bill require, under certain circumstances, county and city clerks, respectively, to establish at least one polling place for the day of a primary election, general election, primary city election or general city election, as applicable, within the boundaries of an Indian reservation or Indian colony at a location or locations approved by the Indian tribe.

Existing law generally requires a voter to sign his or her name in a roster when the voter applies to vote in person. (NRS 293.277, 293.285, 293C.270, 293C.275) ~~Existing law also provides that a roster may be in printed or electronic form. Section 7 of this bill requires a roster to be in electronic form. Sections 19 and 21 of this bill make conforming changes.~~ Sections 5, 12, 12.5, 13, 17.5, 17.7, 30, 34, 34.5 and 35 of this bill allow a person to sign a signature card rather than the roster.

Existing law requires voting materials to be provided in English and any other languages necessary to be in compliance with federal law. (NRS 293.2699) Section 9 of this bill authorizes a county or city clerk to provide voting materials in additional languages if the clerk determines that there is a significant and substantial need for such.

Existing law authorizes a county or city clerk to establish permanent polling places for early voting by personal appearance and provides that the period for early voting begins the third Saturday preceding an election and extends through the Friday before election day, Sundays and federal holidays excepted. (NRS 293.3564, 293.3568, 293C.3564, 293C.3568) Sections 15 and 37 of this bill require a county or city clerk to establish at least one permanent polling place for early voting. Sections 16 and 38 of this bill authorize a county or city

clerk to extend the period for early voting through the Sunday before election day. Sections 17 and 39 of this bill require, under certain circumstances, a county or city clerk to establish at least one temporary place for early voting within the boundaries of an Indian reservation or Indian colony.

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

Section 1. Chapter 293 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 6, inclusive, of this act.

Sec. 2. 1. *A county clerk may establish one or more polling places in the county where any person entitled to vote in the county by personal appearance may do so on the day of the primary election or general election.*

2. *Any person entitled to vote in the county by personal appearance may do so at any polling place established pursuant to subsection 1.*

Sec. 3. 1. *Except as otherwise provided in subsection 2, if a county clerk establishes one or more polling places pursuant to section 2 of this act, the county clerk must:*

(a) Publish during the week before the election in a newspaper of general circulation a notice of the location of each such polling place.

(b) Post a list of the location of each such polling place on any bulletin board used for posting notice of meetings of the board of county commissioners. The list must be posted continuously for a period beginning not later than the fifth business day before the election and ending at 7 p.m. on the day of the election. The county clerk shall make copies of the list available to the public during the period of posting in reasonable quantities without charge.

2. *The provisions of subsection 1 do not apply if every polling place in the county is a polling place where any person entitled to vote in the county by personal appearance may do so on the day of the primary election or general election.*

3. *No additional polling place may be established pursuant to section 2 of this act after the publication pursuant to this section, except in the case of an emergency and if approved by the Secretary of State.*

Sec. 4. 1. *For each polling place established pursuant to section 2 of this act, if any, the county clerk shall prepare a roster that contains, for every registered voter in the county, the voter's name, the address where he or she is registered to vote, his or her voter identification number, the voter's precinct or district number and the voter's signature.*

2. *The roster must be delivered or caused to be delivered by the county clerk to an election board officer of the proper polling place before the opening of the polls.*

Sec. 5. 1. *Except as otherwise provided in NRS 293.283, upon the appearance of a person to cast a ballot at a polling place established pursuant to section 2 of this act, the election board officer shall:*

(a) Determine that the person is a registered voter in the county and has not already voted in that county in the election;

- (b) *Instruct the voter to sign the roster or a signature card; and*
- (c) *Verify the signature of the voter in the manner set forth in NRS 293.277.*

2. *If the signature of the voter does not match, the voter must be identified by:*

- (a) *Answering questions from the election board officer covering the personal data which is reported on the application to register to vote;*
- (b) *Providing the election board officer, orally or in writing, with other personal data which verifies the identity of the voter; or*
- (c) *Providing the election board officer with proof of identification as described in NRS 293.277 other than the card issued to the voter at the time he or she registered to vote.*

3. *If the signature of the voter has changed in comparison to the signature on the application to register to vote, the voter must update his or her signature on a form prescribed by the Secretary of State.*

4. *The county clerk shall prescribe a procedure, approved by the Secretary of State, to verify that the voter has not already voted in that county in the current election.*

5. *When a voter is entitled to cast a ballot and has identified himself or herself to the satisfaction of the election board officer, the voter is entitled to receive the appropriate ballot or ballots, but only for his or her own use at the polling place where he or she applies to vote.*

6. *If the ballot is voted on a mechanical recording device which directly records the votes electronically, the election board officer shall:*

- (a) *Prepare the mechanical voting device for the voter;*
- (b) *Ensure that the voter's precinct or voting district and the form of the ballot are indicated on the voting receipt, if the county clerk uses voting receipts; and*
- (c) *Allow the voter to cast a vote.*

7. *A voter applying to vote at a polling place established pursuant to section 2 of this act may be challenged pursuant to NRS 293.303.*

Sec. 6. 1. *If an Indian reservation or Indian colony is located in whole or in part within a county, the Indian tribe may submit a request to the county clerk for the establishment of a polling place within the boundaries of the Indian reservation or Indian colony ~~for~~ for the day of a primary election or general election.*

2. *A request for the establishment of a polling place within the boundaries of an Indian reservation or Indian colony ~~for~~ for the day of a primary election or general election:*

- (a) *Must be submitted to the county clerk by the Indian tribe on or before:*
 - (1) *If the request is for a primary election, the first Friday in January of the year in which the primary election is to be held.*
 - (2) *If the request is for a general election, the first Friday in July of the year in which the general election is to be held.*
- (b) *May include one or more proposed locations within the boundaries of the Indian reservation or Indian colony for the polling place. Any proposed*

location must satisfy the criteria the county clerk uses for the establishment of any other polling place.

3. Except as otherwise provided in this subsection, if the county clerk receives a request that satisfies the requirements set forth in subsection 2, the county clerk must establish at least one polling place within the boundaries of the Indian reservation or Indian colony at a location or locations, as applicable, approved by the Indian tribe ~~for the day of a primary election or general election.~~ The county clerk is not required to establish a polling place within the boundaries of an Indian reservation or Indian colony for the day of a primary election or general election if the county clerk established a temporary branch polling place for early voting pursuant to NRS 293.3572 within the boundaries of the Indian reservation or Indian colony for the same election.

Sec. 7. ~~NRS 293.095 is hereby amended to read as follows:
293.095 "Roster" means the record in [printed or] electronic form furnished to election board officers which contains a list of eligible voters and is to be used for obtaining the signature of each person applying for a ballot.]~~
(Deleted by amendment.)

Sec. 8. NRS 293.2546 is hereby amended to read as follows:

293.2546 The Legislature hereby declares that each voter has the right:

1. To receive and cast a ballot that:
 - (a) Is written in a format that allows the clear identification of candidates; and
 - (b) Accurately records the voter's preference in the selection of candidates.
2. To have questions concerning voting procedures answered and to have an explanation of the procedures for voting posted in a conspicuous place at the polling place.
3. To vote without being intimidated, threatened or coerced.
4. To vote on election day if the voter is waiting in line at ~~his or her~~ a polling place *at which he or she is entitled* to vote before 7 p.m. and the voter has not already cast a vote in that election.
5. To return a spoiled ballot and is entitled to receive another ballot in its place.
6. To request assistance in voting, if necessary.
7. To a sample ballot which is accurate, informative and delivered in a timely manner.
8. To receive instruction in the use of the equipment for voting during early voting or on election day.
9. To have nondiscriminatory equal access to the elections system, including, without limitation, a voter who is elderly, disabled, a member of a minority group, employed by the military or a citizen who is overseas.
10. To have a uniform, statewide standard for counting and recounting all votes accurately.
11. To have complaints about elections and election contests resolved fairly, accurately and efficiently.

Sec. 9. NRS 293.2699 is hereby amended to read as follows:

293.2699 1. Each voting system used by a county or city shall provide voting materials in :

(a) English ~~[and other languages]~~ ; and

(b) Every language in which voting materials are required to be prepared in ~~[compliance with the provisions of 42 U.S.C. § 1973aa-1a.]~~ the county or city pursuant to 52 U.S.C. § 10503.

2. In addition to the requirements set forth in subsection 1, if a county clerk or city clerk determines that there is a significant and substantial need for voting materials of the county or city, as applicable, to be provided in the language or languages of a minority group, the county clerk or city clerk may prepare voting materials in such language or languages. For the purposes of this subsection, there is a significant and substantial need for voting materials to be provided in the language or languages of a minority group if, without limitation, the minority group has been subject to historical discrimination and unequal educational opportunities, and, as a result, members of the minority group are of limited-English proficiency.

3. As used in this section ~~[, the term "voting"]~~ :

(a) "Limited-English proficiency" means being unable to speak or understand English adequately to participate in the electoral process.

(b) "Minority group" includes, without limitation, United States citizens of Chinese heritage.

(c) "Voting materials" has the meaning ascribed to it in ~~[42]~~ 52 U.S.C. § ~~[1973aa-1a.]~~ 10503.

Sec. 10. NRS 293.273 is hereby amended to read as follows:

293.273 1. Except as otherwise provided in subsection 2 and NRS 293.305, at all elections held under the provisions of this title, the polls must open at 7 a.m. and close at 7 p.m.

2. ~~[Whenever]~~ Except as otherwise provided in this subsection, whenever at any election all the votes of the polling place, as shown on the roster, have been cast, the election board officers shall close the polls, and the counting of votes must begin and continue without unnecessary delay until the count is completed. *This subsection does not apply to a polling place established pursuant to section 2 of this act.*

3. Upon opening the polls, one of the election board officers shall cause a proclamation to be made that all present may be aware of the fact that applications of registered voters to vote will be received.

4. No person other than election board officers engaged in receiving, preparing or depositing ballots may be permitted inside the guardrail during the time the polls are open, except by authority of the election board as necessary to keep order and carry out the provisions of this title.

Sec. 11. NRS 293.275 is hereby amended to read as follows:

293.275 ~~[No]~~

1. Except as otherwise provided in subsection 2, an election board may not perform its duty in serving registered voters at any polling place in any

election provided for in this title, unless it has before it the roster for the polling place.

2. *For a polling place established pursuant to section 2 or 27 of this act, an election board may perform its duty in serving registered voters at the polling place in an election if the election board has before it the roster for the county or city, as applicable.*

Sec. 12. NRS 293.277 is hereby amended to read as follows:

293.277 1. Except as otherwise provided in NRS 293.283 and 293.541, if a person's name appears in the roster or if the person provides an affirmation pursuant to NRS 293.525, the person is entitled to vote and must sign his or her name in the roster *or on a signature card* when he or she applies to vote. The signature must be compared by an election board officer with the signature or a facsimile thereof on the person's application to register to vote or one of the forms of identification listed in subsection 2.

2. Except as otherwise provided in NRS 293.2725, the forms of identification which may be used individually to identify a voter at the polling place are:

- (a) The card issued to the voter at the time he or she registered to vote;
- (b) A driver's license;
- (c) An identification card issued by the Department of Motor Vehicles;
- (d) A military identification card; or
- (e) Any other form of identification issued by a governmental agency which contains the voter's signature and physical description or picture.

3. *The county clerk shall prescribe a procedure, approved by the Secretary of State, to determine that the voter has not already voted in that county in the election.*

Sec. 12.5. NRS 293.283 is hereby amended to read as follows:

293.283 1. If, because of physical limitations, a registered voter is unable to sign his or her name in the roster *or on a signature card* as required by NRS 293.277, the voter must be identified by:

- (a) Answering questions from the election board officer covering the personal data which is reported on the application to register to vote;
- (b) Providing the election board officer, orally or in writing, with other personal data which verifies the identity of the voter; or
- (c) Providing the election board officer with proof of identification as described in NRS 293.277 other than the card issued to the voter at the time he or she registered to vote.

2. If the identity of the voter is verified, the election board officer shall indicate in the roster "Identified" by the voter's name.

Sec. 13. NRS 293.285 is hereby amended to read as follows:

293.285 1. Except as otherwise provided in NRS 293.283, a registered voter applying to vote shall state his or her name to the election board officer in charge of the roster, and the officer shall immediately announce the name, instruct the voter to sign the roster ~~and~~ *or signature card*, verify the signature

of the voter in the manner set forth in NRS 293.277 ~~[-] and verify that the registered voter has not already voted in that county in the current election.~~

2. If the signature does not match, the voter must be identified by:

(a) Answering questions from the election board officer covering the personal data which is reported on the application to register to vote;

(b) Providing the election board officer, orally or in writing, with other personal data which verifies the identity of the voter; or

(c) Providing the election board officer with proof of identification as described in NRS 293.277 other than the card issued to the voter at the time he or she registered to vote.

3. If the signature of the voter has changed in comparison to the signature on the application to register to vote, the voter must update his or her signature on a form prescribed by the Secretary of State.

Sec. 14. NRS 293.296 is hereby amended to read as follows:

293.296 1. Any registered voter who by reason of a physical disability or an inability to read or write English is unable to mark a ballot or use any voting device without assistance is entitled to assistance from a consenting person of his or her own choice, except:

(a) The voter's employer or an agent of the voter's employer; or

(b) An officer or agent of the voter's labor organization.

2. A person providing assistance pursuant to this section to a voter in casting a vote shall not disclose any information with respect to the casting of that ballot.

3. The right to assistance in casting a ballot may not be denied or impaired when the need for assistance is apparent or is known to the election board or any member thereof or when the registered voter requests such assistance in any manner.

4. In addition to complying with the requirements of this section, the county clerk and election board officer shall, upon the request of a registered voter with a physical disability, make reasonable accommodations to allow the voter to vote at ~~his or her~~ a polling place ~~[-] at which he or she is entitled to vote.~~

Sec. 15. NRS 293.3564 is hereby amended to read as follows:

293.3564 1. ~~{The}~~ Each county clerk ~~{may}~~ shall establish at least one permanent polling ~~{places}~~ place for early voting by personal appearance in the county. ~~{at the locations selected pursuant to NRS 293.3561.~~

~~— 2. Except as otherwise provided in subsection 3, any~~

2. Any person entitled to vote early by personal appearance may do so at any polling place for early voting.

~~{3. If it is impractical for the county clerk to provide at each polling place for early voting a ballot in every form required in the county, the county clerk may:~~

~~— (a) Provide appropriate forms of ballots for all offices within a township, city, town or county commissioner election district, as determined by the county clerk; and~~

~~—(b) Limit voting at that polling place to registered voters in that township, city, town or county commissioner election district.]~~

Sec. 16. NRS 293.3568 is hereby amended to read as follows:

293.3568 1. The period for early voting by personal appearance begins the third Saturday preceding a primary or general election and , *except as otherwise provided in this subsection*, extends through the Friday before election day, Sundays and federal holidays excepted. *A county clerk may extend the period for early voting by personal appearance through the Sunday before election day.*

2. The county clerk may:

(a) ~~[Include]~~ *Except as otherwise provided in subsection 3, include* any Sunday or federal holiday that falls within the period for early voting by personal appearance.

(b) Require a permanent polling place for early voting to remain open until 8 p.m. on any Saturday that falls within the period for early voting.

3. A permanent polling place for early voting must remain open:

(a) On Monday through Friday:

(1) During the first week of early voting, from 8 a.m. until 6 p.m.

(2) During the second week of early voting, from 8 a.m. until 6 p.m., or until 8 p.m. if the county clerk so requires.

(b) On any Saturday that falls within the period for early voting, for at least 4 hours between 10 a.m. and 6 p.m.

(c) *If a county clerk extends the period for early voting by personal appearance through the Sunday before election day pursuant to subsection 1, on the Sunday before election day during such hours as the clerk may establish.*

(d) If the county clerk includes a Sunday that falls within the period for early voting pursuant to subsection 2, during such hours as the county clerk may establish.

Sec. 17. NRS 293.3572 is hereby amended to read as follows:

293.3572 1. In addition to permanent polling places for early voting, *except as otherwise provided in subsection 3*, the county clerk may establish temporary branch polling places for early voting which may include, without limitation, the clerk's office pursuant to NRS 293.3561.

2. *If an Indian reservation or Indian colony is located in whole or in part within a county, the Indian tribe may submit a request to the county clerk for the establishment of a temporary branch polling place for early voting within the boundaries of the Indian reservation or Indian colony.*

3. *A request for the establishment of a temporary branch polling place for early voting within the boundaries of an Indian reservation or Indian colony:*

(a) *Must be submitted to the county clerk by the Indian tribe on or before:*

(1) *If the request is for a primary election, the first Friday in January of the year in which the primary election is to be held.*

(2) *If the request is for a general election, the first Friday in July of the year in which the general election is to be held.*

(b) May include one or more proposed locations within the boundaries of the Indian reservation or Indian colony for the temporary branch polling place and proposed hours of operation thereof. Any proposed location must satisfy the criteria established by the county clerk for the selection of temporary branch polling places pursuant to NRS 293.3561.

4. Except as otherwise provided in this subsection, if the county clerk receives a request that satisfies the requirements set forth in subsection 3, the county clerk must establish at least one temporary branch polling place for early voting within the boundaries of the Indian reservation or Indian colony. The location and hours of operation of such a temporary branch polling place for early voting must be approved by the Indian tribe. The county clerk is not required to establish a temporary branch polling place within the boundaries of the Indian reservation or Indian colony if the county clerk determines that it is not logistically feasible to establish a temporary branch polling place within the boundaries of the Indian Reservation or colony.

5. The provisions of subsection 3 of NRS 293.3568 do not apply to a temporary branch polling place. Voting at a temporary branch polling place may be conducted on any one or more days and during any hours within the period for early voting by personal appearance, as determined by the county clerk.

~~{3-}~~ 6. The schedules for conducting voting are not required to be uniform among the temporary branch polling places.

~~{4-}~~ 7. The legal rights and remedies which inure to the owner or lessor of private property are not impaired or otherwise affected by the leasing of the property for use as a temporary branch polling place for early voting, except to the extent necessary to conduct early voting at that location.

Sec. 17.5. NRS 293.3585 is hereby amended to read as follows:

293.3585 1. Except as otherwise provided in NRS 293.283, upon the appearance of a person to cast a ballot for early voting, an election board officer shall:

- (a) Determine that the person is a registered voter in the county.
- (b) Instruct the voter to sign the roster for early voting ~~{-}~~ or a signature card.
- (c) Verify the signature of the voter in the manner set forth in NRS 293.277.
- (d) Verify that the voter has not already voted *in that county* in the current election pursuant to this section.

2. If the signature of the voter does not match, the voter must be identified by:

- (a) Answering questions from the election board officer covering the personal data which is reported on the application to register to vote;

- (b) Providing the election board officer, orally or in writing, with other personal data which verifies the identity of the voter; or

- (c) Providing the election board officer with proof of identification as described in NRS 293.277 other than the card issued to the voter at the time he or she registered to vote.

3. If the signature of the voter has changed in comparison to the signature on the application to register to vote, the voter must update his or her signature on a form prescribed by the Secretary of State.

4. The county clerk shall prescribe a procedure, approved by the Secretary of State, to verify that the voter has not already voted *in that county* in the current election pursuant to this section.

5. The roster for early voting *or signature card, as applicable*, must contain:

(a) The voter's name, the address where he or she is registered to vote, his or her voter identification number and a place for the voter's signature;

(b) The voter's precinct or voting district number, if that information is available; and

(c) The date of voting early in person.

6. When a voter is entitled to cast a ballot and has identified himself or herself to the satisfaction of the election board officer, the voter is entitled to receive the appropriate ballot or ballots, but only for his or her own use at the polling place for early voting.

7. If the ballot is voted on a mechanical recording device which directly records the votes electronically, the election board officer shall:

(a) Prepare the mechanical recording device for the voter;

(b) Ensure that the voter's precinct or voting district, if that information is available, and the form of ballot are indicated on the voting receipt, if the county clerk uses voting receipts; and

(c) Allow the voter to cast a vote.

8. A voter applying to vote early by personal appearance may be challenged pursuant to NRS 293.303.

Sec. 17.7. NRS 293.3604 is hereby amended to read as follows:

293.3604 If ballots which are voted on a mechanical recording device which directly records the votes electronically are used during the period for early voting by personal appearance in an election other than a presidential preference primary election:

1. At the close of each voting day, the election board shall:

(a) Prepare and sign a statement for the polling place. The statement must include:

(1) The title of the election;

(2) The number which identifies the mechanical recording device and the storage device required pursuant to NRS 293B.084;

(3) The number of ballots voted on the mechanical recording device for that day; ~~and~~

(4) The number of signatures in the roster for early voting for that day ~~[-]~~ ; and

(5) *The number of signatures on signature cards for that day.*

(b) Secure:

(1) The ballots pursuant to the plan for security required by NRS 293.3594; and

(2) Each mechanical voting device in the manner prescribed by the Secretary of State pursuant to NRS 293.3594.

2. At the close of the last voting day, the county clerk shall deliver to the ballot board for early voting:

- (a) The statements for all polling places for early voting;
- (b) The voting rosters used for early voting;
- (c) *The signature cards used for early voting;*
- (d) The storage device required pursuant to NRS 293B.084 from each mechanical recording device used during the period for early voting; and
- ~~{{(d)}} (e)~~ Any other items as determined by the county clerk.

3. Upon receipt of the items set forth in subsection 2 at the close of the last voting day, the ballot board for early voting shall:

- (a) Indicate the number of ballots on an official statement of ballots; and
- (b) Place the storage devices in the container provided to transport those items to the central counting place and seal the container with a numbered seal. The official statement of ballots must accompany the storage devices to the central counting place.

Sec. 18. NRS 293.4689 is hereby amended to read as follows:

293.4689 1. If a county clerk maintains a website on the Internet for information related to elections, the website must contain public information maintained, collected or compiled by the county clerk that relates to elections, which must include, without limitation:

- (a) The locations of polling places for casting a ballot on election day in such a format that a registered voter may search the list to determine the location of the polling place *or places* at which the registered voter is ~~[required]~~ *entitled* to cast a ballot; and

- (b) The abstract of votes required pursuant to the provisions of NRS 293.388.

2. The abstract of votes required to be maintained on the website pursuant to paragraph (b) of subsection 1 must be maintained in such a format as to permit the searching of the abstract of votes for specific information.

3. If the information required to be maintained by a county clerk pursuant to subsection 1 may be obtained by the public from a website on the Internet maintained by the Secretary of State, another county clerk or a city clerk, the county clerk may provide a hyperlink to that website to comply with the provisions of subsection 1 with regard to that information.

