

Amendment No. 1083

Senate Amendment to Senate Bill No. 361

(BDR 54-921)

**Proposed by:** Senate Committee on Finance

**Amendment Box:** Replaces Amendment No. 1053.

**Amends:** Summary: Yes Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes

Adoption of this amendment will MAINTAIN the unfunded mandate not requested by the affected local government to S.B. 361 (§ 13).

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

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

EWR/RBL



Date: 6/2/2019

S.B. No. 361—Provides for the prescribing, ordering and dispensing of contraceptive supplies by pharmacists. (BDR 54-921)





SENATE BILL NO. 361—SENATORS CANNIZZARO, SCHEIBLE; CANCELA, DONDERO  
LOOP, D. HARRIS, RATTI AND WOODHOUSE

MARCH 19, 2019

Referred to Committee on Commerce and Labor

SUMMARY—Provides for the ~~prescribing, ordering and~~ dispensing of ~~contraceptive supplies by pharmacists;~~ self-administered hormonal contraceptives to any patient. (BDR 54-921)

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

CONTAINS UNFUNDED MANDATE (§ 13)  
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

AN ACT relating to health care; authorizing a pharmacist to ~~prescribe or order and~~ dispense ~~contraceptive supplies;~~ self-administered hormonal contraceptives to ~~to~~ any patient; requiring the Chief Medical Officer to issue a standing order authorizing a pharmacist to dispense self-administered hormonal contraceptives to any patient; requiring the State Plan for Medicaid and certain health insurance plans to provide certain benefits relating to ~~contraceptive supplies;~~ self-administered hormonal contraceptives; and providing other matters properly relating thereto.

**Legislative Counsel's Digest:**

Existing law requires a pharmacist to dispense up to a 12-month supply or an amount equivalent to the balance of the plan year, whichever is less, of contraceptives or their therapeutic equivalent pursuant to a valid prescription or order if certain conditions are met. (NRS 639.28075) ~~[Section 4 of this bill authorizes a pharmacist to prescribe or order and to dispense contraceptives or their therapeutic equivalent and certain contraceptive devices to a patient and establishes the procedures the pharmacist must follow to do so. Specifically, section 4 requires such a pharmacist to: (1) complete a program related to prescribing or ordering contraceptive supplies; (2) provide a self-screening risk assessment tool that the patient must complete before the pharmacist prescribes or orders any contraceptive supplies; (3) advise the patient to consult with the primary care provider of the patient upon prescribing or ordering and dispensing the contraceptive supplies or to consult a provider of health care if the patient does not have a primary care provider; (4) provide the patient with a written record of the contraceptive supplies prescribed or ordered and dispensed; and (5) dispense the contraceptive supplies as soon as practicable after the pharmacist issues the prescription or order. Section 4 prohibits such a pharmacist from requiring a patient to schedule an appointment with the pharmacist for the prescribing or ordering or the dispensing of contraceptive supplies. Section 10 of this bill makes conforming changes.] Section 11.5 of this bill requires: (1) the Chief Medical Officer or his or her designee to issue a standing~~

order to allow a pharmacist to dispense a self-administered hormonal contraceptive to any patient; and (2) the State Board of Health, in consultation with the Chief Medical Officer, to prescribe by regulation a protocol for dispensing a self-administered hormonal contraceptive. Section 4.5 of this bill authorizes a pharmacist to dispense a self-administered hormonal contraceptive under that standing order and establishes the procedures the pharmacist must follow to dispense such a contraceptive. Specifically, section 4.5 requires such a pharmacist to: (1) complete a program of training on dispensing such contraceptives; (2) provide a risk assessment questionnaire prescribed by the State Board of Health pursuant to section 11.5 upon the request of the patient before the pharmacist dispenses the self-administered hormonal contraceptive; (3) create a record concerning the dispensing of the self-administered hormonal contraceptive; (4) provide the patient with a record of the self-administered hormonal contraceptive dispensed and certain additional information; and (5) comply with the regulations adopted pursuant to section 11.5 and any guidelines recommended by the manufacturer. Section 4.5 additionally requires a pharmacist to provide a patient with a record of a request for a self-administered hormonal contraceptive, regardless of whether the contraceptive is dispensed. Sections 4.5 and 11.5 require the State Board of Pharmacy and the Division of Public and Behavioral Health of the Department of Health and Human Services to post on an Internet website a list of pharmacies that dispense self-administered hormonal contraceptives under the standing order.