Sec. 19. ~~[NRS 293.511 is hereby amended to read as follows:~~

~~293.511 [If a] The registrar of voters' register or [roster is kept by computer, the register or] roster, as applicable, must include the name, address, precinct, political affiliation and signature or facsimile thereof of each voter and any additional information required by the county clerk.] (Deleted by amendment.)~~

Sec. 20. ~~[NRS 293.541 is hereby amended to read as follows:~~

~~293.541 1. The county clerk shall cancel the registration of a voter if:~~

~~—(a) After consultation with the district attorney, the district attorney determines that there is probable cause to believe that information in the registration concerning the identity or residence of the voter is fraudulent;~~

~~—(b) The county clerk provides a notice as required pursuant to subsection 2 or executes an affidavit of cancellation pursuant to subsection 3; and~~

~~—(c) The voter fails to present satisfactory proof of identity and residence pursuant to subsection 2, 4 or 5.~~

~~—2. Except as otherwise provided in subsection 3, the county clerk shall notify the voter by registered or certified mail, return receipt requested, of a determination made pursuant to subsection 1. The notice must set forth the grounds for cancellation. Unless the voter, within 15 days after the return receipt has been filed in the office of the county clerk, presents satisfactory proof of identity and residence to the county clerk, the county clerk shall cancel the voter's registration.~~

~~—3. If insufficient time exists before a pending election to provide the notice required by subsection 2, the county clerk shall execute an affidavit of cancellation and file the affidavit of cancellation with the registrar of voters' register and [:~~

~~—(a) In counties where records of registration are not kept by computer, the county clerk shall attach a copy of the affidavit of cancellation in the roster.~~

~~—(b) In counties where records of registration are kept by computer, the county clerk shall have the affidavit of cancellation printed on the computer entry for the registration and] add a copy of [it] the affidavit to the roster.~~

~~—4. If a voter appears to vote at the election next following the date that an affidavit of cancellation was executed for the voter pursuant to this section, the voter must be allowed to vote only if the voter furnishes:~~

~~—(a) Official identification which contains a photograph of the voter, including, without limitation, a driver's license or other official document; and~~

~~—(b) Satisfactory identification that contains proof of the address at which the voter actually resides and that address is consistent with the address listed on the roster.~~

~~—5. If a determination is made pursuant to subsection 1 concerning information in the registration to vote of a voter and an absent ballot or a ballot voted by a voter who resides in a mailing precinct is received from the voter, the ballot must be kept separate from other ballots and must not be counted unless the voter presents satisfactory proof to the county clerk of identity and residence before such ballots are counted on election day.~~

~~—6. For the purposes of this section, a voter registration card issued pursuant to NRS 293.517 does not provide proof of the:~~

~~—(a) Address at which a person actually resides; or~~

~~—(b) Residence or identity of a person.] (Deleted by amendment.)~~

Sec. 21. ~~[NRS 293.547 is hereby amended to read as follows:~~

~~293.547 1. After the 30th day but not later than the 25th day before any election, a written challenge may be filed with the county clerk.~~

~~—2. A registered voter may file a written challenge if:~~

~~—(a) He or she is registered to vote in the same precinct as the person whose right to vote is challenged; and~~

~~—(b) The challenge is based on the personal knowledge of the registered voter.~~

~~—3. The challenge must be signed and verified by the registered voter and name the person whose right to vote is challenged and the ground of the challenge.~~

~~—4. A challenge filed pursuant to this section must not contain the name of more than one person whose right to vote is challenged. The county clerk shall not accept for filing any challenge which contains more than one such name.~~

~~—5. The county clerk shall:~~

~~—(a) File the challenge in the registrar of voters' register and [:~~

~~—(1) In counties where records of registration are not kept by computer, he or she shall attach a copy of the challenge to the challenged registration in the roster;~~

~~—(2) In counties where records of registration are kept by computer, he or she shall have the challenge printed on the computer entry for the challenged registration and] add a copy of [it] the challenge to the roster.~~

~~—(b) Within 5 days after a challenge is filed, mail a notice in the manner set forth in NRS 293.530 to the person whose right to vote has been challenged pursuant to this section informing the person of the challenge. If the person fails to respond or appear to vote within the required time, the county clerk shall cancel the person's registration. A copy of the challenge and information describing how to reregister properly must accompany the notice.~~

~~—(c) Immediately notify the district attorney. A copy of the challenge must accompany the notice.~~

~~—6. Upon receipt of a notice pursuant to this section, the district attorney shall investigate the challenge within 14 days and, if appropriate, cause proceedings to be instituted and prosecuted in a court of competent jurisdiction without delay. The court shall give such proceedings priority over other civil matters that are not expressly given priority by law. Upon court order, the county clerk shall cancel the registration of the person whose right to vote has been challenged pursuant to this section.] (Deleted by amendment.)~~

Sec. 22. NRS 293.563 is hereby amended to read as follows:

293.563 1. During the interval between the closing of registration and the election, the county clerk shall prepare for ~~each~~ :

(a) Each polling place a roster containing the registered voters eligible to vote at the polling place.

(b) Each polling place established pursuant to section 2 or 27 of this act, if any, a roster containing the registered voters eligible to vote in the county or city, respectively.

2. The ~~roster~~ rosters must be delivered or caused to be delivered by the county or city clerk to an election board officer of the proper polling place before the opening of the polls.

Sec. 23. NRS 293.565 is hereby amended to read as follows:

293.565 1. Except as otherwise provided in subsection 3, sample ballots must include:

- (a) If applicable, the statement required by NRS 293.267;
- (b) The fiscal note or description of anticipated financial effect, as provided pursuant to NRS 218D.810, 293.250, 293.481, 295.015, 295.095 or 295.230 for each proposed constitutional amendment, statewide measure, measure to be voted upon only by a special district or political subdivision and advisory question;
- (c) An explanation, as provided pursuant to NRS 218D.810, 293.250, 293.481, 295.121 or 295.230, of each proposed constitutional amendment, statewide measure, measure to be voted upon only by a special district or political subdivision and advisory question;
- (d) Arguments for and against each proposed constitutional amendment, statewide measure, measure to be voted upon only by a special district or political subdivision and advisory question, and rebuttals to each argument, as provided pursuant to NRS 218D.810, 293.250, 293.252 or 295.121; and
- (e) The full text of each proposed constitutional amendment.

2. If, pursuant to the provisions of NRS 293.2565, the word "Incumbent" must appear on the ballot next to the name of the candidate who is the incumbent, the word "Incumbent" must appear on the sample ballot next to the name of the candidate who is the incumbent.

3. Sample ballots that are mailed to registered voters may be printed without the full text of each proposed constitutional amendment if:

- (a) The cost of printing the sample ballots would be significantly reduced if the full text of each proposed constitutional amendment were not included;
- (b) The county clerk ensures that a sample ballot that includes the full text of each proposed constitutional amendment is provided at no charge to each registered voter who requests such a sample ballot; and
- (c) The sample ballots provided to each polling place include the full text of each proposed constitutional amendment.

4. A county clerk may establish a system for distributing sample ballots by electronic means to each registered voter who elects to receive a sample ballot by electronic means. Such a system may include, without limitation, electronic mail or electronic access through an Internet website. If a county clerk establishes such a system and a registered voter elects to receive a sample ballot by electronic means, the county clerk shall distribute the sample ballot to the registered voter by electronic means pursuant to the procedures and requirements set forth by regulations adopted by the Secretary of State.

5. If a registered voter does not elect to receive a sample ballot by electronic means pursuant to subsection 4, the county clerk shall distribute the sample ballot to the registered voter by mail.

6. Before the period for early voting for any election begins, the county clerk shall distribute to each registered voter in the county by mail or electronic means, as applicable, the sample ballot for his or her precinct, with a notice

informing the voter of the location of his or her polling place ~~[-]~~ *or places*. If the location of the polling place *or places* has changed since the last election:

(a) The county clerk shall mail a notice of the change to each registered voter in the county not sooner than 10 days before distributing the sample ballots; or

(b) The sample ballot must also include a notice in bold type immediately above the location which states:

NOTICE: THE LOCATION OF YOUR POLLING PLACE *OR*
PLACES HAS CHANGED SINCE THE LAST ELECTION

7. Except as otherwise provided in subsection 8, a sample ballot required to be distributed pursuant to this section must:

(a) Be prepared in at least 12-point type; and

(b) Include on the front page, in a separate box created by bold lines, a notice prepared in at least 20-point bold type that states:

NOTICE: TO RECEIVE A SAMPLE BALLOT IN
LARGE TYPE, CALL (Insert appropriate telephone number)

8. A portion of a sample ballot that contains a facsimile of the display area of a voting device may include material in less than 12-point type to the extent necessary to make the facsimile fit on the pages of the sample ballot.

9. The sample ballot distributed to a person who requests a sample ballot in large type by exercising the option provided pursuant to NRS 293.508, or in any other manner, must be prepared in at least 14-point type, or larger when practicable.

10. If a person requests a sample ballot in large type, the county clerk shall ensure that all future sample ballots distributed to that person from the county are in large type.

11. The county clerk shall include in each sample ballot a statement indicating that the county clerk will, upon request of a voter who is elderly or disabled, make reasonable accommodations to allow the voter to vote at his or her polling place *or places* and provide reasonable assistance to the voter in casting his or her vote, including, without limitation, providing appropriate materials to assist the voter. In addition, if the county clerk has provided pursuant to subsection 4 of NRS 293.2955 for the placement at centralized voting locations of specially equipped voting devices for use by voters who are elderly or disabled, the county clerk shall include in the sample ballot a statement indicating:

(a) The addresses of such centralized voting locations;

(b) The types of specially equipped voting devices available at such centralized voting locations; and

(c) That a voter who is elderly or disabled may cast his or her ballot at such a centralized voting location rather than at his or her regularly designated polling place ~~[-]~~ *or places*.

12. The cost of distributing sample ballots for any election other than a primary or general election must be borne by the political subdivision holding the election.

Sec. 24. NRS 293.730 is hereby amended to read as follows:

293.730 1. A person shall not:

(a) Remain in or outside of any polling place so as to interfere with the conduct of the election.

(b) Except an election board officer, receive from any voter a ballot prepared by the voter.

(c) Remove a ballot from any polling place before the closing of the polls.

(d) Apply for or receive a ballot at any election precinct or district other than ~~the~~ one at which the person is entitled to vote.

(e) Show his or her ballot to any person, after voting, so as to reveal any of the names voted for.

(f) Inside a polling place, ask another person for whom he or she intends to vote.

(g) Except an election board officer, deliver a ballot to a voter.

(h) Except an election board officer in the course of the election board officer's official duties, inside a polling place, ask another person his or her name, address or political affiliation.

2. A voter shall not:

(a) Receive a ballot from any person other than an election board officer.

(b) Deliver to an election board or to any member thereof any ballot other than the one received.

(c) Place any mark upon his or her ballot by which it may afterward be identified as the one voted by the person.

3. Any person who violates any provision of this section is guilty of a category E felony and shall be punished as provided in NRS 193.130.

Sec. 25. NRS 293.790 is hereby amended to read as follows:

293.790 If any person whose vote has been rejected offers to vote at the same election, at any polling place other than ~~the~~ one in which the person is ~~registered~~ entitled to vote, such person is guilty of a gross misdemeanor.

Sec. 26. Chapter 293C of NRS is hereby amended by adding thereto the provisions set forth as sections 27 to 31, inclusive, of this act.

Sec. 27. 1. *A city clerk may establish one or more polling places in the city where any person entitled to vote in the city by personal appearance may do so on the day of the primary city election or general city election.*

2. *Any person entitled to vote in the city by personal appearance may do so at any polling place established pursuant to subsection 1.*

Sec. 28. 1. *Except as otherwise provided in subsection 2, if a city clerk establishes one or more polling places pursuant to section 27 of this act, the city clerk must:*

(a) Publish during the week before the election in a newspaper of general circulation a notice of the location of each such polling place.

(b) Post a list of the location of each such polling place on any bulletin board used for posting notice of meetings of the governing body of the city. The list must be posted continuously for a period beginning not later than the fifth business day before the election and ending at 7 p.m. on the day of the

election. The city clerk shall make copies of the list available to the public during the period of posting in reasonable quantities without charge.

2. The provisions of subsection 1 do not apply if every polling place in the city is designated as a polling place where any person entitled to vote in the city by personal appearance may do so on the day of the primary city election or general city election.

3. No additional polling place may be established pursuant to section 27 of this act after the publication pursuant to this section, except in the case of an emergency and if approved by the Secretary of State.

Sec. 29. 1. For each polling place established pursuant to section 27 of this act, if any, the city clerk shall prepare a roster that contains, for every registered voter in the city, the voter's name, the address where he or she is registered to vote, his or her voter identification number, the voter's precinct or district number and the voter's signature.

2. The roster must be delivered or caused to be delivered by the city clerk to an election board officer of the proper polling place before the opening of the polls.

Sec. 30. 1. Except as otherwise provided in NRS 293C.272, upon the appearance of a person to cast a ballot at a polling place established pursuant to section 27 of this act, if any, the election board officer shall:

(a) Determine that the person is a registered voter in the city and has not already voted in that city in the election;

(b) Instruct the voter to sign the roster or a signature card; and

(c) Verify the signature of the voter in the manner set forth in NRS 293C.270.

2. If the signature of the voter does not match, the voter must be identified by:

(a) Answering questions from the election board officer covering the personal data which is reported on the application to register to vote;

(b) Providing the election board officer, orally or in writing, with other personal data which verifies the identity of the voter; or

(c) Providing the election board officer with proof of identification as described in NRS 293C.270 other than the card issued to the voter at the time he or she registered to vote.

3. If the signature of the voter has changed in comparison to the signature on the application to register to vote, the voter must update his or her signature on a form prescribed by the Secretary of State.

4. The city clerk shall prescribe a procedure, approved by the Secretary of State, to verify that the voter has not already voted in that city in the current election.

5. When a voter is entitled to cast a ballot and has identified himself or herself to the satisfaction of the election board officer, the voter is entitled to receive the appropriate ballot or ballots, but only for his or her own use at the polling place where he or she applies to vote.

6. *If the ballot is voted on a mechanical recording device which directly records the votes electronically, the election board officer shall:*

- (a) Prepare the mechanical voting device for the voter;*
- (b) Ensure that the voter's precinct or voting district and the form of the ballot are indicated on the voting receipt, if the city clerk uses voting receipts; and*
- (c) Allow the voter to cast a vote.*

7. *A voter applying to vote at a polling place established pursuant to section 27 of this act, if any, may be challenged pursuant to NRS 293C.292.*

Sec. 31. 1. *If an Indian reservation or Indian colony is located in whole or in part within a city, the Indian tribe may request to the city clerk for the establishment of a polling place within the boundaries of the Indian reservation or Indian colony ~~for~~ for the day of a primary city election or general city election.*

2. *A request for the establishment of a polling place within the boundaries of an Indian reservation or Indian colony ~~for~~ for the day of a primary city election or general city election:*

- (a) Must be submitted to the city clerk by the Indian tribe on or before:*
 - (1) If the request is for a primary city election that is held:*
 - (I) On the dates set forth for primary elections pursuant to the provisions of chapter 293 of NRS, the first Friday in January of the year in which the primary city election is to be held.*
 - (II) On the dates set forth for primary city elections pursuant to the provisions of this chapter, the first Friday in December of the year immediately preceding the year in which the primary city election is to be held.*
 - (2) If the request is for a general city election that is held:*
 - (I) On the dates set forth for general elections pursuant to the provisions of chapter 293 of NRS, the first Friday in July of the year in which the general city election is to be held.*
 - (II) On the dates set forth for general city elections pursuant to the provisions of this chapter, the first Friday in January of the year in which the general city election is to be held.*

(b) May include one or more proposed locations within the boundaries of the Indian reservation or Indian colony for the polling place. Any proposed location for a polling place must satisfy the criteria the city clerk uses for the establishment of any other polling place.

3. *Except as otherwise provided in this subsection, if the city clerk receives a request that satisfies the requirements set forth in subsection 2, the city clerk must establish at least one polling place within the boundaries of the Indian reservation or Indian colony at a location or locations, as applicable, approved by the Indian tribe ~~for~~ for the day of a primary city election or general city election. The city clerk is not required to establish a polling place within the boundaries of the Indian reservation or Indian colony for the day of a primary city election or general city election if the city clerk established a temporary branch polling place for early voting pursuant to NRS 293C.3572*

within the boundaries of the Indian reservation or Indian colony for the same election.

Sec. 32. NRS 293C.112 is hereby amended to read as follows:

293C.112 1. The governing body of a city may conduct a city election in which all ballots must be cast by mail if:

- (a) The election is a special election; or
- (b) The election is a primary city election or general city election in which the ballot includes only:

(1) Offices and ballot questions that may be voted on by the registered voters of only one ward; or

(2) One office or ballot question.

2. The provisions of NRS 293C.265 to 293C.302, inclusive, *and section 31 of this act*, 293C.305 to 293C.340, inclusive, and 293C.355 to 293C.361, inclusive, do not apply to an election conducted pursuant to this section.

3. For the purposes of an election conducted pursuant to this section, each precinct in the city shall be deemed to have been designated a mailing precinct pursuant to NRS 293C.342.

Sec. 33. NRS 293C.267 is hereby amended to read as follows:

293C.267 1. Except as otherwise provided in subsection 2 and NRS 293C.297, at all elections held pursuant to the provisions of this chapter, the polls must open at 7 a.m. and close at 7 p.m.

2. Whenever at any election all the votes of the polling place, as shown on the roster, have been cast, the election board officers shall close the polls and the counting of votes must begin and continue without unnecessary delay until the count is completed. *The provisions of this subsection do not apply to any polling place established pursuant to section 27 of this act where any person entitled to vote in the city by personal appearance on the day of the election may do so.*

3. Upon opening the polls, one of the election board officers shall cause a proclamation to be made so that all present may be aware of the fact that applications of registered voters to vote will be received.

4. No person other than election board officers engaged in receiving, preparing or depositing ballots may be permitted inside the guardrail during the time the polls are open, except by authority of the election board as necessary to keep order and carry out the provisions of this chapter.

Sec. 34. NRS 293C.270 is hereby amended to read as follows:

293C.270 1. Except as otherwise provided in NRS 293C.272, if a person's name appears in the roster or if the person provides an affirmation pursuant to NRS 293C.525, the person is entitled to vote and must sign his or her name in the roster *or on a signature card* when he or she applies to vote. The signature must be compared by an election board officer with the signature or a facsimile thereof on the person's application to register to vote or one of the forms of identification listed in subsection 2.

2. The forms of identification that may be used to identify a voter at the polling place are:

- (a) The card issued to the voter at the time he or she registered to vote;
- (b) A driver's license;
- (c) An identification card issued by the Department of Motor Vehicles;
- (d) A military identification card; or
- (e) Any other form of identification issued by a governmental agency that contains the voter's signature and physical description or picture.

3. *The city clerk shall prescribe a procedure, approved by the Secretary of State, to determine that the voter has not already voted in that city in the current election.*

Sec. 34.5. NRS 293C.272 is hereby amended to read as follows:

293C.272 1. If, because of physical limitations, a registered voter is unable to sign his or her name in the roster *or on a signature card* as required by NRS 293C.270, the voter must be identified by:

- (a) Answering questions from the election board officer covering the personal data which is reported on the application to register to vote;
- (b) Providing the election board officer, orally or in writing, with other personal data which verifies the identity of the voter; or
- (c) Providing the election board officer with proof of identification as described in NRS 293C.270 other than the card issued to the voter at the time he or she registered to vote.

2. If the identity of the voter is verified, the election board officer shall indicate in the roster "Identified" by the voter's name.

Sec. 35. NRS 293C.275 is hereby amended to read as follows:

293C.275 1. Except as otherwise provided in NRS 293C.272, a registered voter who applies to vote must state his or her name to the election board officer in charge of the roster, and the officer shall immediately announce the name, instruct the voter to sign the roster ~~and~~ *or signature card*, verify the signature of the voter in the manner set forth in NRS 293C.270 ~~and~~ *and verify that the registered voter has not already voted in that city in the current election.*

2. If the signature does not match, the voter must be identified by:

- (a) Answering questions from the election board officer covering the personal data which is reported on the application to register to vote;
- (b) Providing the election board officer, orally or in writing, with other personal data which verifies the identity of the voter; or
- (c) Providing the election board officer with proof of identification as described in NRS 293C.270 other than the card issued to the voter at the time he or she registered to vote.

3. If the signature of the voter has changed in comparison to the signature on the application to register to vote, the voter must update his or her signature on a form prescribed by the Secretary of State.

Sec. 36. NRS 293C.282 is hereby amended to read as follows:

293C.282 1. Any registered voter who, because of a physical disability

or an inability to read or write English, is unable to mark a ballot or use any voting device without assistance is entitled to assistance from a consenting person of his or her own choice, except:

- (a) The voter's employer or an agent of the voter's employer; or
- (b) An officer or agent of the voter's labor organization.

2. A person providing assistance pursuant to this section to a voter in casting a vote shall not disclose any information with respect to the casting of that ballot.

3. The right to assistance in casting a ballot may not be denied or impaired when the need for assistance is apparent or is known to the election board or any member thereof or when the registered voter requests such assistance in any manner.

4. In addition to complying with the requirements of this section, the city clerk and election board officer shall, upon the request of a registered voter with a physical disability, make reasonable accommodations to allow the voter to vote at ~~his or her~~ a polling place ~~at which he or she is entitled to vote~~.

Sec. 37. NRS 293C.3564 is hereby amended to read as follows:

293C.3564 1. The city clerk ~~may~~ *in a city providing for early voting pursuant to subparagraph (1) of paragraph (b) of subsection 2 of NRS 293C.110 shall establish at least one permanent polling ~~places~~ place for early voting by personal appearance in the city at the locations selected pursuant to NRS 293C.3561.*

2. Any person entitled to vote early by personal appearance may do so at any polling place for early voting.

Sec. 38. NRS 293C.3568 is hereby amended to read as follows:

293C.3568 1. The period for early voting by personal appearance begins the third Saturday preceding a primary city election or general city election, and , *except as otherwise provided in this subsection, extends through the Friday before election day, ~~Sundays and~~ federal holidays excepted. A city clerk may extend the period for early voting by personal appearance through the Sunday before election day.*

2. The city clerk may:

(a) ~~Include~~ *Except as otherwise provided in subsection 3, include any Sunday or federal holiday that falls within the period for early voting by personal appearance.*

(b) Require a permanent polling place for early voting to remain open until 8 p.m. on any Saturday that falls within the period for early voting.