Existing law defines the term "practice of pharmacy." (NRS 639.0124) Section 6 of this bill provides that the practice of pharmacy includes the ~~prescribing or ordering and the~~ dispensing of ~~contraceptive supplies~~ self-administered hormonal contraceptives by a pharmacist in accordance with section ~~4.4~~ 4.5.

Existing law sets forth the procedures for renewing a certificate as a registered pharmacist. (NRS 639.180) Existing law further requires an applicant for the renewal of his or her certificate as a registered pharmacist to complete a certain number of continuing education units. (NRS 639.2174) Sections 7 and 9 of this bill require a pharmacist who ~~prescribes or orders and~~ dispenses ~~contraceptive supplies~~ self-administered hormonal contraceptives in accordance with section ~~4.4~~ 4.5 to complete, once every 3 years, a program related to ~~prescribing or ordering contraceptive supplies~~ dispensing self-administered hormonal contraceptives before his or her registration as a pharmacist may be renewed.

Existing law authorizes the State Board of Pharmacy to suspend or revoke any certificate to practice as a registered pharmacist if the holder of or applicant for such a certificate commits certain acts. (NRS 639.210) Section 8 of this bill authorizes the Board to suspend or revoke any certificate to practice as a registered pharmacist if the holder or applicant has ~~prescribed or ordered or~~ dispensed ~~contraceptive supplies~~ self-administered hormonal contraceptives under the standing order issued pursuant to section 11.5 without complying with the provisions of section ~~4.4~~ 4.5.

Existing law requires the State Plan for Medicaid to pay the nonfederal share of expenditures incurred for certain contraceptive drugs and devices, including: (1) up to a 12-month supply of contraceptives; and (2) certain devices for contraception. (NRS 422.27172) Section 11 of this bill requires the State Plan for Medicaid to pay the nonfederal share of expenditures incurred for ~~contraceptive supplies prescribed or ordered and~~ self-administered hormonal contraceptives dispensed by a pharmacist in accordance with section ~~4.4~~ 4.5.

Existing law requires certain contraceptive drugs and devices to be covered by a health insurance plan, including: (1) up to a 12-month supply of contraceptives; and (2) certain devices for contraception. (NRS 287.010, 287.04335, 689A.0418, 689B.0378, 689C.1676, 695A.1865, 695B.1919, 695C.1696, 695G.1715) Sections 12-18 of this bill require health insurance plans to cover ~~contraceptive supplies prescribed or ordered and~~ self-administered hormonal contraceptives dispensed by a pharmacist in accordance with section ~~4.4~~ 4.5.

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

Section 1. Chapter 639 of NRS is hereby amended by adding thereto the provisions set forth as sections ~~[2, 3 and 4]~~ 2 to 4.5, inclusive, of this act.

Sec. 2. ~~["Contraceptive supplies" means any of the following that may be self-administered by a patient:~~

~~1. A drug to be used for contraception or its therapeutic equivalent which has been approved by the Food and Drug Administration; and~~

~~2. Any type of device for contraception which has been approved by the Food and Drug Administration.] (Deleted by amendment.)~~

Sec. 2.5. "Self-administered hormonal contraceptive" means a self-administered contraceptive that utilizes a hormone and is approved for use by the United States Food and Drug Administration to prevent pregnancy. The term includes, without limitation, an oral contraceptive, a vaginal contraceptive ring, a contraceptive patch and any other method of hormonal contraceptive identified by the standing order issued by the Chief Medical Officer or his or her designee pursuant to section 11.5 of this act.

Sec. 3. ~~["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.] (Deleted by amendment.)~~

Sec. 4. ~~[1. A pharmacist may prescribe or order and dispense in accordance with NRS 639.28075, if applicable, contraceptive supplies to a patient regardless of whether the patient has evidence of a previous prescription or order for contraceptive supplies from:~~

~~(a) A physician who holds a license to practice his or her profession in this State;~~

~~(b) An advanced practice registered nurse who has been authorized to prescribe controlled substances, poisons, dangerous drugs and devices;~~

~~(c) A physician assistant who is authorized by the Board to possess, administer, prescribe or dispense controlled substances, poisons, dangerous drugs or devices under the supervision of a physician as required by chapter 630 of NRS or an osteopathic physician as required by chapter 633 of NRS; or~~

~~(d) A provider of health care who has been authorized to prescribe controlled substances, poisons, dangerous drugs or devices.~~

~~2. A pharmacist who prescribes or orders and dispenses contraceptive supplies pursuant to subsection 1 shall:~~

~~(a) Complete a program related to prescribing or ordering contraceptive supplies that is:~~

~~(1) Accredited by the Accreditation Council for Pharmacy Education or its successor organization; and~~

~~(2) Approved by the Board.~~

~~(b) Provide a self-screening risk assessment tool that the patient must complete before the pharmacist prescribes or orders any contraceptive supplies. Such a self-screening risk assessment tool must be based on the current version of the United States Medical Eligibility Criteria for Contraceptive Use developed by the federal Centers for Disease Control and Prevention of the United States Department of Health and Human Services.~~

~~(c) Advise the patient to consult with the primary care provider of the patient upon prescribing or ordering and dispensing the contraceptive supplies. If the patient does not have a primary care provider, the pharmacist shall advise the patient to consult;~~

~~(1) A physician who holds a license to practice his or her profession in this State;~~

~~(2) An advanced practice registered nurse who has been authorized to prescribe controlled substances, poisons, dangerous drugs or devices;~~

~~(3) A physician assistant who is authorized by the Board to possess, administer, prescribe or dispense controlled substances, poisons, dangerous drugs or devices under the supervision of a physician as required by chapter 630 of NRS or an osteopathic physician as required by chapter 633 of NRS; or~~

~~(4) A provider of health care who has been authorized to prescribe controlled substances, poisons, dangerous drugs or devices;~~

~~(d) Provide the patient with a written record of the contraceptive supplies prescribed or ordered and dispensed and advise the patient to consult with the primary care provider of the patient or a provider of health care of the patient's choice;~~

~~(e) Dispense the contraceptive supplies to the patient as soon as practicable after the pharmacist issues the prescription or order;~~

~~3. A pharmacist who prescribes or orders and dispenses contraceptive supplies pursuant to subsection 1 shall not require a patient to schedule an appointment with the pharmacist for the prescribing or ordering or the dispensing of contraceptive supplies.~~

~~4. As used in this section:~~

~~(a) "Primary care provider" means a provider of health care who provides or has provided care to the patient;~~

~~(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031; (Deleted by amendment.)~~

Sec. 4.5. 1. A pharmacist may dispense a self-administered hormonal contraceptive under the standing order issued pursuant to section 11.5 of this act to a patient, regardless of whether the patient has obtained a prescription from:

(a) A physician who holds a license to practice his or her profession in this State;

(b) An advanced practice registered nurse who has been authorized to prescribe controlled substances, poisons, dangerous drugs and devices;

(c) A physician assistant who is authorized by the Board to possess, administer, prescribe or dispense controlled substances, poisons, dangerous drugs or devices under the supervision of a physician as required by chapter 630 of NRS or an osteopathic physician as required by chapter 633 of NRS; or

(d) A provider of health care who has been authorized to prescribe controlled substances, poisons, dangerous drugs or devices.