3. A permanent polling place for early voting must remain open:

(a) On Monday through Friday:

(1) During the first week of early voting, from 8 a.m. until 6 p.m.

(2) During the second week of early voting, from 8 a.m. until 6 p.m., or until 8 p.m. if the city clerk so requires.

(b) On any Saturday that falls within the period for early voting, for at least 4 hours between 10 a.m. and 6 p.m.

(c) *If a city clerk extends the period for early voting by personal appearance through the Sunday before election day pursuant to subsection 1, on the Sunday before election day during such hours as the clerk may establish.*

(d) *If the city clerk includes a Sunday that falls within the period for early voting pursuant to subsection 2, during such hours as the city clerk may establish.*

Sec. 39. NRS 293C.3572 is hereby amended to read as follows:

293C.3572 1. *In addition to permanent polling places for early voting, except as otherwise provided in subsection 3, the city clerk may establish temporary branch polling places for early voting pursuant to NRS 293C.3561.*

2. *If an Indian reservation or Indian colony is located in whole or in part within a city, the Indian tribe may submit a request to the city clerk for the establishment of a temporary branch polling place within the boundaries of the Indian reservation or Indian colony.*

3. *A request for the establishment of a temporary branch polling place within the boundaries of an Indian reservation or Indian colony:*

(a) *Must be submitted to the city clerk by the Indian tribe on or before:*

(1) *If the request is for a primary city election that is held:*

(I) *On the dates set forth for primary elections pursuant to the provisions of chapter 293 of NRS, the first Friday in January of the year in which the primary city election is to be held.*

(II) *On the dates set forth for primary city elections pursuant to the provisions of this chapter, the first Friday in December of the year immediately preceding the year in which the primary city election is to be held.*

(2) *If the request is for a general city election that is held:*

(I) *On the dates set forth for general elections pursuant to the provisions of chapter 293 of NRS, the first Friday in July of the year in which the general city election is to be held.*

(II) *On the dates set forth for general city elections pursuant to the provisions of this chapter, the first Friday in January of the year in which the general city election is to be held.*

(b) *May include one or more proposed locations within the boundaries of the Indian reservation or Indian colony for the temporary branch polling place and proposed hours thereof. Any proposed location must satisfy the criteria established by the city clerk pursuant to NRS 293C.3561.*

4. *Except as otherwise provided in this subsection, if the city clerk receives a request that satisfies the requirements set forth in subsection 3, the city clerk must establish at least one temporary branch polling place for early voting within the boundaries of the Indian reservation or Indian colony. The location and hours of operation of such a temporary branch polling place for early voting must be approved by the Indian tribe. The city clerk is not required to establish a temporary branch polling place within the boundaries of the Indian reservation or Indian colony if the city clerk determines that it is not logistically feasible to establish a temporary branch polling place within the boundaries of the Indian reservation or Indian colony.*

5. The provisions of subsection 3 of NRS 293C.3568 do not apply to a temporary *branch* polling place. Voting at a temporary branch polling place may be conducted on any one or more days and during any hours within the period for early voting by personal appearance, as determined by the city clerk.

~~{3.}~~ 6. The schedules for conducting voting are not required to be uniform among the temporary branch polling places.

~~{4.}~~ 7. The legal rights and remedies which inure to the owner or lessor of private property are not impaired or otherwise affected by the leasing of the property for use as a temporary branch polling place for early voting, except to the extent necessary to conduct early voting at that location.

Sec. 39.5. NRS 293C.3585 is hereby amended to read as follows:

293C.3585 1. Except as otherwise provided in NRS 293C.272, upon the appearance of a person to cast a ballot for early voting, an election board officer shall:

(a) Determine that the person is a registered voter in the county.

(b) Instruct the voter to sign the roster for early voting ~~{ }~~ *or a signature card*.

(c) Verify the signature of the voter in the manner set forth in NRS 293C.270.

(d) Verify that the voter has not already voted *in that city* in the current election pursuant to this section.

2. If the signature does not match, the voter must be identified by:

(a) Answering questions from the election board officer covering the personal data which is reported on the application to register to vote;

(b) Providing the election board officer, orally or in writing, with other personal data which verifies the identity of the voter; or

(c) Providing the election board officer with proof of identification as described in NRS 293C.270 other than the card issued to the voter at the time he or she registered to vote.

3. If the signature of the voter has changed in comparison to the signature on the application to register to vote, the voter must update his or her signature on a form prescribed by the Secretary of State.

4. The city clerk shall prescribe a procedure, approved by the Secretary of State, to verify that the voter has not already voted *in that city* in the current election pursuant to this section.

5. The roster for early voting *or signature card, as applicable*, must contain:

(a) The voter's name, the address where he or she is registered to vote, his or her voter identification number and a place for the voter's signature;

(b) The voter's precinct or voting district number, if that information is available; and

(c) The date of voting early in person.

6. When a voter is entitled to cast a ballot and has identified himself or herself to the satisfaction of the election board officer, the voter is entitled to

receive the appropriate ballot or ballots, but only for his or her own use at the polling place for early voting.

7. If the ballot is voted on a mechanical recording device which directly records the votes electronically, the election board officer shall:

- (a) Prepare the mechanical recording device for the voter;
- (b) Ensure that the voter's precinct or voting district, if that information is available, and the form of ballot are indicated on the voting receipt, if the city clerk uses voting receipts; and
- (c) Allow the voter to cast a vote.

8. A voter applying to vote early by personal appearance may be challenged pursuant to NRS 293C.292.

Sec. 39.7. NRS 293C.3604 is hereby amended to read as follows:

293C.3604 If ballots which are voted on a mechanical recording device which directly records the votes electronically are used during the period for early voting by personal appearance in an election other than a presidential preference primary election:

1. At the close of each voting day, the election board shall:

(a) Prepare and sign a statement for the polling place. The statement must include:

- (1) The title of the election;
 - (2) The number which identifies the mechanical recording device and the storage device required pursuant to NRS 293B.084;
 - (3) The number of ballots voted on the mechanical recording device for that day; ~~and~~
 - (4) The number of signatures in the roster for early voting for that day ~~+~~
- ; and

(5) *The number of signatures on signature cards for that day.*

(b) Secure:

(1) The ballots pursuant to the plan for security required by NRS 293C.3594; and

(2) Each mechanical voting device in the manner prescribed by the Secretary of State pursuant to NRS 293C.3594.

2. At the close of the last voting day, the city clerk shall deliver to the ballot board for early voting:

- (a) The statements for all polling places for early voting;
- (b) The voting rosters used for early voting;
- (c) *The signature cards used for early voting;*
- (d) The storage device required pursuant to NRS 293B.084 from each mechanical recording device used during the period for early voting; and
- ~~[(d)]~~ (e) Any other items as determined by the city clerk.

3. Upon receipt of the items set forth in subsection 2 at the close of the last voting day, the ballot board for early voting shall:

- (a) Indicate the number of ballots on an official statement of ballots; and
- (b) Place the storage devices in the container provided to transport those items to the central counting place and seal the container with a number seal.

The official statement of ballots must accompany the storage devices to the central counting place.

Sec. 40. NRS 293C.530 is hereby amended to read as follows:

293C.530 1. A city clerk may establish a system for distributing sample ballots by electronic means to each registered voter who elects to receive a sample ballot by electronic means. Such a system may include, without limitation, electronic mail or electronic access through an Internet website. If a city clerk establishes such a system and a registered voter elects to receive a sample ballot by electronic means, the city clerk shall distribute the sample ballot to the registered voter by electronic means pursuant to the procedures and requirements set forth by regulations adopted by the Secretary of State.

2. If a registered voter does not elect to receive a sample ballot by electronic means pursuant to subsection 1, the city clerk shall distribute the sample ballot to the registered voter by mail.

3. Before the period for early voting for any election begins, the city clerk shall distribute to each registered voter in the city by mail or electronic means, as applicable, the sample ballot for his or her precinct, with a notice informing the voter of the location of his or her polling place ~~to~~ *or places*. If the location of the polling place *or places* has changed since the last election:

- (a) The city clerk shall mail a notice of the change to each registered voter in the city not sooner than 10 days before distributing the sample ballots; or
- (b) The sample ballot must also include a notice in bold type immediately above the location which states:

NOTICE: THE LOCATION OF YOUR POLLING PLACE *OR*
PLACES HAS CHANGED SINCE THE LAST ELECTION

4. Except as otherwise provided in subsection 6, a sample ballot required to be distributed pursuant to this section must:

- (a) Be prepared in at least 12-point type;
- (b) Include the description of the anticipated financial effect and explanation of each citywide measure and advisory question, including arguments for and against the measure or question, as required pursuant to NRS 295.205 or 295.217; and
- (c) Include on the front page, in a separate box created by bold lines, a notice prepared in at least 20-point bold type that states:

NOTICE: TO RECEIVE A SAMPLE BALLOT IN

LARGE TYPE, CALL (Insert appropriate telephone number)

5. The word "Incumbent" must appear on the sample ballot next to the name of the candidate who is the incumbent, if required pursuant to NRS 293.2565.

6. A portion of a sample ballot that contains a facsimile of the display area of a voting device may include material in less than 12-point type to the extent necessary to make the facsimile fit on the pages of the sample ballot.

7. The sample ballot distributed to a person who requests a sample ballot in large type by exercising the option provided pursuant to NRS 293.508, or

in any other manner, must be prepared in at least 14-point type, or larger when practicable.

8. If a person requests a sample ballot in large type, the city clerk shall ensure that all future sample ballots distributed to that person from the city are in large type.

9. The city clerk shall include in each sample ballot a statement indicating that the city clerk will, upon request of a voter who is elderly or disabled, make reasonable accommodations to allow the voter to vote at his or her polling place *or places* and provide reasonable assistance to the voter in casting his or her vote, including, without limitation, providing appropriate materials to assist the voter. In addition, if the city clerk has provided pursuant to subsection 4 of NRS 293C.281 for the placement at centralized voting locations of specially equipped voting devices for use by voters who are elderly or disabled, the city clerk shall include in the sample ballot a statement indicating:

- (a) The addresses of such centralized voting locations;
- (b) The types of specially equipped voting devices available at such centralized voting locations; and
- (c) That a voter who is elderly or disabled may cast his or her ballot at such a centralized voting location rather than at the voter's regularly designated polling place ~~{ }~~ *or places*.

10. The cost of distributing sample ballots for a city election must be borne by the city holding the election.

Sec. 41. NRS 293C.535 is hereby amended to read as follows:

293C.535 1. Except as otherwise provided by special charter, registration of electors in incorporated cities must be accomplished in the manner provided in this chapter.

2. The county clerk shall use the statewide voter registration list to prepare for the city clerk of each incorporated city within the county the roster of all electors eligible to vote at a regular or special city election.

3. ~~{The}~~ *Except as otherwise provided in section 27 of this act, the rosters must be prepared, one for each ward or other voting district within each incorporated city. The entries in the roster must be arranged alphabetically with the surnames first.*

4. The county clerk shall keep duplicate originals or copies of the applications to register to vote in the county clerk's office.

Sec. 42. NRS 293C.715 is hereby amended to read as follows:

293C.715 1. If a city clerk maintains a website on the Internet for information relating to elections, the website must contain public information maintained, collected or compiled by the city clerk that relates to elections, which must include, without limitation:

- (a) The locations of polling places for casting a ballot on election day in such a form that a registered voter may search the list to determine the location of the polling place *or places* at which the registered voter is ~~{required}~~ *entitled* to cast a ballot; and

(b) The abstract of votes required to be posted on a website pursuant to the provisions of NRS 293C.387.

2. The abstract of votes required to be maintained on the website pursuant to paragraph (b) of subsection 1 must be maintained in such a format as to permit the searching of the abstract of votes for specific information.

3. If the information required to be maintained by a city clerk pursuant to subsection 1 may be obtained by the public from a website on the Internet maintained by the Secretary of State, a county clerk or another city clerk, the city clerk may provide a hyperlink to that website to comply with the provisions of subsection 1 with regard to that information.

Sec. 43. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 44. This act becomes effective:

1. On July 1, 2017, for the purpose of adopting any regulations and performing any other preparatory administrative tasks necessary to carry out the provisions of this act; and

2. On January 1, 2018, for all other purposes.

Senator Cannizzaro moved the adoption of the amendment.

Remarks by Senator Cannizzaro.

Amendment No. 773 to Assembly Bill No. 272 clarifies that a county clerk is not required to establish a polling place within the boundaries of an Indian reservation or colony on election day if an early-voting polling location had been established for the reservation or colony for that election. It also deletes sections 7 and 31, which would have amended the definition of "roster." Other conforming sections of the bill relating to the election roster definition are also deleted.

Amendment adopted.

Bill ordered reprinted, re-engrossed and to third reading.

Assembly Bill No. 301.

Bill read second time and ordered to third reading.

GENERAL FILE AND THIRD READING

Senate Bill No. 233.

Bill read third time.

The following amendment was proposed by the Committee on Finance:

Amendment No. 693.

JOINT SPONSOR: ASSEMBLYWOMAN BENITEZ-THOMPSON

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

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

Legislative Counsel's Digest:

Existing law requires most health insurance plans which cover prescription drugs and outpatient care to also include coverage for contraceptive drugs and

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

The federal Patient Protection and Affordable Care Act (Public Law 111-148, as amended) requires certain preventative services to be covered by every health insurance plan without any copay, coinsurance or higher deductible, including, without limitation, certain contraceptive drugs, devices and services, certain vaccinations, mammograms, counseling concerning interpersonal and domestic violence, screenings for certain diseases and well-woman preventative visits. (42 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130) This bill places those requirements in Nevada law, requiring all ~~(public and)~~ private health insurance plans and certain public 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 ~~for device~~ for contraception if the insured refused to accept a therapeutic equivalent of the contraceptive drug ~~for device~~. In addition, a health insurance plan must include for each listed 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~~ use medical management techniques, including step therapy ~~for~~ and prior authorization , to ~~obtain coverage for~~ determine the frequency of the preventative services required by this bill ~~for~~ or the type of provider of health care who will provide such services. Sections 7, 8 and 11-57 also require ~~all forms of~~ certain 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. Sections 12, 18, 27, 33, 38, 45 and 54: (1) prohibit the use of medical management techniques to require an insured to use a method of contraception other than that prescribed or ordered by a provider of health care; and (2) require an insurer to provide a process by which an insured can request

an exemption from a medical management technique required by an insurer to obtain contraception.

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 12, 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 ~~full public and~~ private health insurance plans and certain public health insurance plans made available in this State and require such 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 or the balance of the plan year, whichever is shorter, 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.

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~~ to 4.5, inclusive, 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 ~~for 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 ~~for device~~ for contraception if the person refuses to accept a therapeutic equivalent of the contraceptive drug_ ~~for device.~~*

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

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

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

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

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

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

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

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

(c) Counseling for sexually transmitted diseases;

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

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

~~(f)~~ (e) An annual screening for cervical cancer;

~~(g)~~ (f) Screening for depression;

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

~~(i)~~ (h) 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 ~~per year;~~

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

~~(k)~~ (j) 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 ~~the~~

~~(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~~

~~(e) An annual~~ a mammogram ~~for women,~~ not less than once every 2 years, or annually if ordered by a provider of health care, for women 40 years of age or older.

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

- (a) Pay a higher deductible, any copayment or coinsurance; or
- (b) Be subject to a longer waiting period or any other condition.

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

Sec. 4.5. The Director may include in the State Plan for Medicaid a requirement that, to the extent money is available, the State pay the nonfederal share of expenditures incurred for:

- 1. Supplies for breastfeeding; and
- 2. Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization.

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~~ Testing for high-risk strains of human papillomavirus ~~+~~ every 3 years for women 30 years of age or older; and
- (b) Administering the human papillomavirus vaccine ~~to women and girls~~ at such ages as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

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

- (a) Pay a higher deductible, any copayment or coinsurance; or
- (b) Be subject to a longer waiting period or any other condition.

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

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

422.401 As used in NRS 422.401 to 422.406, inclusive, ~~and sections 2, 3 and 4~~ and sections 2, 3 and 4 ~~to 4.5, inclusive, of this act,~~ unless the context otherwise requires, the words and terms defined in NRS 422.4015 and 422.402 have the meanings ascribed to them in those sections.

Sec. 5.7. NRS 422.406 is hereby amended to read as follows:

422.406 1. The Department may, to carry out its duties set forth in NRS 422.401 to 422.406, inclusive, ~~and sections 2, 3 and 4~~ and sections 2, 3 and 4 ~~to 4.5, inclusive, of this act,~~ and to administer the provisions of NRS 422.401 to 422.406, inclusive ~~+~~, ~~and sections 2, 3 and 4~~ to 4.5, inclusive, of this act:

- (a) Adopt regulations; and

(b) Enter into contracts for any services.

2. Any regulations adopted by the Department pursuant to NRS 422.401 to 422.406, inclusive, *and sections 2, ~~3 and 4~~ to 4.5, inclusive, of this act,* must be adopted in accordance with the provisions of chapter 241 of NRS.

Sec. 6. (Deleted by amendment.)

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

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

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

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

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 687B.408, 689B.030 to 689B.050, inclusive, *and sections 20 and 21 of this act* and 689B.287 apply to coverage provided pursuant to this paragraph ~~1~~, *except that the provisions of sections 20 and 21 of this act only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.*

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

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

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

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

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

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

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

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

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

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

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

Sec. 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~~ or therapeutic equivalent, 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 ~~or~~ or any amount which covers the remainder of the plan year if the patient is covered by a health care plan, whichever is less.

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

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

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

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

4. As used in this section:

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

(b) "Plan year" means the year ~~in which an insured is covered by a health care plan.~~ designated in the evidence of coverage of a health care plan in which a person is covered by such 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. ~~{A}~~ *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}~~, 5, 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}~~ ;

~~(1) Lawfully prescribed or ordered ~~{and which has been approved}~~ ;~~

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

~~(3) Listed in subsection 8; and~~

~~(4) Dispensed in accordance with section 8.5 of this act;~~

(b) Any type of device for contraception ~~{for its therapeutic equivalent,}~~ which is ~~{lawfully}~~ ;

~~(1) Lawfully prescribed or ordered ~~{and which has been approved}~~ ;~~

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

~~(3) Listed in subsection 8;~~

(c) ~~{Insertion for removal}~~ of a device for contraception ~~{or removal}~~ of such a device if the device was inserted while the insured was covered by the same policy of health insurance;

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

(e) Voluntary sterilization for women.

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

3. Except as otherwise provided in subsections ~~5~~, 6, 7 and ~~7~~, 9, an insurer that offers or issues a policy of health insurance shall not:

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

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

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

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

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

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

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

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

~~6~~ 7. For each ~~method~~ of the 18 methods of contraception ~~which is~~ listed in subsection 8 that has been approved by the Food and Drug Administration, a policy of health insurance must include at least one ~~contraceptive~~ drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the insured, but the insurer may charge a deductible, copayment or coinsurance for any other ~~contraceptive~~ drug or device that provides the same method of contraception.

~~7. An insurer may require an insured to:~~

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

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

8. The following 18 methods of contraception must be covered pursuant to this section:

- (a) Voluntary sterilization for women;
- (b) Surgical sterilization implants for women;
- (c) Implantable rods;
- (d) Copper-based intrauterine devices;
- (e) Progesterone-based intrauterine devices;
- (f) Injections;
- (g) Combined estrogen- and progestin-based drugs;
- (h) Progestin-based drugs;
- (i) Extended- or continuous-regimen drugs;
- (j) Estrogen- and progestin-based patches;
- (k) Vaginal contraceptive rings;
- (l) Diaphragms with spermicide;
- (m) Sponges with spermicide;
- (n) Cervical caps with spermicide;
- (o) Female condoms;
- (p) Spermicide;
- (q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
- (r) Antiprogesterin-based drugs for emergency contraception.

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

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

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

12. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior

authorization or categorizing drugs and devices based on cost, type or method of administration.

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

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

~~[(b)]~~ (d) "Therapeutic equivalent" means a drug which:

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

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

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

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

(a) Counseling, support and supplies for breastfeeding, including ~~f, without limitation, renting or purchasing~~ breastfeeding equipment ~~f, f~~, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence ~~f, f~~ for women at least annually with intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) ~~Counseling for~~ Behavioral counseling concerning sexually transmitted diseases ~~f, f~~ from a provider of health care for sexually active women who are at increased risk for such 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 ~~f, without limitation,~~ gestational diabetes ~~f, f~~, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) ~~An annual screening~~ Screening for cervical cancer ~~f, f~~ at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Screening for depression;

(h) Screening and counseling for the human immunodeficiency virus ~~f, f~~ consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the insured or as ordered by a provider of health care;

(i) Smoking cessation programs ~~f, including, without limitation,~~ for an insured who is 18 years of age or older consisting of not more than two

cessation attempts per year and four counseling sessions ~~[of not more than 10 minutes each.]~~ per year;

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

(k) Such well-woman preventative visits as recommended by the Health Resources and Services Administration ~~[.]~~, which must include at least one such visit per year beginning at 14 years of age.

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

3. Except as otherwise provided in subsection ~~[4.]~~ 5, an insurer that offers or issues a policy of health insurance shall not:

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

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

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

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

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

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

~~[3.]~~ 4. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

~~[4. An insurer 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. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating

to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section ~~for "provider"~~ :

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

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

(c) "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 ~~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~~ a mammogram every 2 years, or annually if ordered by a provider of health care, for women ~~for~~ 40 years of age or older.

2. ~~[A policy of health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.] An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.~~

3. ~~Except as otherwise provided in subsection ~~4~~ 5,~~ an insurer that offers or issues a policy of health insurance shall not:

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

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

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

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

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

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

~~3-1~~ 4. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~{October 1, 1989,}~~ January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with ~~{subsection 1}~~ 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. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section ~~{, "provider"}~~ :

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

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

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

policy, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

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

~~(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.~~

~~5.1~~ 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 ~~for~~ every 3 years for women 30 years of age or older; and

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

2. ~~{A policy of health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.}~~ An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

~~3.~~ Except as otherwise provided in subsection ~~{4.}~~ 5, an insurer that offers or issues a policy of health insurance shall not:

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

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

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

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

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

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

~~{3.}~~ 4. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~{July 1, 2007,}~~

January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with ~~subsection 1~~ this section 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. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

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

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

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

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

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

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

Sec. 20. 1. Except as otherwise provided in subsection ~~4~~ 5, an insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:

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

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

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

~~(3) Listed in subsection 9; and~~

~~(4) Dispensed in accordance with section 8.5 of this act;~~

(b) Any type of device for contraception ~~for its therapeutic equivalent,~~ which is ~~lawfully~~ ;

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

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

~~(3) Listed in subsection 9;~~

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

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

(e) Voluntary sterilization for women.