2. A pharmacist who dispenses self-administered hormonal contraceptives under the standing order shall complete a program related to dispensing self-administered hormonal contraceptives that is:

(a) Accredited by the Accreditation Council for Pharmacy Education or its successor organization; and

(b) Approved by the Board.

3. A pharmacist shall provide the risk assessment questionnaire prescribed by the State Board of Health pursuant to section 11.5 of this act to a patient who requests the questionnaire before dispensing a self-administered hormonal contraceptive to the patient. If such a questionnaire is provided and the results of

1 the questionnaire indicate that it is unsafe to dispense the self-administered  
2 hormonal contraceptive to the patient, the pharmacist:

3 (a) Must not dispense the self-administered hormonal contraceptive; and  
4 (b) Must refer the patient to a primary care provider or other qualified  
5 provider of health care.

6 4. A pharmacist who dispenses a self-administered hormonal contraceptive  
7 under the standing order shall:

8 (a) Create a record concerning the dispensing of the self-administered  
9 hormonal contraceptive which includes, without limitation, the name of the  
10 patient to whom the self-administered hormonal contraceptive was dispensed, the  
11 type of self-administered hormonal contraceptive dispensed and any other  
12 relevant information required by the protocol prescribed pursuant to section 11.5  
13 of this act. The pharmacist or his or her employer shall maintain the record for  
14 the amount of time prescribed in that protocol.

15 (b) Inform the patient to whom the self-administered hormonal contraceptive  
16 is dispensed concerning:

17 (1) Proper administration and storage of the self-administered hormonal  
18 contraceptive;

19 (2) Potential side effects of the self-administered hormonal  
20 contraceptive; and

21 (3) The need to use other methods of contraception, if appropriate.

22 (c) Provide to the patient to whom the self-administered hormonal  
23 contraceptive is dispensed:

24 (1) The written record required by subsection 5; and

25 (2) Any written information required by the regulations adopted  
26 pursuant to section 11.5 of this act.

27 (d) Comply with the regulations adopted pursuant to section 11.5 of this act  
28 and any guidelines for dispensing the self-administered hormonal contraceptive  
29 recommended by the manufacturer.

30 5. A pharmacist shall provide to any patient who requests a self-  
31 administered hormonal contraceptive under the standing order, regardless of  
32 whether the self-administered hormonal contraceptive is dispensed, a written  
33 record of the request. The record must include, without limitation:

34 (a) A copy of the risk assessment questionnaire if completed pursuant to  
35 subsection 3; and

36 (b) A written record of the self-administered hormonal contraceptive  
37 requested and any self-administered hormonal contraceptive dispensed.

38 6. Any pharmacy that wishes to dispense self-administered hormonal  
39 contraceptives under the standing order must notify the Board of that fact. The  
40 Board shall post on an Internet website maintained by the Board a list of the  
41 names, addresses and contact information of pharmacies that have provided such  
42 notice.

43 7. As used in this section:

44 (a) "Primary care provider" means a provider of health care who provides or  
45 has provided care to the patient.

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

47 **Sec. 5.** NRS 639.001 is hereby amended to read as follows:

48 639.001 As used in this chapter, unless the context otherwise requires, the  
49 words and terms defined in NRS 639.0015 to 639.016, inclusive, ~~and sections 2~~  
50 ~~and 3~~ section 2.5 of this act have the meanings ascribed to them in those sections.

51 **Sec. 6.** NRS 639.0124 is hereby amended to read as follows:

52 639.0124 1. "Practice of pharmacy" includes, but is not limited to, the:

~~[1-]~~ (a) Performance or supervision of activities associated with manufacturing, compounding, labeling, dispensing and distributing of a drug, including the receipt, handling and storage of prescriptions and other confidential information relating to patients.

~~[2-]~~ (b) Interpretation and evaluation of prescriptions or orders for medicine.

~~[3-]~~ (c) Participation in drug evaluation and drug research.

~~[4-]~~ (d) Advising of the therapeutic value, reaction, drug interaction, hazard and use of a drug.

~~[5-]~~ (e) Selection of the source, storage and distribution of a drug.

~~[6-]~~ (f) Maintenance of proper documentation of the source, storage and distribution of a drug.

~~[7-]~~ (g) Interpretation of clinical data contained in a person's record of medication.

~~[8-]~~ (h) Development of written guidelines and protocols in collaboration with a practitioner which are intended for a patient in a licensed medical facility or in a setting that is affiliated with a medical facility where the patient is receiving care and which authorize collaborative drug therapy management. The written guidelines and protocols must comply with NRS 639.2809.

~~[9-]~~ (i) Implementation and modification of drug therapy, administering drugs and ordering and performing tests in accordance with a collaborative practice agreement.

~~(j) [Prescribing or ordering and the dispensing of contraceptive supplies pursuant to section 4 of this act.]~~ Dispensing a self-administered hormonal contraceptive pursuant to section 4.5 of this act.

~~[1-]~~ 2. The term does not include the changing of a prescription by a pharmacist or practitioner without the consent of the prescribing practitioner, except as otherwise provided in NRS 639.2583 ~~[1-]~~ and section ~~[4-]~~ 4.5 of this act.

**Sec. 7.** NRS 639.180 is hereby amended to read as follows:

639.180 1. Except as otherwise provided in this subsection, a certificate, license or permit issued by the Board pursuant to this chapter expires on October 31 of each even-numbered year. A certificate of registration as a pharmacist expires on October 31 of each odd-numbered year.

2. Except as otherwise provided by NRS 639.137, 639.230 and 639.2328, each person to whom a certificate, license or permit has been issued may, if the certificate, license or permit has not been revoked, renew the certificate, license or permit biennially by:

(a) Filing an application for renewal;

(b) Paying the fee for renewal;

(c) Complying with the requirement of continuing professional education, if applicable;

~~(d) If the person is a pharmacist who [prescribes or orders and dispenses contraceptive supplies pursuant to section 4 of this act.]~~ dispenses self-administered hormonal contraceptives pursuant to section 4.5 of this act, submitting proof to the Board that, during the immediately preceding 3 years, the person successfully completed a program related to [prescribing or ordering contraceptive supplies] dispensing self-administered hormonal contraceptives that is accredited by the Accreditation Council for Pharmacy Education or its successor organization and approved by the Board;

(e) If applicable, filing with the Board satisfactory evidence that his or her surety bond or other security required by NRS 639.515 is in full force; and

~~[(e)]~~ (f) Submitting all information required to complete the renewal.

3. The application for renewal, together with the fee for renewal, all required information and the evidence of compliance with NRS 639.515 must be delivered



1 to the Executive Secretary of the Board on or before the expiration date of the  
2 certificate, license or permit, or the current renewal receipt thereof.

3 4. If a certificate, license or permit is renewed, it must be delivered to the  
4 applicant within a reasonable time after receipt of the application for renewal and  
5 the fee for renewal.

6 5. The Board may refuse to renew a certificate, license or permit if the  
7 applicant has committed any act proscribed by NRS 639.210.

8 6. If the application for renewal, the fee for renewal, all required information  
9 and the evidence of compliance with NRS 639.515 are not postmarked on or before  
10 the expiration date of the certificate, license or permit, or the current renewal  
11 receipt thereof, the registration is automatically forfeited.

12 **Sec. 8.** NRS 639.210 is hereby amended to read as follows:

13 639.210 The Board may suspend or revoke any certificate, license,  
14 registration or permit issued pursuant to this chapter, and deny the application of  
15 any person for a certificate, license, registration or permit, if the holder or applicant:

16 1. Is not of good moral character;

17 2. Is guilty of habitual intemperance;

18 3. Becomes or is intoxicated or under the influence of liquor, any depressant  
19 drug or a controlled substance, unless taken pursuant to a lawfully issued  
20 prescription, while on duty in any establishment licensed by the Board;

21 4. Is guilty of unprofessional conduct or conduct contrary to the public  
22 interest;