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

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

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit 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.~~ 4. Except as otherwise provided in subsection ~~4.~~ 5, 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.}~~ 5. 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.}~~ 6. If an insurer refuses, pursuant to subsection ~~{4.}~~ 5, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.

~~{6.}~~ 7. An insurer may require an insured to pay a higher deductible, copayment or coinsurance for a drug ~~for device~~ for contraception if the insured refuses to accept a therapeutic equivalent of the ~~contraceptive~~ drug ~~for device~~.

~~7.}~~ 8. For each ~~method~~ of the 18 methods of contraception ~~which is~~ listed in subsection 9 that has been approved by the Food and Drug Administration, a policy of group health insurance must include at least one ~~contraceptive~~ drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the insured, but the insurer may charge a deductible, copayment or coinsurance for any other ~~contraceptive~~ drug or device that provides the same method of contraception.

~~{ 8. 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.~~

9. The following 18 methods of contraception must be covered pursuant to this section:

- (a) Voluntary sterilization for women;
- (b) Surgical sterilization implants for women;
- (c) Implantable rods;
- (d) Copper-based intrauterine devices;
- (e) Progesterone-based intrauterine devices;
- (f) Injections;
- (g) Combined estrogen- and progestin-based drugs;
- (h) Progestin-based drugs;
- (i) Extended- or continuous-regimen drugs;
- (j) Estrogen- and progestin-based patches;
- (k) Vaginal contraceptive rings;
- (l) Diaphragms with spermicide;
- (m) Sponges with spermicide;
- (n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

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

(r) Antiprogestin-based drugs for emergency contraception.

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

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

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

13. As used in this section:

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

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

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

~~##(b)~~ (d) "Therapeutic equivalent" means a drug which:

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

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

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

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

(a) Counseling, support and supplies for breastfeeding, including ~~f, without limitation, renting or purchasing equipment for~~ breastfeeding ~~f, f~~ equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence ~~for~~ for women at least annually with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) ~~Counseling for~~ Behavioral counseling concerning sexually transmitted diseases ~~for~~ from a provider of health care for sexually active women who are at increased risk for such 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 ~~for~~ without limitation, gestational diabetes ~~for~~, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) ~~An annual screening~~ Screening for cervical cancer ~~for~~ at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Screening for depression;

(h) Screening and counseling for the human immunodeficiency virus ~~for~~ consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the insured or as ordered by a provider of health care;

(i) Smoking cessation programs ~~for~~, including, without limitation, for an insured who is 18 years of age or older consisting of not more than two cessation attempts per year and four counseling sessions ~~for~~ of not more than 10 minutes each, per year;

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

(k) Such well-woman preventative visits as recommended by the Health Resources and Services Administration ~~for~~, which must include at least one such visit per year beginning at 14 years of age.

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

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

~~3.1~~ 4. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

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

6. As used in this section ~~1~~, "provider" :

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

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

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

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

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

(a) Deoxyribonucleic acid testing for high-risk strains of human papillomavirus ~~1~~ every 3 years for women 30 years of age or older; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department

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

2. ~~[A policy of group health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. ~~Except as otherwise provided in subsection 4, 5, 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.]~~ 4. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007.]~~ January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with ~~[subsection 1]~~ this section 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 service is medically necessary or appropriate for the insured.]~~

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

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

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

(d) "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~~ a mammogram every 2 years, or annually if ordered by provider of health care, for women ~~17~~ 40 years of age or older.

2. ~~[A policy of group health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.] An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.~~

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

~~§ 4.~~ 4. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~{October 1, 1989,}~~ January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with ~~{subsection 1}~~ 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. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section ~~{, "provider"}~~ :

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. ~~{An insurer may require an insured to:~~

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

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

~~—5.} The provisions of this section do not {:~~

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

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

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

coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall provide notice to each insured, at the time the insured receives his or her certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~7. 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.~~

~~5.7~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

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

Sec. 27. 1. ~~Except as otherwise provided in subsection 4.4~~ 5, 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~~ :

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

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

~~(3) Listed in subsection 8; and~~

~~(4) Dispensed in accordance with section 8.5 of this act;~~

(b) Any type of device for contraception ~~for its therapeutic equivalent~~ which is ~~lawfully~~ :

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

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

~~(3) Listed in subsection 8;~~

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

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

(e) Voluntary sterilization for women.

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

3. Except as otherwise provided in subsections ~~5, 6 and 7,~~ 6, 7 and 9, a carrier that offers or issues a health benefit plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit 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.

~~3.4~~ 4. Except as otherwise provided in subsection ~~4.4~~ 5, a health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

~~4.4~~ 5. A carrier that offers or issues a health benefit plan and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the carrier objects on religious grounds. Such a carrier shall, before the issuance of a health benefit plan and before the renewal of such a plan, provide to the prospective insured written notice of the coverage that the carrier refuses to provide pursuant to this subsection.

~~5.4~~ 6. A carrier may require an insured to pay a higher deductible, copayment or coinsurance for a drug ~~for device~~ for contraception if the insured refuses to accept a therapeutic equivalent of the ~~contraceptive~~ drug ~~for device~~.

~~6.4~~ 7. For each ~~method~~ of the 18 methods of contraception ~~which is~~ listed in subsection 8 that has been approved by the Food and Drug Administration, a health benefit plan must include at least one ~~contraceptive~~ drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the insured, but the carrier may charge a deductible, copayment or coinsurance for any other ~~contraceptive~~ drug or device that provides the same method of contraception.

~~7. 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.~~

8. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

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

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

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

(r) Antiprogestin-based drugs for emergency contraception.

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

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

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

12. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior

authorization or categorizing drugs and devices based on cost, type or method of administration.

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

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

~~[(b)]~~ (d) "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. 28. 1. A carrier that offers or issues a health benefit plan shall include in the plan coverage for:

(a) Counseling, support and supplies for breastfeeding, including ~~f, without limitation, renting or purchasing equipment for~~ breastfeeding ~~f, equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;~~

(b) Screening and counseling for interpersonal and domestic violence ~~f, for women at least annually, with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;~~

(c) ~~Counseling for~~ Behavioral counseling concerning sexually transmitted diseases ~~f, from a provider of health care for sexually active women who are at increased risk for such diseases;~~

(d) Hormone replacement therapy;

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

(f) Screening for blood pressure abnormalities and diabetes, including ~~f, without limitation,~~ gestational diabetes ~~f,~~, after at least 24 weeks of gestation or as ordered by a provider of health care;

(g) ~~An annual screening~~ Screening for cervical cancer ~~f, at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;~~

(h) Screening for depression;

(i) Screening and counseling for the human immunodeficiency virus ~~f, consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the insured or as ordered by a provider of health care;~~

(j) Smoking cessation programs ~~f, including, without limitation,~~ for an insured who is 18 years of age or older consisting of not more than two

cessation attempts per year and four counseling sessions ~~[of not more than 10 minutes each.]~~ per year;

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

(l) Such well-woman preventative visits as recommended by the Health Resources and Services Administration ~~[.]~~, which must include at least one such visit per year beginning at 14 years of age.

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

3. Except as otherwise provided in subsection ~~[4.]~~ 5, 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.]~~ 4. 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. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section ~~1, "provider"~~ :

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

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

(c) "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 ~~1,1~~ every 3 years for women 30 years of age or older; and

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

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

3. Except as otherwise provided in subsection ~~4,1~~ 5, 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.

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

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

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

(d) "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;~~

~~(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~~ a mammogram every 2 years, or annually if ordered by a provider of health care, for women ~~+~~ 40 years of age or older.

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

3. ~~Except as otherwise provided in subsection ~~4.1~~ 5,~~ 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.

~~3.1~~ 4. 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~~ 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. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section ~~the "provider"~~ :

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

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

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

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

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

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

Sec. 33. 1. Except as otherwise provided in subsection ~~4.4~~ 5, 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~~ :

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

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 8; and

(4) Dispensed in accordance with section 8.5 of this act;

(b) Any type of device for contraception ~~for its therapeutic equivalent~~ which is ~~lawfully~~ :

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

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

(3) Listed in subsection 8;

(c) Insertion ~~for removal~~ of a device for contraception ~~or~~ or removal of such a device if the device was inserted while the insured was covered by the same benefit contract;

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

(e) Voluntary sterilization for women.

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

3. Except as otherwise provided in subsections ~~5, 6 and 7,~~ 6, 7 and 9, a society that offers or issues a benefit contract shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition 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.~~ 4. Except as otherwise provided in subsection ~~4.~~ 5., a benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

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

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

~~§ 6.~~ 7. For each ~~method~~ of the 18 methods of contraception ~~which is~~ listed in subsection 8 that has been approved by the Food and Drug Administration, a benefit contract must include at least one ~~contraceptive~~ drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the insured, but the society may charge a deductible, copayment or coinsurance for any other ~~contraceptive~~ drug or device that provides the same method of contraception.

~~§ 7.~~ A society may require an insured to:

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

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

8. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

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

- (h) Progestin-based drugs;
- (i) Extended- or continuous-regimen drugs;
- (j) Estrogen- and progestin-based patches;
- (k) Vaginal contraceptive rings;
- (l) Diaphragms with spermicide;
- (m) Sponges with spermicide;
- (n) Cervical caps with spermicide;
- (o) Female condoms;
- (p) Spermicide;
- (q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
- (r) Antiprogestin-based drugs for emergency contraception.

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

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

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

12. As used in this section:

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

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

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

~~##~~ (d) "Therapeutic equivalent" means a drug which:

- (1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;
- (2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

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

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

(a) Counseling, support and supplies for breastfeeding, including ~~f, without limitation, renting or purchasing equipment for~~ breastfeeding ~~f, equipment,~~ counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence ~~f, f~~ for women at least annually with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) ~~f Counseling for~~ Behavioral counseling concerning sexually transmitted diseases ~~f, f~~ from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Hormone replacement therapy;

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

(f) Screening for blood pressure abnormalities and diabetes, including ~~f, without limitation,~~ gestational diabetes ~~f, f~~, after at least 24 weeks of gestation or as ordered by a provider of health care;

(g) ~~f An annual screening~~ Screening for cervical cancer ~~f, f~~ at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(h) Screening for depression;

(i) Screening and counseling for the human immunodeficiency virus ~~f, f~~ consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the insured or as ordered by a provider of health care;

(j) Smoking cessation programs ~~f, including, without limitation,~~ for an insured who is 18 years of age or older consisting of not more than two cessation attempts per year and four counseling sessions ~~f, of not more than 10 minutes each,~~ per year;

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

(l) Such well-woman preventative visits as recommended by the Health Resources and Services Administration ~~f, f~~, which must include at least one such visit per year beginning at 14 years of age.

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

3. Except as otherwise provided in subsection ~~f, f~~ 5, 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.}~~ 4. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the 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. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

~~{5.}~~ 6. As used in this section ~~{, "provider"}~~ :

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

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

(c) "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 ~~for~~ every 3 years for women 30 years of age and older; and

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

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

3. ~~Except as otherwise provided in subsection 4,~~ 5. 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.~~ 4. A benefit contract subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the benefit contract or the renewal which is in conflict with ~~subsection 1~~ 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. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating

to any benefit required by this section or the type of provider of health care to use for such treatment.

~~5.1~~ 6. 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) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

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

(d) "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 ~~the~~

~~(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~~ a mammogram every 2 years, or annually if ordered by a provider of health care, for women ~~at~~ 40 years of age or older.

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

3. Except as otherwise provided in subsection ~~4.1~~ 5, a society that offers or issues a benefit contract shall not:

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

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

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

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

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

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

~~§ 4.~~ 4. A benefit contract subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the benefit contract or the renewal which is in conflict with ~~subsection 1~~ 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. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

~~§ 5.~~ 6. As used in this section ~~the~~ "provider" :

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

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

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

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

Sec. 38. 1. Except as otherwise provided in subsection ~~4.1~~ 5, an insurer that offers or issues a contract for hospital or medical service shall include in the contract coverage for:

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

(1) Lawfully prescribed or ordered ~~and which has been approved~~ :

- (2) Approved by the Food and Drug Administration;
(3) Listed in subsection 9; and
(4) Dispensed in accordance with section 8.5 of this act;
 (b) Any type of device for contraception ~~for its therapeutic equivalent~~ which is ~~lawfully~~ :
(1) Lawfully prescribed or ordered ~~and which has been approved~~ ;
(2) Approved by the Food and Drug Administration; and
(3) Listed in subsection 9;
 (c) ~~Insertion for removal~~ of a device for contraception ~~for~~ or removal of such a device if the device was inserted while the insured was covered by the same contract for hospital or medical service;
 (d) Education and counseling relating to ~~contraception~~ the initiation of the use of contraception and any necessary follow-up after initiating such use; and
 (e) Voluntary sterilization for women.
2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.
3. Except as otherwise provided in subsections ~~6, 7 and 8,~~ 7, 8 and 10, an insurer that offers or issues a contract for hospital or medical service shall not:
- (a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the contract for hospital or medical service pursuant to subsection 1;
- (b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use any such benefit;
- (c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;
- (d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;
- (e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or
- (f) Impose any other restrictions or delays on the access of an insured to any such benefit.
- ~~3.~~ 4. Except as otherwise provided in subsection ~~4,~~ 5, a contract for hospital or medical service subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

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

~~{5.}~~ 6. If an insurer refuses, pursuant to subsection ~~{4.}~~ 5, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.

~~{6.}~~ 7. An insurer may require an insured to pay a higher deductible, copayment or coinsurance for a drug ~~for device~~ for contraception if the insured refuses to accept a therapeutic equivalent of the ~~contraceptive~~ drug ~~for device~~.

~~{7.}~~ 8. For each ~~method~~ of the 18 methods of contraception ~~which is~~ listed in subsection 9 that has been approved by the Food and Drug Administration, a contract for hospital or medical service must include at least one ~~contraceptive~~ drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the insured, but the insurer may charge a deductible, copayment or coinsurance for any other ~~contraceptive~~ drug or device that provides the same method of contraception.

~~{ 8. 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.}~~

9. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

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

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

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

(r) Antiprogestin-based drugs for emergency contraception.

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

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

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

13. As used in this section:

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

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

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

~~[(b)]~~ (d) "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. 39. 1. An insurer that offers or issues a contract for hospital or medical service shall include in the contract coverage for:

(a) Counseling, support and supplies for breastfeeding, including ~~without limitation, renting or purchasing equipment for~~ breastfeeding ~~equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;~~

(b) Screening and counseling for interpersonal and domestic violence ~~for~~ for women at least annually with initial intervention services consisting of

education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) ~~Behavioral counseling concerning sexually transmitted diseases~~ Behavioral counseling concerning sexually transmitted diseases ~~from a provider of health care for sexually active women who are at increased risk for such 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 ~~after at least 24 weeks of gestation or as ordered by a provider of health care;~~

(f) ~~An annual screening~~ Screening for cervical cancer ~~at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;~~

(g) Screening for depression;

(h) Screening and counseling for the human immunodeficiency virus ~~consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the insured or as ordered by a provider of health care;~~

(i) Smoking cessation programs ~~including, without limitation, for an insured who is 18 years of age or older consisting of not more than two cessation attempts per year and four counseling sessions of not more than 10 minutes each, per year;~~

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

(k) Such well-woman preventative visits as recommended by the Health Resources and Services Administration ~~which must include at least one such visit per year beginning at 14 years of age.~~

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

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

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

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

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

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

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

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

~~§ 3-1~~ 4. A contract for hospital or medical service subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

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

6. As used in this section ~~§~~, "provider" :

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

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

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

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

695B.1912 1. ~~[A policy of health insurance issued by a hospital or medical service corporation]~~ An insurer that offers or issues a contract for hospital or medical service must provide coverage for benefits payable for expenses incurred for ~~it~~.

~~(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~~ a mammogram every 2 years, or annually if ordered by a provider of health care, for women ~~40~~ 40 years of age or older.

2. ~~[A policy of health insurance issued by a hospital or medical service corporation must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 4, 5, 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.]~~ 4. 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]~~ 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. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any

available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

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

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

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

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

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

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

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

~~—(b) Any] any type of hormone replacement therapy ~~["~~~~

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

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

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

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

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

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

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

~~[any of the services listed in subsection 1]~~ hormone replacement therapy to an insured.

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

4. ~~[An insurer may require an insured to:~~
~~—(a) Participate in a reasonable program of step therapy to obtain coverage for any benefit required by subsection 1.~~
~~—(b) Obtain prior authorization before obtaining coverage for any benefit required by subsection 1 as part of a determination by the insurer that the benefit is medically necessary or appropriate for the insured.~~

~~—5.]~~ The provisions of this section do not ~~[-~~
~~—(a) Require]~~ require an insurer to provide coverage for fertility drugs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~—7.— An insurer may require an insured to:~~

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

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

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

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

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

(a) Deoxyribonucleic acid testing for high-risk strains of human papillomavirus ~~+++ every 3 years for women 30 years of age and older; and~~

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

2. ~~[A policy of health insurance issued by a hospital or medical service corporation must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. ~~Except as otherwise required by subsection 4, 5,~~ an insurer that offers or issues a contract for hospital or medical service shall not:

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

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

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

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

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

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

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

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

(c) "Network plan" means a contract for hospital or medical service offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(d) "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 ~~44~~ 5, 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~~ :

(1) ~~Lawfully~~ prescribed or ordered ~~[and which has been approved]~~ ;

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

(3) ~~Listed~~ in subsection 9; and

(4) ~~Dispensed~~ in accordance with section 8.5 of this act;

(b) Any type of device for contraception ~~for its therapeutic equivalent]~~ which is ~~lawfully~~ :

(1) ~~Lawfully~~ prescribed or ordered ~~[and which has been approved]~~ ;

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

(3) Listed in subsection 9;

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

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

(e) Voluntary sterilization for women.

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

3. Except as otherwise provided in subsections ~~6, 7 and 8,~~ 7, 8 and 10, a health maintenance organization that offers or issues a health care plan shall not:

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

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

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

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

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

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

3. ~~4.~~ Except as otherwise provided in subsection ~~4,~~ 5, 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,~~ 5. A health maintenance organization that offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the health maintenance organization objects on religious grounds. Such an organization shall, before the issuance of a health care plan and before the renewal of such a plan, provide to the prospective insured written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection.

~~[5.]~~ 6. If a health maintenance organization ~~refuses,~~ pursuant to subsection ~~[4, refuses]~~ 5, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.

~~[6.]~~ 7. A health maintenance organization may require an enrollee to pay a higher deductible, copayment or coinsurance for a drug ~~for device~~ for contraception if the enrollee refuses to accept a therapeutic equivalent of the ~~[contraceptive]~~ drug ~~for device~~.

~~7.]~~ 8. For each ~~[method]~~ of the 18 methods of contraception ~~[which is]~~ listed in subsection 9 that has been approved by the Food and Drug Administration, a health care plan must include at least one ~~[contraceptive]~~ drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the enrollee, but the health maintenance organization may charge a deductible, copayment or coinsurance for any other ~~[contraceptive]~~ drug or device that provides the same method of contraception.

~~[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. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

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

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

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

(r) Antiprogestin-based drugs for emergency contraception.

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

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

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

13. As used in this section:

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

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

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

~~[(b)]~~ (d) "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.]~~ Meets any other criteria required by the Food and Drug Administration for classification as 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 ~~[,]~~ equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence ~~[,]~~ for women at least annually with initial intervention services consisting of

education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) ~~{Counseling for}~~ Behavioral counseling concerning sexually transmitted diseases ~~{,}~~ from a provider of health care for sexually active women who are at increased risk for such 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 ~~{,}~~, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) ~~{An annual screening}~~ Screening for cervical cancer ~~{,}~~ at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Screening for depression;

(h) Screening and counseling for the human immunodeficiency virus ~~{,}~~ consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the enrollee or as ordered by a provider of health care;

(i) Smoking cessation programs ~~{, including, without limitation,}~~ for an enrollee who is 18 years of age or older not more than two cessation attempts per year and four counseling sessions ~~{of not more than 10 minutes each,}~~ per year;

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

(k) Such well-woman preventative visits as recommended by the Health Resources and Services Administration ~~{,}~~, which must include at least one such visit per year beginning at 14 years of age.

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

3. Except as otherwise provided in subsection ~~{4,}~~ 5, a health maintenance organization that offers or issues a health care plan shall not:

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

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

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

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

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

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

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

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

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

6. As used in this section ~~1~~, "provider" :

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

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

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

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

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

pursuant to this title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

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

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

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

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

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

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

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

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

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

2. A ~~{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.~~

~~5.1~~ The provisions of this section do not {:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~—5.— A health maintenance organization which offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required~~

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

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

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

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

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

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

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

695C.1735 1. A health ~~{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~~ a mammogram every 2 years, or annually if ordered by a provider of health care, for women ~~†~~ 40 years of age or older.

2. ~~{A health maintenance plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.} A health maintenance organization must ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.~~

3. ~~Except as otherwise provided in subsection {4.} 5,~~ 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.

~~§ 4.~~ 4. A ~~policy~~ health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~October 1, 1989,~~ January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the ~~policy~~ plan or the renewal which is in conflict with ~~subsection 1,~~ 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. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

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

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

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

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

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

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

(a) *Deoxyribonucleic acid testing for high-risk strains of human papillomavirus ~~for every 3 years for women 30 years of age and older; and~~*

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

2. ~~{A health care plan of a health maintenance organization must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.}~~ A health maintenance organization must ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.

~~3.~~ Except as otherwise provided in subsection ~~4.1~~ 5, a health maintenance organization that offers or issues a health care plan shall not:

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

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

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

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

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

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

~~3.1~~ 4. Any evidence of coverage subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~{July 1, 2007,}~~ January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with ~~{subsection 1}~~ this section is void.

~~{4. For the purposes of 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. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

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

(c) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

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

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

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

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

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

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

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

(1) Does not meet the requirements of subsection 1 of NRS 695C.080; or
(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 54. 1. *Except as otherwise provided in subsection ~~44~~ 5, a managed care organization that offers or issues a health care plan shall include in the plan coverage for:*

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

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

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

~~(3) Listed in subsection 8; and~~

~~(4) Dispensed in accordance with section 8.5 of this act;~~

(b) Any type of device for contraception ~~for its therapeutic equivalent~~ which is ~~lawfully~~ ;

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

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

~~(3) Listed in subsection 8;~~

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

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

(e) Voluntary sterilization for women; and

(f) Hormone replacement therapy.

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

3. Except as otherwise provided in subsections ~~5, 6 and 7,~~ 6, 7 and 9, 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.

~~3.~~ 4. Except as otherwise provided in subsection ~~4,~~ 5, 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.}~~ 5. A managed care organization that offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the managed care organization objects on religious grounds. Such an organization shall, before the issuance of a health care plan and before the renewal of such a plan, provide to the prospective insured written notice of the coverage that the managed care organization refuses to provide pursuant to this subsection.

~~{5.}~~ 6. A managed care organization may require an insured to pay a higher deductible, copayment or coinsurance for a drug ~~for device~~ for contraception if the insured refuses to accept a therapeutic equivalent of the ~~{contraceptive}~~ drug, ~~for device~~.

~~{6.}~~ 7. For each ~~{method}~~ of the 18 methods of contraception ~~{which is}~~ listed in subsection 8 that has been approved by the Food and Drug Administration, a health care plan must include at least one ~~{contraceptive}~~ drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the insured, but the managed care organization may charge a deductible, copayment or coinsurance for any other ~~{contraceptive}~~ drug or device that provides the same method of contraception.

~~{7.}~~ 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.~~

8. The following 18 methods of contraception must be covered pursuant to this section:

- (a) Voluntary sterilization for women;
- (b) Surgical sterilization implants for women;
- (c) Implantable rods;
- (d) Copper-based intrauterine devices;
- (e) Progesterone-based intrauterine devices;
- (f) Injections;
- (g) Combined estrogen- and progestin-based drugs;
- (h) Progestin-based drugs;
- (i) Extended- or continuous-regimen drugs;
- (j) Estrogen- and progestin-based patches;
- (k) Vaginal contraceptive rings;
- (l) Diaphragms with spermicide;
- (m) Sponges with spermicide;
- (n) Cervical caps with spermicide;
- (o) Female condoms;
- (p) Spermicide;

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

(r) Antiprogestin-based drugs for emergency contraception.

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

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

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

12. As used in this section:

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

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

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

~~[(b)]~~ (d) "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;

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

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

(a) Counseling, support and supplies for breastfeeding, including ~~f, without limitation, renting or purchasing equipment for~~ breastfeeding ~~f, equipment,~~ counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence ~~for~~ for women at least annually with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) ~~Counseling for~~ Behavioral counseling concerning sexually transmitted diseases ~~for~~ from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Hormone replacement therapy;

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

(f) Screening for blood pressure abnormalities and diabetes, including ~~without limitation,~~ gestational diabetes ~~for~~, after at least 24 weeks of gestation or as ordered by a provider of health care;

(g) Screening for cervical cancer ~~for an annual basis,~~ at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(h) Screening for depression;

(i) Screening and counseling for the human immunodeficiency virus ~~for~~ consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the insured or as ordered by a provider of health care;

(j) Smoking cessation programs ~~for, including, without limitation,~~ for an insured who is 18 years of age or older consisting of not more than two cessation attempts per year and four counseling sessions ~~for not more than 10 minutes each,~~ per year;

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

(l) Such well-woman preventative visits as recommended by the Health Resources and Services Administration ~~for~~, which must include at least one such visit per year beginning at 14 years of age.

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

3. Except as otherwise provided in subsection ~~4,~~ 5, a managed care organization that offers or issues a health care plan shall not:

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

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

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

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

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

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

~~§ 4.~~ 4. 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. Except as otherwise provided in this section and federal law, a managed care organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section ~~§~~, "provider" :

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

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

(c) "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~~ a mammogram every 2 years, or annually if ordered by a provider of health care, for women ~~40~~ 40 years of age or older.

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

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

~~3.~~ 4. 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. Except as otherwise provided in this section and federal law, a managed care organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section ~~,"provider"~~ :

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

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

(c) "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 ~~for~~ every 3 years for women 30 years of age and older; and

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

2. ~~[A health care plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.] A managed care organization must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization.~~

3. ~~Except as otherwise provided in subsection 4, 5, a managed care organization that offers or issues a health care plan which provides coverage for prescription drugs shall not:~~

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

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

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

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

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

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

~~§ 4.~~ 4. An evidence of coverage for a health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~July 1, 2007,~~ January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal thereof which is in conflict with ~~subsection 1~~ this section is void.

~~4. For the purposes of 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. Except as otherwise provided in this section and federal law, a managed care organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

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

(c) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

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

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

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

Senator Woodhouse moved the adoption of the amendment.

Remarks by Senator Woodhouse.

Amendment 693 makes various changes to Senate Bill No. 233. Specifically, it revises the services of the Director of the Department of Health and Human Services must include an estate plan for Medicaid; it authorizes an insurer to use medical-management techniques including step-therapy and prior authorization to determine the frequency of preventative services required by the bill or the type of health-care provider who provides such services; it requires health-insurance plans to cover certain contraceptive drugs; prohibits the use of medical-management techniques to require an insured to use a contraception method other than that prescribed by the health-care provider; it requires an insurer to have a process by which an insured can request an exemption from a medical-management technique required by an insurer to obtain contraception.; it also requires a pharmacist to dispense up to a 12-month supply of contraceptives or the balance of the plan year, whichever is shorter, and it adds Assemblywoman Benitz-Thompson as a sponsor.

Amendment adopted.

The following amendment was proposed by Senator Ratti:

Amendment No. 809.

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

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

Legislative Counsel's Digest:

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

The federal Patient Protection and Affordable Care Act (Public Law 111-148, as amended) requires certain preventative services to be covered by every health insurance plan without any copay, coinsurance or higher deductible, including, without limitation, certain contraceptive drugs, devices and services, certain vaccinations, mammograms, counseling concerning interpersonal and domestic violence, screenings for certain diseases and

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

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

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

Existing law requires this State to develop a State Plan for Medicaid which includes, without limitation, a list of the medical services provided to Medicaid recipients. (42 U.S.C. § 1396a; NRS 422.063) Existing federal law authorizes a state to charge a copay, coinsurance or deductible for most Medicaid services, but prohibits any copay, coinsurance or deductible for certain contraceptive drugs, devices and services. (42 U.S.C. § 1396o-1) Existing federal law also authorizes a state to define the parameters of contraceptive coverage provided under Medicaid. (42 U.S.C. § 1396u-7) Existing law requires a number of specific medical services to be covered under Medicaid.

(NRS 422.2717-422.27241) Sections 2-5.5 of this bill require the State Plan for Medicaid to include the preventative services currently required to be covered by private health insurance plans pursuant to existing Nevada law, the Patient Protection and Affordable Care Act (Public Law 111-148 as amended) as well as the additional drugs, devices, supplies and services required by sections 7, 8 and 11-57 without any copay, coinsurance or deductible in most cases. The benefits relating to contraceptive drugs which are provided by section 2 of this bill are subject to step therapy and prior authorization requirements pursuant to existing law.

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

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~~ :

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

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

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

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

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

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

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

(f) Voluntary sterilization for 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 ~~for device~~ for contraception if the person refuses to accept a therapeutic equivalent of the contraceptive drug ~~for device~~.

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

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

- (a) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;
- (b) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and
- (c) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

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

- (a) Counseling, support and supplies for breastfeeding, including, without limitation, renting or purchasing equipment for breastfeeding, to the extent money is available for this purpose;
- (b) Screening and counseling for interpersonal and domestic violence;
- (c) Counseling for sexually transmitted diseases;
- (d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization, to the extent money is available for this purpose;
- (e) Screening for blood pressure abnormalities and diabetes, including, without limitation, gestational diabetes;
- (f) An annual screening for cervical cancer;
- (g) Screening for depression;
- (h) Screening and counseling for the human immunodeficiency virus;
- (i) Smoking cessation programs, including, without limitation, not more than two cessation attempts per year and four counseling sessions of not more than 10 minutes each;
- (j) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of

the United States Department of Health and Human Services or its successor organization; ~~and~~

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

(l) Hormone replacement therapy.

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

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

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

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

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

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

(1) Every 3 years; or

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

(c) An annual mammogram for women.

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

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

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

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

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

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

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

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

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

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

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

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

422.401 As used in NRS 422.401 to 422.406, inclusive, *and sections 2, 3 and 4 of this act*, unless the context otherwise requires, the words and terms defined in NRS 422.4015 and 422.402 have the meanings ascribed to them in those sections.

Sec. 5.7. NRS 422.406 is hereby amended to read as follows:

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

- (a) Adopt regulations; and
- (b) Enter into contracts for any services.

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

Sec. 6. (Deleted by amendment.)

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

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

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

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

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

charges in relation to contributions collected and benefits provided. The provisions of NRS 687B.408, 689B.030 to 689B.050, inclusive, *and sections 20 and 21 of this act* and 689B.287 apply to coverage provided pursuant to this paragraph.

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 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.

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. ~~{A}~~ *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.

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

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

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

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

7. An insurer may require an insured to:

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

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

8. *As used in this section:*

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

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

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

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

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

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

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

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

(c) *Counseling for sexually transmitted diseases;*

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

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

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

(g) *Screening for depression;*

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

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

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

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

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

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

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

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

(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 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;

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

4. An insurer may require an insured to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 ~~fr~~:

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

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

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

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

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

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

2. ~~[An]~~ Except as otherwise provided in subsection 4, an insurer that offers or issues a policy of health insurance that provides coverage for outpatient care shall not:

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

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses

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

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

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

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

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

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

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

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

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

4. ~~[For the purposes of]~~ 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. 18. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the

Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~[-]~~, and sections 12 and 13 of this act.

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

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

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

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

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

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

(e) *Voluntary sterilization for 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 contraception if the insured refuses to accept a therapeutic equivalent of the contraceptive drug or device.

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

8. 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.

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

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

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

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

(c) Counseling for sexually transmitted diseases;

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

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

(f) An annual screening for cervical cancer;

(g) Screening for depression;

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

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

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

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

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

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

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

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

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

2. ~~[A policy of group health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ 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;*

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

4. ~~[For the purposes of]~~ 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 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;

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

4. An insurer may require an insured to:

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

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

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

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

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

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

~~—(b) Any~~ any type of hormone replacement therapy ~~for~~,

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

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

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

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

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

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

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

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

4. An insurer may require an insured to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~[any of the services listed in subsection 1]~~ *hormone replacement therapy* to an insured.

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

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

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

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

~~—7.—~~ An insurer may require an insured to:

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

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

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

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

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

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

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

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

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

(e) *Voluntary sterilization for women.*

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

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

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

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

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

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

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

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

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

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

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

7. *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.*

8. *As used in this section:*

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

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

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

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

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

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

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

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

(c) *Counseling for sexually transmitted diseases;*

(d) *Hormone replacement therapy;*

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

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

(g) *An annual screening for cervical cancer;*

(h) *Screening for depression;*

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

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

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

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

2. *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;*

(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 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, "provider of health care" has the meaning ascribed to it in NRS 629.031.*

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

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

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

Sec. 33. 1. *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, and any provision of the contract or the renewal which is in conflict with this section is void.

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

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

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

7. A society may require an insured to:

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

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

8. As used in this section:

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

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

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

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

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

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

- (a) Counseling, support and supplies for breastfeeding, including, without limitation, renting or purchasing equipment for breastfeeding;*
- (b) Screening and counseling for interpersonal and domestic violence;*
- (c) Counseling for sexually transmitted diseases;*
- (d) Hormone replacement therapy;*
- (e) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;*
- (f) Screening for blood pressure abnormalities and diabetes, including, without limitation, gestational diabetes;*
- (g) An annual screening for cervical cancer;*
- (h) Screening for depression;*
- (i) Screening and counseling for the human immunodeficiency virus;*
- (j) Smoking cessation programs, including, without limitation, not more than two cessation attempts per year and four counseling sessions of not more than 10 minutes each;*
- (k) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and*
- (l) Such well-woman preventative visits as recommended by the Health Resources and Services Administration.*

2. *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 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 that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any*

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

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

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

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

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

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

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

(d) Education and counseling relating to contraception; and

(e) Voluntary sterilization for women.

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

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

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

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

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

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

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

3. Except as otherwise provided in subsection 4, a contract for hospital or medical service subject to the provisions of this chapter that is delivered,

issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

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

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

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

8. 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.

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

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

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

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

(c) Counseling for sexually transmitted diseases;

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

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

(f) An annual screening for cervical cancer;

(g) Screening for depression;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) An annual cytologic screening test for women ~~[18 years of age or older;]~~ 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 the insurer that the benefit is medically necessary or appropriate for the insured.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~—7.—~~ An insurer may require an insured to:

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

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

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

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

695B.1925 1. ~~{A policy of health insurance issued by a hospital or medical service corporation}~~ An insurer that offers or issues a contract for

hospital or medical service must provide coverage for benefits payable for expenses incurred for ~~administering~~ :

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

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

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

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

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

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

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

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

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:*

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

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

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

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

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

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

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

4. *A health maintenance organization that offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the health maintenance organization objects on religious grounds. Such an organization shall, before*

the issuance of a health care plan and before the renewal of such a plan, provide to the prospective insured written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection.

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

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

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

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;*
- (j) *All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and*
- (k) *Such well-woman preventative visits as recommended by the Health Resources and Services Administration.*

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

- (a) *Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;*
- (b) *Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;*
- (c) *Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any such benefit;*
- (d) *Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;*
- (e) *Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an enrollee; or*
- (f) *Impose any other restrictions or delays on the access of an enrollee to any such benefit.*

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

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

- (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. 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 type of hormone replacement therapy;~~

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

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

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

~~The health maintenance organization shall provide notice to each enrollee, at the time the enrollee receives his or her evidence of coverage, that the health maintenance organization refused to provide coverage pursuant to this subsection.~~

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

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

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

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

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

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

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

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

(d) Penalize a provider of health care who provides ~~{any of the services listed in subsection 1}~~ *hormone replacement therapy* to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~{any of the services listed in subsection 1}~~ *hormone replacement therapy* to an enrollee.

3. ~~{Except as otherwise provided in subsection 5, evidence}~~ Evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

4. ~~{The provisions of this section do not prohibit a health maintenance organization from requiring an enrollee to pay a deductible, copayment or~~

coinsurance for the coverage required by subsection 1 that is the same as the enrollee is required to pay for other outpatient care covered by the plan.

~~—5. A health maintenance organization which offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the health maintenance organization objects on religious grounds. The health maintenance organization shall, before the issuance of a health care plan and before renewal of enrollment in such a plan, provide to the group policyholder or prospective enrollee, as applicable, written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection. The health maintenance organization shall provide notice to each enrollee, at the time the enrollee receives his or her evidence of coverage, that the health maintenance organization refused to provide coverage pursuant to this subsection.~~

~~—6. If a health maintenance organization refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~—7.} A health maintenance organization may require an enrollee to:~~

(a) Participate in a reasonable program of step therapy to obtain coverage for any benefit required by subsection 1.

(b) Obtain prior authorization before obtaining coverage for any benefit required by subsection 1 as part of a determination by the health maintenance organization that the benefit is medically necessary or appropriate for the enrollee.

5. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 50. NRS 695C.1735 is hereby amended to read as follows:

695C.1735 1. A health ~~{maintenance}~~ care plan of a health maintenance organization must provide coverage for benefits payable for expenses incurred for:

(a) An annual cytologic screening test for women ~~{18 years of age or older;}~~ between the ages of 21 and 29 years;

(b) ~~{A baseline mammogram for women between the ages of 35 and 40;}~~ A cytologic screening test for women between the ages of 30 and 65 years:

(1) Every 3 years; or

(2) Every 5 years if carried out at the same time as testing for human papillomavirus; and

(c) An annual mammogram for women . ~~{40 years of age or older.}~~

2. ~~{A health maintenance plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.}~~ Except as otherwise provided in subsection 4, a health maintenance organization that offers or issues a health care plan shall not:

(a) Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any benefit provided in the health care plan pursuant to subsection 1;

(d) Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an enrollee; or

(f) Impose any other restrictions or delays on the access of an enrollee to any such benefit.

3. A ~~policy~~ health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~October 1, 1989,~~ January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the ~~policy~~ plan or the renewal which is in conflict with subsection 1 is void.

4. A health maintenance organization may require an enrollee to:

(a) Participate in a reasonable program of step therapy to obtain coverage for any benefit required by subsection 1.

(b) Obtain prior authorization before obtaining coverage for any benefit required by subsection 1 as part of a determination by the health maintenance organization that the benefit is medically necessary or appropriate for the enrollee.

5. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 51. NRS 695C.1745 is hereby amended to read as follows:

695C.1745 1. A health care plan of a health maintenance organization must provide coverage for benefits payable for expenses incurred for ~~administering~~:

(a) Deoxyribonucleic acid testing for high-risk strains of human papillomavirus; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. ~~[A health care plan of a health maintenance organization must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.] Except as otherwise provided in subsection 4, a health maintenance organization that offers or issues a health care plan shall not:~~

(a) *Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;*

(b) *Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;*

(c) *Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any such benefit;*

(d) *Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;*

(e) *Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an enrollee; or*

(f) *Impose any other restrictions or delays on the access of an enrollee to any such benefit.*

3. Any evidence of coverage subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with subsection 1 is void.

4. ~~{For the purposes of}~~ 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 ~~{, "human"}~~:

(a) *"Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.*

(b) *"Provider of health care" has the meaning ascribed to it in NRS 629.031.*

Sec. 52. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if the Commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140,

unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, *and sections 45 and 46 of this act* or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The Commissioner certifies that the health maintenance organization:

(1) Does not meet the requirements of subsection 1 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or

solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 53. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 54, 55 and 56 of this act.

Sec. 54. 1. *Except as otherwise provided in subsection 4, a managed care organization that offers or issues a health care plan shall include in the plan coverage for:*

(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; and*

(f) *Hormone replacement therapy.*

2. *Except as otherwise provided in subsections 5, 6 and 7, 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.*

3. *Except as otherwise provided in subsection 4, 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 that offers or issues a health care plan and which is affiliated with a religious organization is not required to provide*

the coverage required by subsection 1 if the managed care organization objects on religious grounds. Such an organization shall, before the issuance of a health care plan and before the renewal of such a plan, provide to the prospective insured written notice of the coverage that the managed care organization refuses to provide pursuant to this subsection.

5. A managed care organization may require an insured to pay a higher deductible, copayment or coinsurance for a drug or device for contraception if the insured refuses to accept a therapeutic equivalent of the contraceptive drug or device.

6. For each method of contraception which is approved by the Food and Drug Administration, a health care plan must include at least one contraceptive drug or device for which no deductible, copayment or coinsurance may be charged to the insured, but the managed care organization may charge a deductible, copayment or coinsurance for any other contraceptive drug or device that provides the same method of contraception.

7. 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.

8. As used in this section:

(a) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(b) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug;

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 55. 1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:

(a) Counseling, support and supplies for breastfeeding, including, without limitation, renting or purchasing equipment for breastfeeding;

(b) Screening and counseling for interpersonal and domestic violence;

(c) Counseling for sexually transmitted diseases;

(d) Hormone replacement therapy;

(e) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(f) Screening for blood pressure abnormalities and diabetes, including, without limitation, gestational diabetes;

(g) Screening for cervical cancer on an annual basis;

(h) Screening for depression;
(i) Screening and counseling for the human immunodeficiency virus;
(j) Smoking cessation programs, including, without limitation, not more than two cessation attempts per year and four counseling sessions of not more than 10 minutes each;
(k) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and

(l) Such well-woman preventative visits as recommended by the Health Resources and Services Administration.

2. Except as otherwise provided in subsection 4, a managed care organization that offers or issues a health care plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

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. 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.

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, 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. *An evidence of coverage for a health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007.]~~ January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal thereof which is in conflict with subsection 1 is void.*

4. ~~[For the purposes of]~~ *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 ~~[- "human"]~~ :*

(a) *"Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by*

the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 58. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 59. This act becomes effective on January 1, 2018.

Senator Ratti moved the adoption of the amendment.

Remarks by Senator Ratti.

Amendment No. 809 to Senate Bill No. 233 is a minor amendment that adds a bit more flexibility to Medicaid in their adoption of the State plan.

Amendment adopted.

Bill read third time.

Remarks by Senators Ratti and Kieckhefer.

SENATOR RATTI:

I am extremely proud to bring forward Senate Bill No. 233, which will ensure that woman in Nevada, have access to the preventative health care that is so important to their quality of life. This bill ensures that the provisions of the Affordable Care Act specifically that relate to women's preventive health are codified in State law. It adds one new piece of protection for woman, which is what is known as 12-month contraception. We know that in our busy lives sometimes it's not easy to get back to the pharmacists to pick up your prescriptions. In some case the insurance company will only dispense 3 months even though a doctor has prescribed 12 months. So, what this allows for is an initial 3 month dispensing so that we can make sure that that is the right pharmaceutical for the patient and then it allows for a woman to pick up the balance of her contraception on that plan- year and then 12-months thereafter if it's the same contraception on the same plan.

Again, this bill makes sure that there is access to preventative screenings like cervical exams, mammograms, hormone replacement therapy, domestic violence counseling. Basically, all things that are currently covered in the Affordable Care Act. I think is it critically important that women maintain access to these services. When woman are healthier Nevada is healthier.

SENATOR KIECKHEFER:

I rise in opposition to Senate Bill No. 233. This bill takes a lot of the Affordable Care Act mandates and puts them into State mandates. It also requires that the State cover the non-federal share of any Medicaid expenses that are now mandated under this bill. If the feds change their requirements and stop paying for certain coverages which we may now be getting reimbursed for at 90 percent, we would go down to zero reimbursement, and that would have a dramatic effect on our Medicaid budget on a go-forward basis. The idea that we are going to pick full cost when there may be no cost sharing from the feds is untenable in my mind so I am opposed.

SENATOR RATTI:

I appreciate the remarks from my colleague. I did a lot of work to make sure there was no fiscal note on this bill. I acknowledge there are things in the future that may change and over which we have no control. If there are significant changes to federal policy, we will probably all be back here taking a comprehensive look at healthcare in Nevada. In the meantime, I want to make sure women are protected.

Roll call on Senate Bill No. 233:

YEAS—13.

NAYS—Goicoechea, Gustavson, Hammond, Hardy, Harris, Kieckhefer, Roberson, Settelmeyer—8.

Senate Bill No. 233 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

REPORTS OF COMMITTEES

Mr. President:

Your Committee on Transportation, to which were referred Assembly Bills Nos. 233, 261, 334, 364, has had the same under consideration, and begs leave to report the same back with the recommendation: Do pass.