23 5. Is addicted to the use of any controlled substance;

24 6. Has been convicted of a violation of any law or regulation of the Federal  
25 Government or of this or any other state related to controlled substances, dangerous  
26 drugs, drug samples, or the wholesale or retail distribution of drugs;

27 7. Has been convicted of:

28 (a) A felony relating to holding a certificate, license, registration or permit  
29 pursuant to this chapter;

30 (b) A felony pursuant to NRS 639.550 or 639.555; or

31 (c) Other crime involving moral turpitude, dishonesty or corruption;

32 8. Has been convicted of violating any of the provisions of NRS 616D.200,  
33 616D.220, 616D.240 or 616D.300 to 616D.440, inclusive;

34 9. Has willfully made to the Board or its authorized representative any false  
35 statement which is material to the administration or enforcement of any of the  
36 provisions of this chapter;

37 10. Has obtained any certificate, certification, license or permit by the filing  
38 of an application, or any record, affidavit or other information in support thereof,  
39 which is false or fraudulent;

40 11. Has violated any provision of the Federal Food, Drug and Cosmetic Act  
41 or any other federal law or regulation relating to prescription drugs;

42 12. Has violated, attempted to violate, assisted or abetted in the violation of or  
43 conspired to violate any of the provisions of this chapter or any law or regulation  
44 relating to drugs, the manufacture or distribution of drugs or the practice of  
45 pharmacy, or has knowingly permitted, allowed, condoned or failed to report a  
46 violation of any of the provisions of this chapter or any law or regulation relating to  
47 drugs, the manufacture or distribution of drugs or the practice of pharmacy  
48 committed by the holder of a certificate, license, registration or permit;

49 13. Has failed to renew a certificate, license or permit by failing to submit the  
50 application for renewal or pay the renewal fee therefor;

51 14. Has had a certificate, license or permit suspended or revoked in another  
52 state on grounds which would cause suspension or revocation of a certificate,  
53 license or permit in this State;

15. Has, as a managing pharmacist, violated any provision of law or regulation concerning recordkeeping or inventory in a store over which he or she presides, or has knowingly allowed a violation of any provision of this chapter or other state or federal laws or regulations relating to the practice of pharmacy by personnel of the pharmacy under his or her supervision;

16. Has repeatedly been negligent, which may be evidenced by claims of malpractice settled against him or her;

17. Has failed to maintain and make available to a state or federal officer any records in accordance with the provisions of this chapter or chapter 453 or 454 of NRS;

18. Has failed to file or maintain a bond or other security if required by NRS 639.515; ~~for~~

19. ~~Has [prescribed or ordered or] dispensed [contraceptive supplies] self-administered hormonal contraceptives under the standing order issued pursuant to section 11.5 of this act without complying with section 4.5 of this act; or~~

20. Has operated a medical facility, as defined in NRS 449.0151, at any time during which:

(a) The license of the facility was suspended or revoked; or

(b) An act or omission occurred which resulted in the suspension or revocation of the license pursuant to NRS 449.160.

➤ This subsection applies to an owner or other principal responsible for the operation of the facility.

**Sec. 9.** NRS 639.2174 is hereby amended to read as follows:

639.2174 The Board shall not renew the certificate of any registered pharmacist until the applicant has submitted proof to the Board of ~~the~~:

1. *The receipt of the required number of continuing education units, obtained through the satisfactory completion of an accredited program of continuing professional education during the period for which the certificate was issued ~~it~~; and*

2. *If the person is a pharmacist who ~~prescribes or orders and dispenses contraceptive supplies pursuant to section 4 of this act,~~ dispenses self-administered hormonal contraceptives pursuant to section 4.5 of this act, the successful completion, within the immediately preceding 3 years, of a program related to ~~prescribing or ordering contraceptive supplies,~~ dispensing self-administered hormonal contraceptives that is accredited by the Accreditation Council for Pharmacy Education or its successor organization and approved by the Board.*