MARK A. MANENDO, *Chair*

SECOND READING AND AMENDMENT

Senate Bill No. 203.

Bill read second time.

The following amendment was proposed by the Committee on Judiciary:
Amendment No. 699.

SUMMARY—Revises provisions relating to domestic corporations.
(BDR 7-71)

AN ACT relating to business associations; expressing the intent of the Legislature concerning the law of domestic corporations; ~~requiring attorneys to verify that they have read certain relevant statutes before filing a complaint for certain causes of action relating to domestic corporations;~~ revising the presumption against negligence for the actions of corporate directors and officers; clarifying the factors that may be considered by corporate directors and officers in the exercise of their respective powers; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Under existing law, with certain exceptions, a director or officer of a domestic corporation is presumed not to be individually liable to the corporation or its stockholders or creditors for damages unless: (1) an act or failure to act of the director or officer was a breach of his or her fiduciary duties; and (2) such breach involved intentional misconduct, fraud or a knowing violation of law. (NRS 78.138)

~~[Section 4 of this bill provides that evidence of simple negligence is insufficient to rebut this presumption.]~~ Section 4 ~~[additionally]~~ of this bill specifies that ~~[a rebuttal of this presumption is insufficient]~~ to establish liability on the part of a corporate director or officer ~~[, and instead]~~ requires : (1) a rebuttal of this presumption; and (2) a breach of a fiduciary duty accompanied by intentional misconduct, ~~factual~~ fraud or a knowing violation of law. Sections 4 and 5 of this bill clarify the factors that a director or officer of a domestic corporation is entitled to consider in exercising his or her respective powers in certain circumstances, including, without limitation, resisting a change or potential change in the control of a corporation.

Section 2 of this bill expresses the intent of the Legislature regarding the law of domestic corporations, including that the laws of other jurisdictions must not supplant or modify Nevada law. ~~[Section 3 of this bill requires a plaintiff to verify that he or she has read certain statutes (NRS 78.138, 78.139)]~~

~~pertaining to the duties and powers of corporate directors and officers before filing a complaint that alleges a breach of a fiduciary duty or seeks to enforce a right of a shareholder against a domestic corporation.]~~

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 78 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. *The Legislature hereby finds and declares that:*

1. *It is important to the economy of this State, and to domestic corporations, ~~and~~ their directors ~~and~~ and officers, and their stockholders, employees, ~~and~~ creditors ~~and~~ and other constituencies, for the laws governing domestic corporations to be clear and comprehensible, ~~without the need for undue or inappropriate reliance on judicial decisions.]~~*

2. *The laws of this State ~~must~~ govern the incorporation and internal affairs of a domestic corporation and the rights, privileges, powers, duties and liabilities, if any, of its directors, officers and stockholders.*

3. *The plain meaning of the laws enacted by the Legislature ~~in this title,~~ including, without limitation, the fiduciary duties and liability of the directors and officers of a domestic corporation set forth in NRS 78.138 and 78.139, must not be supplanted or modified ~~and relying on the~~ by laws or judicial decisions from any other jurisdiction, ~~is contrary to the specific intent of the Legislature.]~~*

4. ~~[Except in the limited circumstances set forth in NRS 78.139, an exercise of the respective powers of directors or officers of a domestic corporation, including, without limitation, in circumstances involving a change or potential change in control of a corporation, is not subject to a heightened standard of review.]~~

~~5. The standards promulgated by the Supreme Court of Delaware in *Unocal Corporation v. Mesa Petroleum Co.*, 493 A.2d 946 (Del. 1985), and *Revlon, Inc. v. MacAndrews & Forbes Holdings, Inc.*, 506 A.2d 173 (Del. 1986), and their progeny have been, and are hereby, rejected by the Legislature.~~

~~6.]~~ The directors and officers of a domestic corporation, in exercising their duties under NRS 78.138 and 78.139, may be informed by the laws and judicial decisions of other jurisdictions and the practices observed by business entities in any such jurisdiction, but the failure or refusal of a director or officer to consider, or to conform the exercise of his or her powers to, the laws, judicial decisions or practices of another jurisdiction does not constitute or indicate a breach of a fiduciary duty.

Sec. 3. ~~[1. In an action involving or relating to a domestic corporation that is subject to the provisions of NRS 41.520 or alleges a breach of a fiduciary duty by a director or officer of a domestic corporation, the complaint must be verified by oath and must aver that each plaintiff named in the action has read the provisions of NRS 78.138 and 78.139 and section 2 of this act in their entirety.]~~

~~2. A court shall give each plaintiff leave to amend the complaint to comply with the requirements of this section, and a dismissal for failure to comply with this section must not operate as an adjudication upon the merits.~~

~~3. The period in which any defendant must file an answer or other responsive pleading with the court commences only upon compliance with this section by all plaintiffs named in the action.~~ (Deleted by amendment.)

Sec. 4. NRS 78.138 is hereby amended to read as follows:

78.138 1. ~~{Directors}~~ The fiduciary duties of directors and officers ~~{shall}~~ are to exercise their respective powers in good faith and with a view to the interests of the corporation.

2. In ~~{performing}~~ exercising their respective ~~{duties,}~~ powers, directors and officers may, and are entitled to, rely on information, opinions, reports, books of account or statements, including financial statements and other financial data, that are prepared or presented by:

(a) One or more directors, officers or employees of the corporation reasonably believed to be reliable and competent in the matters prepared or presented;

(b) Counsel, public accountants, financial advisers, valuation advisers, investment bankers or other persons as to matters reasonably believed to be within the preparer's or presenter's professional or expert competence; or

(c) A committee on which the director or officer relying thereon does not serve, established in accordance with NRS 78.125, as to matters within the committee's designated authority and matters on which the committee is reasonably believed to merit confidence,

↳ but a director or officer is not entitled to rely on such information, opinions, reports, books of account or statements if the director or officer has knowledge concerning the matter in question that would cause reliance thereon to be unwarranted.

3. ~~{Directors}~~ Except as otherwise provided in subsection 1 of NRS 78.139, directors and officers in deciding upon matters of business, are presumed to act in good faith, on an informed basis and with a view to the interests of the corporation. ~~{Simple negligence, alone, is insufficient to rebut this presumption. As provided in subsection 6, rebuttal of this presumption, alone, is also insufficient to establish the individual liability of a}~~ A director or officer is not individually liable for damages as a result of an act or failure to act in his or her capacity as a director or officer ~~if~~ except under circumstances described in subsection 7.

4. Directors and officers, in exercising their respective powers with a view to the interests of the corporation, may ~~consider, and are entitled, but not required to,~~

(a) Consider all relevant facts, circumstances, contingencies or constituencies, including, without limitation:

(1) The interests of the corporation's employees, suppliers, creditors ~~{and}~~ or customers;

~~{(b)}~~ (2) The economy of the State ~~{and}~~ or Nation;

~~[(c)]~~ (3) The interests of the community ~~and~~ or of society; ~~and~~
~~—(d)]~~ (4) The long-term ~~as well as~~ or short-term interests of the corporation
~~and its~~, including the possibility that these interests may be best served by
the continued independence of the corporation; or

(5) The long-term or short-term interests of the corporation's
stockholders, including the possibility that these interests may be best served
by the continued independence of the corporation.

(b) Consider or assign weight to the interests of any particular person or
group, or to any other relevant facts, circumstances, contingencies or
constituencies.

5. Directors and officers are not required to consider, as a dominant
factor, the effect of a proposed corporate action upon any particular group or
constituency having an interest in the corporation. ~~as a dominant factor.~~

6. ~~[(b) Consider or assign weight to the interests of any particular person
or group, or to any other relevant facts, circumstances, contingencies or
constituencies.]~~

~~—5.]~~ The provisions of subsections 4 and 5 ~~subsection 4~~ do not create or
authorize any causes ~~cause~~ of action against the corporation or its directors
or officers.

7. ~~#6.]~~ Except as otherwise provided in NRS 35.230, 90.660, 91.250,
452.200, 452.270, 668.045 and 694A.030, or unless the articles of
incorporation or an amendment thereto, in each case filed on or after
October 1, 2003, provide for greater individual liability, a director or officer is
not individually liable to the corporation or its stockholders or creditors for
any damages as a result of any act or failure to act in his or her capacity as a
director or officer unless ~~it~~:

(a) ~~The court~~ trier of fact determines that the presumption established by
subsection 3 has been rebutted; and

(b) It is proven that:

~~[(a)]~~ (1) The director's or officer's act or failure to act constituted a breach
of his or her fiduciary duties as a director or officer; and

~~[(b)]~~ The

(2) Such breach ~~of those duties~~ involved intentional misconduct,
~~factual~~ fraud or a knowing violation of law.

~~#7.]~~ 8. This section applies to all cases, circumstances and matters unless
otherwise provided in the articles of incorporation, or an amendment thereto,
including, without limitation, any change or potential change in control of the
corporation.

Sec. 5. NRS 78.139 is hereby amended to read as follows:

78.139 1. ~~Except as otherwise provided in subsection 2 or the articles
of incorporation, directors and officers, in connection with a change or
potential change in control of the corporation, have:~~

~~—(a) The duties imposed upon them by subsection 1 of NRS 78.138;~~

~~—(b) The benefit of the presumptions established by subsection 3 of
NRS 78.138; and~~

~~—(e) The prerogative to undertake and act upon consideration pursuant to subsections 2, 4 and 5 of NRS 78.138.~~

~~—2.]~~ If directors or officers take action to resist a change or potential change in control of a corporation, which action impedes the exercise of the right of stockholders to vote for or remove directors:

(a) The directors must have reasonable grounds to believe that a threat to corporate policy and effectiveness exists; and

(b) The action taken which impedes the exercise of the stockholders' rights must be reasonable in relation to that threat.

➤ If those facts are found, the directors and officers have the benefit of the presumption established by subsection 3 of NRS 78.138.

~~{3.}~~ 2. The provisions of subsection ~~{2}~~ 1 do not apply to:

(a) Actions that only affect the time of the exercise of stockholders' voting rights; or

(b) The adoption or signing of plans, arrangements or instruments that deny rights, privileges, power or authority to a holder of a specified number or fraction of shares or fraction of voting power.

~~{4.}~~ 3. The provisions of subsections 1 and 2 ~~{and 3}~~ do not permit directors or officers to abrogate any right conferred by ~~{statute}~~ the laws of this State or the articles of incorporation.

~~{5.—Directors}~~

4. ~~{Except as otherwise provided in}~~ *Without limiting the provisions of NRS 78.138, a director may resist a change or potential change in control of the corporation if the board of directors {by a majority vote of a quorum determine} determines that the change or potential change is opposed to or not in the best interest of the corporation {*

~~—(a) Upon}~~ *upon* consideration of ~~{the interests of the corporation's stockholders or any of the matters set forth in}~~ *any relevant facts, circumstances, contingencies or constituencies pursuant to subsection 4 of NRS 78.138 {*

~~—(b) Because}~~ *, including, without limitation, the amount or nature of the indebtedness and other obligations to which the corporation or any successor to the property of either may become subject, in connection with the change or potential change, provides reasonable grounds to believe that, within a reasonable time:*

~~{{(1)}~~ (a) The assets of the corporation or any successor would be or become less than its liabilities;

~~{{(2)}~~ (b) The corporation or any successor would be or become insolvent; or

~~{{(3)}~~ (c) Any voluntary or involuntary proceeding concerning the corporation or any successor would be commenced by any person pursuant to the federal bankruptcy laws.

~~{ 5. The provisions of subsection 4 do not create or authorize any cause of action against the corporation or its directors or officers. }~~

Sec. 6. ~~[NRS 78.752 is hereby amended to read as follows:~~

~~78.752 1. A corporation may purchase and maintain insurance or make other financial arrangements on behalf of any person who is or was a director, officer, employee or agent of the corporation, or is or was serving at the request of the corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other enterprise for any liability asserted against the person and liability and expenses incurred by the person in his or her capacity as a director, officer, employee or agent, or arising out of his or her status as such, whether or not the corporation has the authority to indemnify such a person against such liability and expenses.~~

~~2. The other financial arrangements made by the corporation pursuant to subsection 1 may include the following:~~

~~(a) The creation of a trust fund.~~

~~(b) The establishment of a program of self insurance.~~

~~(c) The securing of its obligation of indemnification by granting a security interest or other lien on any assets of the corporation.~~

~~(d) The establishment of a letter of credit, guaranty or surety.~~

~~➤ No financial arrangement made pursuant to this subsection may provide protection for a person adjudged by a court of competent jurisdiction, after exhaustion of all appeals therefrom, to be liable for intentional misconduct, actual fraud or a knowing violation of law, except with respect to the advancement of expenses or indemnification ordered by a court.~~

~~3. Any insurance or other financial arrangement made on behalf of a person pursuant to this section may be provided by the corporation or any other person approved by the board of directors, even if all or part of the other person's stock or other securities is owned by the corporation.~~

~~4. In the absence of fraud:~~

~~(a) The decision of the board of directors as to the propriety of the terms and conditions of any insurance or other financial arrangement made pursuant to this section and the choice of the person to provide the insurance or other financial arrangement is conclusive; and~~

~~(b) The insurance or other financial arrangement:~~

~~(1) Is not void or voidable; and~~

~~(2) Does not subject any director approving it to personal liability for his or her action,~~

~~➤ even if a director approving the insurance or other financial arrangement is a beneficiary of the insurance or other financial arrangement.~~

~~5. A corporation or its subsidiary which provides self insurance for itself or for another affiliated corporation pursuant to this section is not subject to the provisions of title 57 of NRS.] (Deleted by amendment.)~~

Sec. 7. ~~[NRS 41.520 is hereby amended to read as follows:~~

~~41.520 1. As used in this section "corporation" includes an unincorporated association, and "board of directors" includes the managing body of an unincorporated association.~~

~~2. In an action brought to enforce a secondary right on the part of one or more shareholders in a corporation or association, incorporated or unincorporated, because the corporation or association refuses to enforce rights which may properly be asserted by it, the complaint must [be]:~~

~~(a) Be verified by oath and must aver that the plaintiff was a shareholder at the time of the transaction of which the plaintiff complains or that the plaintiff's share thereafter devolved on the plaintiff by operation of law [; The complaint must also set]:~~

~~(b) Set forth with particularity the efforts of the plaintiff to secure from the board of directors or trustees and, if necessary, from the shareholders such action as the plaintiff desires, and the reasons for the plaintiff's failure to obtain such action or the reasons for not making such effort [;]; and~~

~~(c) Comply with the provisions of section 3 of this act.~~

~~3. In any such action, at any time within 30 days after service of summons upon the corporation or any defendant who is an officer or director of the corporation, or held such office at the time of the acts complained of, the corporation or such defendant may move the court for an order, upon notice and hearing, requiring the plaintiff to furnish security as hereinafter provided. Such motion must be based upon one or more of the following grounds:~~

~~(a) That there is no reasonable possibility that the prosecution of the cause of action alleged in the complaint against the moving party will benefit the corporation or its security holders.~~

~~(b) That the moving party, if other than the corporation, did not participate in the transaction complained of in any capacity.~~

~~4. The court on application of the corporation or any defendant may, for good cause shown, extend the 30 day period for an additional period or periods not exceeding 60 days.~~

~~4. At the hearing upon such motion, the court shall consider such evidence, written or oral, by witnesses or affidavit, as may be material:~~

~~(a) To the ground or grounds upon which the motion is based; or~~

~~(b) To a determination of the probable reasonable expenses, including attorney's fees, of the corporation and the moving party which will be incurred in the defense of the action. If the court determines, after hearing the evidence adduced by the parties at the hearing, that the moving party has established a probability in support of any of the grounds upon which the motion is based, the court shall fix the nature and amount of security to be furnished by the plaintiff for reasonable expenses, including attorney's fees, which may be incurred by the moving party and the corporation in connection with such action, including expenses which the corporation may incur by reason of any obligation which it may have to indemnify its officers or directors pursuant to NRS 78.7502 or otherwise. A determination by the court that security either must or must not be furnished or must be furnished as to one or more defendants and not as to others shall not be deemed a determination of any one or more issues in the action or of the merits thereof. The corporation and the moving party have recourse to the security in such amount as the court~~

~~determines upon the termination of the action. The amount of the security may thereafter from time to time be increased or decreased in the discretion of the court upon showing that the security provided has or may become inadequate or is excessive. If the court, upon any such motion, makes a determination that security must be furnished by the plaintiff as to any one or more defendants, the action must be dismissed as to such defendant or defendants, unless the security required by the court is furnished within such reasonable time as may be fixed by the court.~~

~~5. If any such motion is filed, no pleadings need be filed by the corporation or any other defendants, and the prosecution of the action must be stayed, until 10 days after the motion has been disposed of.] (Deleted by amendment.)~~

Senator Segerblom moved the adoption of the amendment.

Remarks by Senator Segerblom.

Amendment No. 699 to Senate Bill No. 203 deletes language requiring that an attorney must verify having read relevant statutes before filing a complaint for certain causes of action related to domestic corporations. It also revises section 4 of the bill to provide that in order to establish liability on the part of a corporate director or officer one must rebut the statutory presumption that liability does not exist; adds new language to the bill providing that a director or officer may take into consideration or assign weight to, among other factors, the interests of any particular person or group, relevant facts or circumstances, contingencies or constituencies in deciding matters of business, but provides that these are not required to be considered as dominant factors, and deletes sections 6 and 7 from the bill in their entirety.

Amendment adopted.

Bill ordered reprinted, engrossed and to third reading.

Assembly Bill No. 233.

Bill read second time and ordered to third reading.

Assembly Bill No. 261.

Bill read second time and ordered to third reading.

Assembly Bill No. 334.

Bill read second time and ordered to third reading.

Assembly Bill No. 364.

Bill read second time and ordered to third reading.

GENERAL FILE AND THIRD READING

Senate Bill No. 265.

Bill read third time.

The following amendment was proposed by the Committee on Finance:

Amendment No. 736.

SUMMARY—Revises provisions relating to prescription drugs.
(BDR 40-809)

AN ACT relating to prescription drugs; requiring the Department of Health and Human Services to compile a list of prescription drugs essential for treating diabetes in this State; requiring the manufacturer of a prescription drug included on the list to report certain information to the Department; requiring

a manufacturer to notify the Department in advance of planned price increases for such drugs; requiring a manufacturer of prescription drugs to submit a list of each pharmaceutical sales representative who markets prescription drugs to certain persons in this State; prohibiting a pharmaceutical sales representative who is not included on such a list from marketing prescription drugs on behalf of a manufacturer; requiring each pharmaceutical sales representative included on such a list to report certain information to the Department; requiring certain nonprofit organizations to report to the Department certain information concerning contributions received from drug manufacturers or trade and advocacy groups for such manufacturers; requiring the Department to place certain information on its Internet website; authorizing the Department to impose an administrative penalty in certain circumstances; ~~requiring a pharmaceutical sales representative to obtain a license from the Division of Public and Behavioral Health of the Department;~~ requiring a private school to allow a pupil to keep and self-administer certain drugs; requiring certain insurers to provide certain notice to insureds; providing a penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Department of Health and Human Services to compile and post on its Internet website information relating to the prices charged for certain prescription drugs. (NRS 439.915) Section 6 of this bill requires the Department to annually compile and post on its Internet website a list of drugs that the Department determines to be essential for treating diabetes in this State, including the wholesale acquisition cost of such a drug. Section 7 of this bill requires the manufacturer of a prescription drug included on the list to submit to the Department an annual report that contains certain information concerning the cost of the drug. Section 7 also requires the Department to compile and post on its Internet website a report concerning the prices of the essential diabetes drugs included on the list and the effect of those prices on overall spending on health care in this State. Section 27.5 of this bill further excludes the information reported by the manufacturer from the definition of "trade secret." Section 9 of this bill requires a nonprofit organization that advocates for patients or funds medical research in this State to post on its Internet website or, if it does not maintain an Internet website, submit to the Department certain information concerning payments, donations and anything else of value that the organization receives from manufacturers of prescription drugs or trade or advocacy groups for such manufacturers. Section 8 of this bill requires the manufacturer of a prescription drug included on the list of essential diabetes drugs to notify the Department at least 90 days before a planned price increase. Section 12 of this bill requires the Department to place the information submitted by nonprofit organizations, information submitted by manufacturers concerning planned price increases and certain additional information on the Internet website maintained by the Department. Section 13 of this bill provides that the Department is not liable for any act, omission, error or technical problem that results in the failure to provide information or

the provision of any incorrect information placed on the Internet website of the Department. Section 14 of this bill requires the Department to adopt any necessary regulations concerning the reporting of information by manufacturers and nonprofit organizations for inclusion on the Internet website of the Department. Section 16 of this bill authorizes the Department to impose an administrative penalty on a manufacturer or nonprofit organization that fails to post or submit required information. Section 30 of this bill requires an insurer that issues a plan of individual health insurance and uses a formulary to provide, during each open enrollment period, a notice of any drugs on the list of essential diabetes drugs that have been removed from the formulary or will be removed from the formulary during the current plan year or the next plan year.

~~[Under existing law, the Division of Public and Behavioral Health of the Department of Health and Human Services licenses and regulates certain health care facilities and organizations that provide health care. (Chapter 449 of NRS) Sections 17-24 of this bill require the Division to also license and regulate pharmaceutical sales representatives. Section 19 of this bill makes it a misdemeanor to practice as a pharmaceutical sales representative in this State without a license. Section 23 of this bill requires a pharmaceutical sales representative to submit an annual report to the Division containing certain information about his or her activities.]~~

Section 8.5 of this bill requires a manufacturer to provide to the Department a list of each pharmaceutical sales representative who markets prescription drugs to providers of health care, pharmacies, medical facilities and insurers in this State on behalf of the manufacturer. Section 8.5 also prohibits: (1) a person who is not included on such a list from marketing prescription drugs on behalf of a manufacturer to providers of health care, pharmacies, medical facilities and insurers; and (2) a provider of health care, pharmacy, medical facility or insurer from communicating about prescription drugs with a person who is marketing prescription drugs on behalf of a manufacturer unless the person is included on such a list. Additionally, section 8.5 requires each pharmaceutical sales representative who is included on such a list to submit an annual report to the Department. Finally, section 8.5 requires the Department to compile an annual report based on the information submitted by pharmaceutical sales representatives. Section 16 authorizes the Department to impose an administrative penalty against a manufacturer or pharmaceutical sales representative who fails to provide the required information.

Upon the submission of a written request, existing law requires a public school to allow a pupil who has asthma, anaphylaxis or diabetes to carry and self-administer medication to treat his or her disorder while the pupil is on the grounds of a public school, participating in an activity sponsored by a public school or on a school bus. (NRS 392.425) Willful failure to carry out this requirement is grounds for suspending, demoting, dismissing or refusing to reemploy a teacher or administrator. (NRS 391.750) Section 27 of this bill: (1)

imposes similar requirements for private schools; and (2) makes a willful violation of those requirements a misdemeanor.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 439 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 9, inclusive, of this act.

Sec. 2. *"Manufacturer" means a person who derives, produces, prepares, cultivates, grows or processes a prescription drug.*

Sec. 3. *"Pharmacy" means every store or shop licensed by the State Board of Pharmacy where drugs, controlled substances, poisons, medicines or chemicals are stored or possessed, or dispensed or sold at retail, or displayed for sale at retail, or where prescriptions are compounded or dispensed. The term does not include an institutional pharmacy as defined in NRS 639.0085.*

Sec. 4. (Deleted by amendment.)

Sec. 5. *"Wholesale acquisition cost" means the manufacturer's list price for a prescription drug to wholesalers or direct purchasers in the United States, not including any discounts, rebates or reductions in price, as reported in wholesale price guides or other publications of drug pricing data.*

Sec. 6. *On or before February 1 of each year, the Department shall compile a list of prescription drugs that the Department determines to be essential for treating diabetes in this State and the wholesale acquisition cost of each such drug on the list. The list must include, without limitation, all forms of insulin and biguanides marketed for sale in this State.*

Sec. 7. 1. *On or before April 1 of each year, the manufacturer of a prescription drug that appears on the most current list compiled by the Department pursuant to section 6 of this act shall prepare and submit to the Department, in the form prescribed by the Department, a report which must include:*

(a) The total cost of research and development for the drug, including, without limitation, any cost for research and development incurred with respect to the drug by a predecessor entity of the manufacturer;

(b) Any other costs of producing the drug;

(c) The total administrative expenditures relating to the drug, including marketing and advertising costs;

(d) The profit that the manufacturer has earned from the drug and the percentage of the manufacturer's total profit attributable to the drug;

(e) The total amount of financial assistance that the manufacturer has provided through any patient prescription assistance program;

(f) The cost associated with coupons provided directly to consumers and for programs to assist consumers in paying copayments, and the cost to the manufacturer attributable to the redemption of those coupons and the use of those programs;

(g) The wholesale acquisition cost of the drug;

(h) A history of any increases in the wholesale acquisition cost of the drug over the 5 years immediately preceding the date on which the report is

submitted, including the amount of each such increase expressed as a percentage of the total wholesale acquisition cost of the drug, the month and year in which each increase became effective and any explanation for the increase;

(i) The aggregate amount of all rebates that the manufacturer has provided to pharmacy benefit managers for sales of the drug within this State; and

~~[(i)]~~ (j) Any additional information prescribed by regulation of the Department for the purpose of analyzing the cost of prescription drugs that appear on the list compiled pursuant to section 6 of this act, trends in those costs and rebates available for such drugs.

2. On or before June 1 of each year, the Department shall analyze the information submitted pursuant to subsection 1 and compile and post on the Internet website maintained by the Department a report on the price of the prescription drugs that appear on the most current list compiled by the Department pursuant to section 6 of this act and the effect of those prices on overall spending on prescription drugs in this State. The report may include, without limitation, opportunities for persons and entities in this State to lower the cost of drugs for the treatment of diabetes while maintaining access to such drugs.

3. As used in this section, "pharmacy benefit manager" means a person or entity that contracts to administer the prescription drug coverage of any insurer or organization that provides health coverage or benefits in accordance with federal law or the law of this State.

Sec. 8. At least 90 days before increasing the wholesale acquisition cost of a prescription drug included on the list compiled by the Department pursuant to section 6 of this act, the manufacturer of the drug shall notify the Department of the planned price increase.

Sec. 8.5. 1. A manufacturer shall provide to the Department a list of each pharmaceutical sales representative who markets prescription drugs on behalf of the manufacturer to providers of health care licensed, certified or registered in this State, pharmacies or employees thereof, operators or employees of medical facilities or persons licensed or certified under the provisions of title 57 of NRS and update the list at least once each month.

2. The Department shall provide electronic access to the most recent list provided by each manufacturer pursuant to subsection 1 to each provider of health care licensed, certified or registered in this State, operator of a pharmacy, operator of a medical facility or person licensed or certified under the provisions of title 57 of NRS to ensure compliance with the requirements of subsection 4.

3. A pharmaceutical sales representative who is not included on a current list submitted pursuant to subsection 1 shall not market prescription drugs on behalf of a manufacturer:

(a) To any provider of health care licensed, certified or registered in this State, pharmacy or employee thereof, operator or employee of a medical

facility or person licensed or certified under the provisions of title 57 of NRS;
or

(b) For sale to any resident of this State.

4. A provider of health care licensed, certified or registered in this State, pharmacy or employee thereof, operator or employee of a medical facility or person licensed or certified under the provisions of title 57 of NRS shall not communicate about prescription drugs with a pharmaceutical sales representative who is marketing prescription drugs on behalf of a manufacturer unless the pharmaceutical sales representative is included on a current list submitted pursuant to subsection 1.

5. On or before March 1 of each year, each pharmaceutical sales representative who was included on a list of pharmaceutical sales representatives submitted pursuant to subsection 1 at any time during the immediately preceding calendar year shall submit to the Department a report, which must include, for the immediately preceding calendar year:

(a) A list of providers of health care licensed, certified or registered in this State, pharmacies and employees thereof, operators and employees of medical facilities and persons licensed or certified under the provisions of title 57 of NRS whom the pharmaceutical sales representative contacted;

(b) The name and manufacturer of each prescription drug for which the pharmaceutical sales representative provided a free sample to a provider of health care licensed, certified or registered in this State, pharmacy or employee thereof, operator or employee of a medical facility or person licensed or certified under the provisions of title 57 of NRS and the name of each such person to whom a free sample was provided; and

(c) The name of each provider of health care licensed, certified or registered in this State, pharmacy or employee thereof, operator or employee of a medical facility or person licensed or certified under the provisions of title 57 of NRS to whom the pharmaceutical sales representative provided anything of value, including, without limitation, any gift, food or free supplies, and the value of such items.

6. The Department shall analyze annually the information submitted pursuant to subsection 5 and compile a report on the activities of pharmaceutical sales representatives in this State. On or before June 1 of each year, the Department shall:

(a) Post the report on the Internet website maintained by the Department; and

(b) Submit the report to the Governor and the Director of the Legislative Counsel Bureau for transmittal to the Legislative Committee on Health Care and, in even-numbered years, the next regular session of the Legislature.

7. Except as otherwise provided in subsection 2, each list submitted to the Department pursuant to subsection 1 and each report submitted by a pharmaceutical sales representative pursuant to subsection 5 is confidential.

8. As used in this section:

(a) "Medical facility" has the meaning ascribed to it in NRS 629.026.

(b) "Pharmaceutical sales representative" means a person who markets prescription drugs to providers of health care licensed, certified or registered in this State, pharmacies or employees thereof, operators or employees of medical facilities or persons licensed or certified under the provisions of title 57 of NRS.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 9. On or before February 1 of each year, a nonprofit organization that advocates on behalf of patients or funds medical research in this State and has received a payment, donation, subsidy or anything else of value from a manufacturer or a trade or advocacy group for manufacturers during the immediately preceding calendar year shall:

1. Compile a report which includes:

(a) For each such contribution, the amount of the contribution and the manufacturer or group that provided the payment, donation, subsidy or other contribution; and

(b) The percentage of the total gross income of the organization during the immediately preceding calendar year attributable to payments, donations, subsidies or other contributions from each manufacturer or group; and

2. Except as otherwise provided in this subsection, post the report on an Internet website that is maintained by the nonprofit organization and accessible to the public. If the nonprofit organization does not maintain an Internet website that is accessible to the public, the nonprofit organization shall submit the report compiled pursuant to subsection 1 to the Department.

Sec. 10. ~~[NRS 439.150 is hereby amended to read as follows:~~

~~439.150 1. The State Board of Health is hereby declared to be supreme in all nonadministrative health matters. It has general supervision over all matters, except for administrative matters and as otherwise provided in NRS 439.950 to 439.983, inclusive, relating to the preservation of the health and lives of citizens of this State and over the work of the Chief Medical Officer and all district, county and city health departments, boards of health and health officers.~~

~~2. The Department is hereby designated as the agency of this State to cooperate with the federal authorities in the administration of those parts of the Social Security Act which relate to the general promotion of public health. It may receive and expend all money made available to the Division by the Federal Government, the State of Nevada or its political subdivisions, or from any other source, for the purposes provided in this chapter. In developing and revising any state plan in connection with federal assistance for health programs, the Department shall consider, without limitation, the amount of money available from the Federal Government for those programs, the conditions attached to the acceptance of that money and the limitations of legislative appropriations for those programs.~~

~~3. Except as otherwise provided in NRS 576.128 [,] and section 19 of this act, the State Board of Health may set reasonable fees for the~~

~~— (a) Licensing, registering, certifying, inspecting or granting of permits for any facility, establishment or service regulated by the Division;~~

~~— (b) Programs and services of the Division;~~

~~— (c) Review of plans; and~~

~~— (d) Certification and licensing of personnel.~~

~~→ Fees set pursuant to this subsection must be calculated to produce for that period the revenue from the fees projected in the budget approved for the Division by the Legislature. (Deleted by amendment.)~~

Sec. 11. NRS 439.900 is hereby amended to read as follows:

439.900 As used in NRS 439.900 to 439.940, inclusive, *and sections 2 to 9, inclusive, of this act*, unless the context otherwise requires, ~~["pharmacy" means every store or shop licensed by the State Board of Pharmacy where drugs, controlled substances, poisons, medicines or chemicals are stored or possessed, or dispensed or sold at retail, or displayed for sale at retail, or where prescriptions are compounded or dispensed. The term does not include an institutional pharmacy as defined in NRS 639.0085.]~~ *the words and terms defined in sections 2 to 5, inclusive, of this act have the meanings ascribed to them in those sections.*

Sec. 12. NRS 439.915 is hereby amended to read as follows:

439.915 1. Except as otherwise provided in subsection 2, the Department shall:

(a) Place or cause to be placed on the Internet website maintained by the Department ~~the~~ :

(1) *The list of essential diabetes drugs compiled by the Department pursuant to section 6 of this act;*

(2) *The wholesale acquisition cost of each prescription drug reported pursuant to section 7 of this act;*

(3) *The name of each drug for which the manufacturer has notified the Department of a planned increase in the wholesale acquisition cost of the drug pursuant to section 8 of this act; and*

(4) *The information provided by each pharmacy pursuant to NRS 439.910 ~~[-]~~ and each nonprofit organization that is required to submit a report pursuant to section 9 of this act;*

(b) Ensure that the information ~~provided by each pharmacy pursuant to NRS 439.910 and~~ placed on the Internet website maintained by the Department pursuant to paragraph (a) is organized so that each individual pharmacy, manufacturer and nonprofit organization has its own separate entry on that website; ~~and~~

(c) *Ensure that the information described in subparagraph (3) of paragraph (a) is placed on the Internet website maintained by the Department as soon as practicable after the Department receives the information; and*

(d) Ensure that the usual and customary price that each pharmacy charges for each prescription drug that is on the list prepared pursuant to NRS 439.905 and that is stocked by the pharmacy:

(1) Is presented on the Internet website maintained by the Department in a manner which complies with the requirements of NRS 439.920; and

(2) Is updated not less frequently than once each calendar quarter.

➡ Nothing in this subsection prohibits the Department from determining the usual and customary price that a pharmacy charges for a prescription drug by extracting or otherwise obtaining such information from claims reported by pharmacies to the Medicaid program.

2. If a pharmacy is part of a larger company or corporation or a chain of pharmacies or retail stores, the Department may present the pricing information pertaining to such a pharmacy in such a manner that the pricing information is combined with the pricing information relative to other pharmacies that are part of the same company, corporation or chain, to the extent that the pricing information does not differ among those pharmacies.

3. The Department may establish additional or alternative procedures by which a consumer who is unable to access the Internet or is otherwise unable to receive the information described in subsection 1 in the manner in which it is presented by the Department may obtain that information:

(a) In the form of paper records;

(b) Through the use of a telephonic system; or

(c) Using other methods or technologies designed specifically to assist consumers who are hearing impaired or visually impaired.

4. As used in this section, "usual and customary price" means the usual and customary charges that a ~~{provider}~~ pharmacy charges to the general public for a drug, as described in 42 C.F.R. § ~~{447.331}~~ 447.512.

Sec. 13. NRS 439.925 is hereby amended to read as follows:

439.925 The Department and its members, officers and employees are not liable civilly or criminally for any act, omission, error or technical problem that results in:

1. The failure to provide to consumers information regarding a pharmacy, *prescription drug or nonprofit organization*, including, without limitation, the ~~{prices charged by the pharmacy for the prescription drugs and generic equivalents that are on the list prepared pursuant to NRS 439.905; or}~~ *information made available on the Department's Internet website pursuant to NRS 439.915; or*

2. The providing to consumers of incorrect information regarding a pharmacy, *prescription drug or nonprofit organization*, including, without limitation, the ~~{prices charged by the pharmacy for the prescription drugs and generic equivalents that are on the list prepared pursuant to NRS 439.905}~~ *information made available on the Department's Internet website pursuant to NRS 439.915.*

Sec. 14. NRS 439.930 is hereby amended to read as follows:

439.930 The Department shall adopt such regulations as it determines to be necessary or advisable to carry out the provisions of NRS 439.900 to 439.940, inclusive ~~{ }~~, and sections 2 to 9, inclusive, of this act. Such regulations must provide for, without limitation:

1. Notice to consumers stating that:

(a) Although the Department will strive to ensure that consumers receive accurate information regarding pharmacies, *prescription drugs and nonprofit organizations*, including, without limitation, the ~~{prices charged by those pharmacies for the prescription drugs and generic equivalents that are on the list prepared pursuant to NRS 439.905,}~~ *information made available on the Department's Internet website pursuant to NRS 439.915*, the Department is unable to guarantee the accuracy of such information;

(b) If a consumer follows an Internet link from the Internet website maintained by the Department to an Internet website *not* maintained by ~~{a pharmacy,}~~ the Department, *the Department* is unable to guarantee the accuracy of any information made available on ~~{the Internet}~~ *that website*; ~~{maintained by the pharmacy;}~~ and

(c) The Department advises consumers to contact a pharmacy, *manufacturer or nonprofit organization* directly to verify the accuracy of any information regarding the pharmacy, *a prescription drug manufactured by the manufacturer or the nonprofit organization, as applicable*, which is made available to consumers pursuant to NRS 439.900 to 439.940, inclusive ~~{,}~~, *and sections 2 to 9, inclusive, of this act*;

2. Procedures adopted to direct consumers who have questions regarding the program described in NRS 439.900 to 439.940, inclusive, *and sections 2 to 9, inclusive, of this act* to contact the Office for Consumer Health Assistance of the Department;

3. Provisions in accordance with which the Department will allow an Internet link to the information ~~{provided by each pharmacy pursuant to NRS 439.910}~~ and made available on the Department's Internet website *pursuant to NRS 439.915 and sections 6 and 7 of this act* to be placed on other Internet websites managed or maintained by other persons and entities, including, without limitation, Internet websites managed or maintained by:

(a) Other governmental entities, including, without limitation, the State Board of Pharmacy and the Office of the Governor; and

(b) Nonprofit organizations and advocacy groups;

4. Procedures pursuant to which consumers, ~~{and}~~ pharmacies, *manufacturers and nonprofit organizations* may report to the Department that information made available to consumers pursuant to NRS 439.900 to 439.940, inclusive, *and sections 2 to 9, inclusive, of this act* is inaccurate;

5. The form and manner in which pharmacies are to provide to the Department the information described in NRS 439.910; ~~{and}~~

6. *The form and manner in which manufacturers are to provide to the Department the information described in sections 7, ~~{and}~~ 8 and 8.5 of this act*;

7. *The form and manner in which pharmaceutical sales representatives are to provide to the Department the information described in section 8.5 of this act*;

8. *The form and manner in which nonprofit organizations are to provide to the Department the information described in section 9 of this act, if required; and*

~~8.1~~ 9. Standards and criteria pursuant to which the Department may remove from its Internet website information regarding a pharmacy or an Internet link to the Internet website maintained by a pharmacy, or both, if the Department determines that the pharmacy has:

(a) Ceased to be licensed and in good standing pursuant to chapter 639 of NRS; or

(b) Engaged in a pattern of providing to consumers information that is false or would be misleading to reasonably informed persons.

Sec. 15. NRS 439.935 is hereby amended to read as follows:

439.935 1. On or before July 1 of each odd-numbered year, the Department shall make a determination of whether sufficient money is available and authorized for expenditure to fund one or more components of the programs and other duties of the Department relating to NRS 439.900 to 439.940, inclusive ~~1~~, *and sections 2 to 9, inclusive, of this act.*

2. The Department shall temporarily suspend any components of the program or duties of the Department for which it determines pursuant to subsection 1 that sufficient money is not available.

3. The Department may apply for and accept any available grants and may accept any bequests, devises, donations or gifts from any public or private source to carry out the provisions of NRS 439.900 to 439.940, inclusive ~~1~~, *and sections 2 to 9, inclusive, of this act.*

Sec. 16. NRS 439.940 is hereby amended to read as follows:

439.940 1. If a pharmacy that is licensed under the provisions of chapter 639 of NRS and is located within the State of Nevada fails to provide to the Department the information required to be provided pursuant to NRS 439.910 or fails to provide such information on a timely basis, and the failure was not caused by excusable neglect, technical problems or other extenuating circumstances, the Department may impose against the pharmacy an administrative penalty of not more than \$500 for each day of such failure.

2. *If a manufacturer fails to provide to the Department the information required by section 7 ~~7.1~~ 8 or 8.5 of this act, a nonprofit organization fails to post or provide to the Department, as applicable, the information required by section 9 of this act or a manufacturer or nonprofit organization fails to post or provide, as applicable, such information on a timely basis, and the failure was not caused by excusable neglect, technical problems or other extenuating circumstances, the Department may impose against the manufacturer or nonprofit organization, as applicable, an administrative penalty of not more than \$5,000 for each day of such failure.*

3. Except as otherwise provided in subsection 2, if a person fails to comply with the requirements of section 8.5 of this act, the Department may impose against the person an administrative penalty of not more than \$500 for each day of such failure.

Sec. 17. ~~[Chapter 449 of NRS is hereby amended by adding thereto the provisions set forth as sections 18 to 24, inclusive, of this act.] (Deleted by amendment.)~~

Sec. 18. ~~[As used in sections 18 to 24, inclusive, of this act, unless the context otherwise requires, "pharmaceutical sales representative" means a person who markets prescription drugs to providers of health care in this State.] (Deleted by amendment.)~~

Sec. 19. ~~[1. A person shall not practice as a pharmaceutical sales representative in this State for more than 15 days in any calendar year unless the person holds a valid license as a pharmaceutical sales representative issued by the Division. Such a license expires 1 year after the date on which the license is issued. A person who violates the requirements of this subsection is guilty of a misdemeanor.~~

~~2. The Board shall adopt regulations to carry out the provisions of sections 18 to 24, inclusive, of this act. Those regulations must establish, without limitation:~~

~~(a) The qualifications for obtaining or renewing a license as a pharmaceutical sales representative, which must include a requirement that a pharmaceutical sales representative obtain continuing education each year concerning ethics, pharmacology or the laws and regulations concerning the marketing of prescription drugs.~~

~~(b) The requirements to apply for or renew a license as a pharmaceutical sales representative. No fee may be charged to apply for, reinstate or renew such a license.~~

~~(c) Standards of practice for pharmaceutical sales representatives.~~

~~(d) Disciplinary action that may be imposed for violating the standards of practice established pursuant to paragraph (c), which may include, without limitation, the suspension or revocation of a license and the imposition of an administrative penalty of not more than \$3,000 for each day on which a violation occurs.~~

~~(e) Procedures for imposing disciplinary action.] (Deleted by amendment.)~~

Sec. 20. ~~[An application for the issuance of a license as a pharmaceutical sales representative pursuant to section 19 of this act must include the social security number of the applicant.] (Deleted by amendment.)~~

Sec. 21. ~~[1. An applicant for the issuance or renewal of a license as a pharmaceutical sales representative must submit to the Division of Public and Behavioral Health the statement prescribed by the Division of Welfare and Supportive Services of the Department pursuant to NRS 425.520. The statement must be completed and signed by the applicant.~~

~~2. The Division of Public and Behavioral Health shall include the statement required pursuant to subsection 1 in:~~

~~(a) The application or any other forms that must be submitted for the issuance or renewal of the certificate; or~~

~~(b) A separate form prescribed by the Division.~~

~~3. A license as a pharmaceutical sales representative may not be issued or renewed by the Division if the applicant:~~

~~(a) Fails to submit the statement required pursuant to subsection 1; or~~

~~(b) Indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.~~

~~4. If an applicant indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order, the Division shall advise the applicant to contact the district attorney or other public agency enforcing the order to determine the actions that the applicant may take to satisfy the arrearage.]~~

~~(Deleted by amendment.)~~

Sec. 22. ~~[1. If the Division receives a copy of a court order issued pursuant to NRS 425.540 that provides for the suspension of all professional, occupational and recreational licenses, certificates and permits issued to a person who is the holder of a license as a pharmaceutical sales representative, the Division shall deem the certificate issued to that person to be suspended at the end of the 30th day after the date on which the court order was issued unless the Division receives a letter issued to the holder of the certificate by the district attorney or other public agency pursuant to NRS 425.550 stating that the holder of the certificate has complied with the subpoena or warrant or has satisfied the arrearage pursuant to NRS 425.560.~~

~~2. The Division shall reinstate a license as a pharmaceutical sales representative that has been suspended by a district court pursuant to NRS 425.540 if the Division receives a letter issued by the district attorney or other public agency pursuant to NRS 425.550 to the person whose certificate was suspended stating that the person whose certificate was suspended has complied with the subpoena or warrant or has satisfied the arrearage pursuant to NRS 425.560.] (Deleted by amendment.)~~

Sec. 23. ~~[When a pharmaceutical sales representative submits an application to renew his or her license, he or she shall also submit to the Division a report, which must include, for the immediately preceding year:~~

~~1. A list of providers of health care whom the pharmaceutical sales representative contacted;~~

~~2. The name and manufacturer of each prescription drug for which the pharmaceutical sales representative provided a free sample and the name of each provider of health care to whom a free sample was provided; and~~

~~3. The name of each provider of health care to whom the pharmaceutical sales representative provided compensation, including, without limitation, gifts, food or free supplies, and the value of such compensation.] (Deleted by amendment.)~~

Sec. 24. ~~[1. In addition to any other requirements set forth in sections 18 to 24, inclusive, of this act, an applicant for the renewal of a license as a pharmaceutical sales representative must indicate in the application submitted to the Division whether the applicant has a state business license. If the applicant has a state business license, the applicant must include in the application the business identification number assigned by the Secretary of State upon compliance with the provisions of chapter 76 of NRS.~~

~~2. The license of a pharmaceutical sales representative may not be renewed if:~~

~~(a) The applicant fails to submit the information required by subsection 1;~~

~~(b) The State Controller has informed the Division pursuant to subsection 5 of NRS 353C.1965 that the applicant owes a debt to an agency that has been assigned to the State Controller for collection and the applicant has not:~~

~~(1) Satisfied the debt;~~

~~(2) Entered into an agreement for the payment of the debt pursuant to NRS 353C.130; or~~

~~(3) Demonstrated that the debt is not valid.~~

~~3. As used in this section:~~

~~(a) "Agency" has the meaning ascribed to it in NRS 353C.020.~~

~~(b) "Debt" has the meaning ascribed to it in NRS 353C.040.] (Deleted by amendment.)~~

Sec. 25. (Deleted by amendment.)

Sec. 26. (Deleted by amendment.)

Sec. 26.5. NRS 239.010 is hereby amended to read as follows:

239.010 1. Except as otherwise provided in this section and NRS 1.4683, 1.4687, 1A.110, 41.071, 49.095, 62D.420, 62D.440, 62E.516, 62E.620, 62H.025, 62H.030, 62H.170, 62H.220, 62H.320, 75A.100, 75A.150, 76.160, 78.152, 80.113, 81.850, 82.183, 86.246, 86.54615, 87.515, 87.5413, 87A.200, 87A.580, 87A.640, 88.3355, 88.5927, 88.6067, 88A.345, 88A.7345, 89.045, 89.251, 90.730, 91.160, 116.757, 116A.270, 116B.880, 118B.026, 119.260, 119.265, 119.267, 119.280, 119A.280, 119A.653, 119B.370, 119B.382, 120A.690, 125.130, 125B.140, 126.141, 126.161, 126.163, 126.730, 127.007, 127.057, 127.130, 127.140, 127.2817, 130.312, 130.712, 136.050, 159.044, 172.075, 172.245, 176.015, 176.0625, 176.09129, 176.156, 176A.630, 178.39801, 178.4715, 178.5691, 179.495, 179A.070, 179A.165, 179A.450, 179D.160, 200.3771, 200.3772, 200.5095, 200.604, 202.3662, 205.4651, 209.392, 209.3925, 209.419, 209.521, 211A.140, 213.010, 213.040, 213.095, 213.131, 217.105, 217.110, 217.464, 217.475, 218A.350, 218E.625, 218F.150, 218G.130, 218G.240, 218G.350, 228.270, 228.450, 228.495, 228.570, 231.069, 231.1473, 233.190, 237.300, 239.0105, 239.0113, 239B.030, 239B.040, 239B.050, 239C.140, 239C.210, 239C.230, 239C.250, 239C.270, 240.007, 241.020, 241.030, 241.039, 242.105, 244.264, 244.335, 250.087, 250.130, 250.140, 250.150, 268.095, 268.490, 268.910, 271A.105, 281.195, 281A.350, 281A.440, 281A.550, 284.4068, 286.110, 287.0438,

289.025, 289.080, 289.387, 289.830, 293.5002, 293.503, 293.558, 293B.135, 293D.510, 331.110, 332.061, 332.351, 333.333, 333.335, 338.070, 338.1379, 338.16925, 338.1725, 338.1727, 348.420, 349.597, 349.775, 353.205, 353A.049, 353A.085, 353A.100, 353C.240, 360.240, 360.247, 360.255, 360.755, 361.044, 361.610, 365.138, 366.160, 368A.180, 372A.080, 378.290, 378.300, 379.008, 385A.830, 385B.100, 387.626, 387.631, 388.1455, 388.259, 388.501, 388.503, 388.513, 388.750, 391.035, 392.029, 392.147, 392.264, 392.271, 392.850, 394.167, 394.1698, 394.447, 394.460, 394.465, 396.3295, 396.405, 396.525, 396.535, 398.403, 408.3885, 408.3886, 408.3888, 408.5484, 412.153, 416.070, 422.2749, 422.305, 422A.342, 422A.350, 425.400, 427A.1236, 427A.872, 432.205, 432B.175, 432B.280, 432B.290, 432B.407, 432B.430, 432B.560, 433.534, 433A.360, 439.840, 439B.420, 440.170, 441A.195, 441A.220, 441A.230, 442.330, 442.395, 445A.665, 445B.570, 449.209, 449.245, 449.720, 450.140, 453.164, 453.720, 453A.610, 453A.700, 458.055, 458.280, 459.050, 459.3866, 459.555, 459.7056, 459.846, 463.120, 463.15993, 463.240, 463.3403, 463.3407, 463.790, 467.1005, 480.365, 481.063, 482.170, 482.5536, 483.340, 483.363, 483.575, 483.659, 483.800, 484E.070, 485.316, 503.452, 522.040, 534A.031, 561.285, 571.160, 584.655, 587.877, 598.0964, 598.098, 598A.110, 599B.090, 603.070, 603A.210, 604A.710, 612.265, 616B.012, 616B.015, 616B.315, 616B.350, 618.341, 618.425, 622.310, 623.131, 623A.137, 624.110, 624.265, 624.327, 625.425, 625A.185, 628.418, 628B.230, 628B.760, 629.047, 629.069, 630.133, 630.30665, 630.336, 630A.555, 631.368, 632.121, 632.125, 632.405, 633.283, 633.301, 633.524, 634.055, 634.214, 634A.185, 635.158, 636.107, 637.085, 637B.288, 638.087, 638.089, 639.2485, 639.570, 640.075, 640A.220, 640B.730, 640C.400, 640C.745, 640C.760, 640D.190, 640E.340, 641.090, 641A.191, 641B.170, 641C.760, 642.524, 643.189, 644.446, 645.180, 645.625, 645A.050, 645A.082, 645B.060, 645B.092, 645C.220, 645C.225, 645D.130, 645D.135, 645E.300, 645E.375, 645G.510, 645H.320, 645H.330, 647.0945, 647.0947, 648.033, 648.197, 649.065, 649.067, 652.228, 654.110, 656.105, 661.115, 665.130, 665.133, 669.275, 669.285, 669A.310, 671.170, 673.430, 675.380, 676A.340, 676A.370, 677.243, 679B.122, 679B.152, 679B.159, 679B.190, 679B.285, 679B.690, 680A.270, 681A.440, 681B.260, 681B.410, 681B.540, 683A.0873, 685A.077, 686A.289, 686B.170, 686C.306, 687A.110, 687A.115, 687C.010, 688C.230, 688C.480, 688C.490, 692A.117, 692C.190, 692C.3536, 692C.3538, 692C.354, 692C.420, 693A.480, 693A.615, 696B.550, 703.196, 704B.320, 704B.325, 706.1725, 706A.230, 710.159, 711.600 ~~and~~ section 8.5 of this act, sections 35, 38 and 41 of chapter 478, Statutes of Nevada 2011 and section 2 of chapter 391, Statutes of Nevada 2013 and unless otherwise declared by law to be confidential, all public books and public records of a governmental entity must be open at all times during office hours to inspection by any person, and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. Any such copies, abstracts or memoranda may be used to supply the general

public with copies, abstracts or memoranda of the records or may be used in any other way to the advantage of the governmental entity or of the general public. This section does not supersede or in any manner affect the federal laws governing copyrights or enlarge, diminish or affect in any other manner the rights of a person in any written book or record which is copyrighted pursuant to federal law.

2. A governmental entity may not reject a book or record which is copyrighted solely because it is copyrighted.

3. A governmental entity that has legal custody or control of a public book or record shall not deny a request made pursuant to subsection 1 to inspect or copy or receive a copy of a public book or record on the basis that the requested public book or record contains information that is confidential if the governmental entity can redact, delete, conceal or separate the confidential information from the information included in the public book or record that is not otherwise confidential.

4. A person may request a copy of a public record in any medium in which the public record is readily available. An officer, employee or agent of a governmental entity who has legal custody or control of a public record:

(a) Shall not refuse to provide a copy of that public record in a readily available medium because the officer, employee or agent has already prepared or would prefer to provide the copy in a different medium.

(b) Except as otherwise provided in NRS 239.030, shall, upon request, prepare the copy of the public record and shall not require the person who has requested the copy to prepare the copy himself or herself.

Sec. 27. Chapter 394 of NRS is hereby amended by adding thereto a new section to read as follows:

1. *The parent or legal guardian of a pupil who has asthma, anaphylaxis or diabetes may submit a written request to the principal or, if applicable, the school nurse of the private school in which the pupil is enrolled to allow the pupil to self-administer medication for the treatment of the pupil's asthma, anaphylaxis or diabetes while the pupil is on the grounds of the private school, participating in an activity sponsored by the private school or on a school bus.*

2. *A private school shall establish protocols for containing blood-borne pathogens and the handling and disposal of needles, medical devices and other medical waste and provide a copy of these protocols and procedures to the parent or guardian of a pupil who requests permission for the pupil to self-administer medication pursuant to subsection 1.*

3. *A written request made pursuant to subsection 1 must include:*

(a) *A signed statement of a physician indicating that the pupil has asthma, anaphylaxis or diabetes and is capable of self-administration of the medication while the pupil is on the grounds of the private school, participating in an activity sponsored by the private school or on a school bus;*

(b) *A written treatment plan prepared by the physician pursuant to which the pupil will manage his or her asthma, anaphylaxis or diabetes if the pupil experiences an asthmatic attack, anaphylactic shock or diabetic episode while*

on the grounds of the private school, participating in an activity sponsored by the private school or on a school bus; and

(c) A signed statement of the parent or legal guardian:

(1) Indicating that the parent or legal guardian grants permission for the pupil to self-administer the medication while the pupil is on the grounds of the private school, participating in an activity sponsored by the private school or on a school bus;

(2) Acknowledging that the parent or legal guardian is aware of and understands the provisions of subsections 4 and 5;

(3) Acknowledging the receipt of the protocols provided pursuant to subsection 2;

(4) Acknowledging that the protocols established pursuant to subsection 2 have been explained to the pupil who will self-administer the medication and that he or she has agreed to comply with the protocols; and

(5) Acknowledging that authorization to self-administer medication pursuant to this section may be revoked if the pupil fails to comply with the protocols established pursuant to subsection 2.

4. The provisions of this section do not create a duty for the private school in which the pupil is enrolled, or an employee or agent thereof, that is in addition to those duties otherwise required in the course of service or employment.

5. If a pupil is granted authorization pursuant to this section to self-administer medication, the governing body of the private school in which the pupil is enrolled, the private school and any employee or agent thereof, are immune from liability for the injury to or death of:

(a) The pupil as a result of self-administration of a medication pursuant to this section or the failure of the pupil to self-administer such a medication; and

(b) Any other person as a result of exposure to or injury caused by needles, medical devices or other medical waste from the self-administration of medication by a pupil pursuant to this section.

6. Upon receipt of a request that complies with subsection 3, the principal or, if applicable, the school nurse of the private school in which the pupil is enrolled shall provide written authorization for the pupil to carry and self-administer medication to treat his or her asthma, anaphylaxis or diabetes while the pupil is on the grounds of the private school, participating in an activity sponsored by the private school or on a school bus. The written authorization must be filed with the principal or, if applicable, the school nurse of the private school in which the pupil is enrolled and must include:

(a) The name and purpose of the medication which the pupil is authorized to self-administer;

(b) The prescribed dosage and the duration of the prescription;

(c) The times or circumstances, or both, during which the medication is required or recommended for self-administration;

(d) *The side effects that may occur from an administration of the medication;*

(e) *The name and telephone number of the pupil's physician and the name and telephone number of the person to contact in the case of a medical emergency concerning the pupil; and*

(f) *The procedures for the handling and disposal of needles, medical devices and other medical waste.*

7. *The written authorization provided pursuant to subsection 6 is valid for 1 school year. If a parent or legal guardian submits a written request that complies with subsection 3, the principal or, if applicable, the school nurse of the private school in which the pupil is enrolled shall renew and, if necessary, revise the written authorization.*

8. *If a parent or legal guardian of a pupil who is authorized pursuant to this section to carry medication on his or her person provides to the principal or, if applicable, the school nurse of the private school in which the pupil is enrolled doses of the medication in addition to the dosage that the pupil carries on his or her person, the principal or, if applicable, the school nurse shall ensure that the additional medication is:*

(a) *Stored on the premises of the private school in a location that is secure; and*

(b) *Readily available if the pupil experiences an asthmatic attack, anaphylactic shock or diabetic episode during school hours.*

9. *An employee of a private school who willfully violates any provision of this section is guilty of a misdemeanor.*

10. *As used in this section:*

(a) *"Medication" has the meaning ascribed to it in NRS 392.425.*

(b) *"Physician" has the meaning ascribed to it in NRS 392.425.*

(c) *"Self-administer" has the meaning ascribed to it in NRS 392.425.*

Sec. 27.5. NRS 600A.030 is hereby amended to read as follows:

600A.030 As used in this chapter, unless the context otherwise requires:

1. "Improper means" includes, without limitation:

(a) Theft;

(b) Bribery;

(c) Misrepresentation;

(d) Willful breach or willful inducement of a breach of a duty to maintain secrecy;

(e) Willful breach or willful inducement of a breach of a duty imposed by common law, statute, contract, license, protective order or other court or administrative order; and

(f) Espionage through electronic or other means.

2. "Misappropriation" means:

(a) Acquisition of the trade secret of another by a person by improper means;

(b) Acquisition of a trade secret of another by a person who knows or has reason to know that the trade secret was acquired by improper means; or

(c) Disclosure or use of a trade secret of another without express or implied consent by a person who:

(1) Used improper means to acquire knowledge of the trade secret;
 (2) At the time of disclosure or use, knew or had reason to know that his or her knowledge of the trade secret was:

(I) Derived from or through a person who had used improper means to acquire it;

(II) Acquired under circumstances giving rise to a duty to maintain its secrecy or limit its use; or

(III) Derived from or through a person who owed a duty to the person seeking relief to maintain its secrecy or limit its use; or

(3) Before a material change of his or her position, knew or had reason to know that it was a trade secret and that knowledge of it had been acquired by accident or mistake.

3. "Owner" means the person who holds legal or equitable title to a trade secret.

4. "Person" means a natural person, corporation, business trust, estate, trust, partnership, association, joint venture, government, governmental subdivision or agency, or any other legal or commercial entity.

5. "Trade secret" means information, including, without limitation, a formula, pattern, compilation, program, device, method, technique, product, system, process, design, prototype, procedure, computer programming instruction or code that:

(a) Derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by the public or any other persons who can obtain commercial or economic value from its disclosure or use; and

(b) Is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

➡ *The term does not include any information that a manufacturer is required to report pursuant to section 7 of this act, to the extent that such information is required to be disclosed by that section.*

Sec. 28. (Deleted by amendment.)

Sec. 29. (Deleted by amendment.)

Sec. 30. NRS 689A.405 is hereby amended to read as follows:

689A.405 1. An insurer that offers or issues a policy of health insurance which provides coverage for prescription drugs shall include with any summary, certificate or evidence of that coverage provided to an insured, notice of whether a formulary is used and, if so, of the opportunity to secure information regarding the formulary from the insurer pursuant to subsection 2. The notice required by this subsection must:

(a) Be in a language that is easily understood and in a format that is easy to understand;

(b) Include an explanation of what a formulary is; and

(c) If a formulary is used, include:

(1) An explanation of:

(I) How often the contents of the formulary are reviewed; and

(II) The procedure and criteria for determining which prescription drugs are included in and excluded from the formulary; and

(2) The telephone number of the insurer for making a request for information regarding the formulary pursuant to subsection 2.

2. If an insurer offers or issues a policy of health insurance which provides coverage for prescription drugs and a formulary is used, the insurer shall:

(a) Provide to any insured or participating provider of health care, upon request:

(1) Information regarding whether a specific drug is included in the formulary.

(2) Access to the most current list of prescription drugs in the formulary, organized by major therapeutic category, with an indication of whether any listed drugs are preferred over other listed drugs. If more than one formulary is maintained, the insurer shall notify the requester that a choice of formulary lists is available.

(b) Notify each person who requests information regarding the formulary, that the inclusion of a drug in the formulary does not guarantee that a provider of health care will prescribe that drug for a particular medical condition.

(c) *During each period for open enrollment, publish on an Internet website that is operated by the insurer and accessible to the public or include in any enrollment materials distributed by the insurer a notice of all prescription drugs that:*

(1) Are included on the most recent list of drugs that are essential for treating diabetes in this State compiled by the Department of Health and Human Services pursuant to section 6 of this act; and

(2) Have been removed or will be removed from the formulary during the current plan year or the next plan year.

(d) Update the notice required by paragraph (c) throughout the period for open enrollment.

Sec. 31. (Deleted by amendment.)

Sec. 32. (Deleted by amendment.)

Sec. 33. (Deleted by amendment.)

Sec. 34. (Deleted by amendment.)

Sec. 35. (Deleted by amendment.)

Sec. 36. (Deleted by amendment.)

Sec. 37. (Deleted by amendment.)

Sec. 38. (Deleted by amendment.)

Sec. 39. (Deleted by amendment.)

Sec. 40. (Deleted by amendment.)

Sec. 41. (Deleted by amendment.)

Sec. 42. (Deleted by amendment.)

Sec. 43. (Deleted by amendment.)

Sec. 44. (Deleted by amendment.)

Sec. 44.3. The provisions of subsection 1 of NRS 218D.380 do not apply to any provision of this act which adds or revises a requirement to submit a report to the Legislature.

Sec. 44.5. 1. Notwithstanding any other provision of this act to the contrary:

(a) On or before November 1, 2017, the Department of Health and Human Services shall place on the Internet website maintained by the Department the information prescribed by section 6 of this act.

(b) On or before July 1, 2018, the manufacturer of a drug included on the list described in section 6 of this act shall submit to the Department a report which includes the information prescribed by subsection 1 of section 7 of this act.

(c) On or before September 1, 2018, the Department shall analyze the reports submitted pursuant to paragraph (b) and compile and post on the Internet website maintained by the Department the initial report required by subsection 2 of section 7 of this act.

2. As used in this section, "manufacturer" has the meaning ascribed to it in section 2 of this act.

Sec. 45. 1. This section and section 44.5 of this act become effective upon passage and approval.

2. Sections 27 and 28 of this act become effective on July 1, 2017.

3. Sections 1 to 9, inclusive, 11, 12, 13, 15, 16, 25, 26 and 27.5 of this act become effective upon passage and approval for the purpose of adopting regulations and performing any other administrative tasks that are necessary to carry out the provisions of this act and on October 1, 2017, for all other purposes.

4. Sections 10, 17 to 24, inclusive, and 29 to 44, inclusive, of this act become effective upon passage and approval for the purpose of adopting regulations and performing any other administrative tasks that are necessary to carry out the provisions of this act and on January 1, 2018, for all other purposes.

5. Section 14 of this act becomes effective upon passage and approval for the purpose of adopting regulations and performing any other administrative tasks that are necessary to carry out the provisions of this act and on May 1, 2018, for all other purposes.

~~[6. Sections 20, 21 and 22 of this act expire by limitation on the date on which the provisions of 42 U.S.C. § 666 requiring each state to establish procedures under which the state has authority to withhold or suspend, or to restrict the use of professional, occupational and recreational licenses of persons who:~~

~~— (a) Have failed to comply with a subpoena or warrant relating to a proceeding to determine the paternity of a child or to establish or enforce an obligation for the support of a child; or~~

~~— (b) Are in arrears in the payment for the support of one or more children,~~
~~are repealed by the Congress of the United States.]~~

Senator Woodhouse moved the adoption of the amendment.

Remarks by Senator Woodhouse.

Amendment No. 736 to Senate Bill No. 265 deletes sections 17 through 24, which eliminates the requirement to license pharmaceutical sales representatives, and adds section 8.5, requiring drug manufacturers to provide the Department of Health and Human Services with a list of pharmaceutical sales representatives and requires each representative on the list to submit an annual report to the Department. As amended, the Department shall analyze the information submitted and post an annual report on its Internet website on the activities of pharmaceutical sales representatives in the State. A report would also be submitted to the Governor and the Legislature.

Amendment adopted.

Bill ordered reprinted, re-engrossed and to third reading.

Senator Cancela moved that the bill be taken from the General File and placed on the General File for the next legislative day.

Motion carried.

GENERAL FILE AND THIRD READING

Assembly Bill No. 319.

Bill read third time.

Remarks by Senator Cannizzaro.

Assembly Bill No. 319 creates a new chapter in Nevada Revised Statutes relating to guardianships of minors and carries over provisions from existing law but with certain revisions. The measure sets forth the procedures for the appointment of a guardian, the powers and duties of a guardian and the termination of the guardianship.

Roll call on Assembly Bill No. 319:

YEAS—21.

NAYS—None.

Assembly Bill No. 319 having received a constitutional majority, Mr. President declared it passed.

Bill ordered transmitted to the Assembly.

UNFINISHED BUSINESS

SIGNING OF BILLS AND RESOLUTIONS

There being no objections, the President and Secretary signed Senate Bills Nos. 13, 15, 19, 20, 27, 29, 32, 35, 40, 42, 110, 112, 131, 177, 202, 241, 277, 301, 313, 326, 362, 412; Senate Resolution No. 6; Assembly Bills Nos. 8, 20, 22, 31, 79, 95, 96, 98, 108, 134, 151, 170, 236, 258, 305, 324, 337, 340, 347, 478.

GUESTS EXTENDED PRIVILEGE OF SENATE FLOOR

On request of President Hutchison, the privilege of the floor of the Senate Chamber for this day was extended to Former Lt. Governor Lonnie Hammargren.

Senator Ford moved that the Senate adjourn until Friday, May 19, 2017, at 11:00 a.m.

Motion carried.

Senate adjourned at 1:10 p.m.

Approved:

MARK A. HUTCHISON
President of the Senate

Attest: CLAIRE J. CLIFT
Secretary of the Senate