**Sec. 10.** ~~NRS 639.28075 is hereby amended to read as follows:~~

~~639.28075 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 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 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 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.]] (Deleted by amendment.)~~

**Sec. 11.** NRS 422.27172 is hereby amended to read as follows:

422.27172 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:

- (1) Lawfully prescribed or ordered;
- (2) Approved by the Food and Drug Administration; and
- (3) Dispensed in accordance with NRS 639.28075;

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

(c) ~~[Contraceptive supplies prescribed or ordered and]~~ Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to section ~~[4]~~ 4.5 of this act;

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

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

~~[(e)]~~ (f) Management of side effects relating to contraception; and

~~[(f)]~~ (g) Voluntary sterilization for women.

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 contraception if the person refuses to accept a therapeutic equivalent of the contraceptive drug.

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:

(a) "Drug Use Review Board" has the meaning ascribed to it in NRS 422.402.

(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. 11.5. Chapter 439 of NRS is hereby amended by adding thereto a new section to read as follows:**

**1. The Chief Medical Officer or his or her designee shall issue a standing order to allow a pharmacist to dispense a self-administered hormonal contraceptive to any patient pursuant to section 4.5 of this act.**

**2. In consultation with the Chief Medical Officer, the State Board of Health shall prescribe by regulation a protocol for dispensing a self-administered hormonal contraceptive. The protocol must include, without limitation:**

**(a) Any information that must be included in a record concerning the dispensing of the self-administered hormonal contraceptive in addition to the information required by section 4.5 of this act; and**

**(b) The amount of time that such a record must be maintained by the dispensing pharmacist or his or her employer.**

**3. In consultation with the State Board of Pharmacy, the State Board of Health shall adopt regulations that prescribe:**

**(a) A risk assessment questionnaire that may be administered upon request to a patient who requests a self-administered hormonal contraceptive pursuant to section 4.5 of this act.**

**(b) Information that must be provided in writing to a patient to whom a self-administered hormonal contraceptive is dispensed pursuant to section 4.5 of this act, which may include, without limitation, information concerning:**

**(1) The importance of obtaining recommended tests and screening from a primary care provider or qualified provider of health care who specializes in women's health;**

**(2) The effectiveness of long-acting reversible contraceptives as an alternative to self-administered hormonal contraceptives;**

**(3) When to seek emergency medical services as a result of administering a self-administered hormonal contraceptive; and**

**(4) The risk of contracting a sexually transmitted infection and ways to reduce that risk.**

**4. The Division shall provide on an Internet website maintained by the Division an electronic link to the list of pharmacies maintained by the State Board of Pharmacy pursuant to section 4.5 of this act.**

**5. As used in this section:**

1 (a) "Primary care provider" means a provider of health care who provides or  
2 has provided care to the patient.

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

4 (c) "Self-administered hormonal contraceptive" has the meaning ascribed to  
5 it in section 2.5 of this act.

6 **Sec. 12.** NRS 689A.0418 is hereby amended to read as follows:

7 689A.0418 1. Except as otherwise provided in subsection 7, an insurer that  
8 offers or issues a policy of health insurance shall include in the policy coverage for:

9 (a) Up to a 12-month supply, per prescription, of any type of drug for  
10 contraception or its therapeutic equivalent which is:

11 (1) Lawfully prescribed or ordered;

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

13 (3) Listed in subsection 10; and

14 (4) Dispensed in accordance with NRS 639.28075;

15 (b) Any type of device for contraception which is:

16 (1) Lawfully prescribed or ordered;

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

18 (3) Listed in subsection 10;

19 ~~(c) [Contraceptive supplies prescribed or ordered and]~~ Self-administered  
20 hormonal contraceptives dispensed by a pharmacist pursuant to section 4.5 of  
21 this act;

22 (d) Insertion of a device for contraception or removal of such a device if the  
23 device was inserted while the insured was covered by the same policy of health  
24 insurance;

25 ~~(e)~~ (e) Education and counseling relating to the initiation of the use of  
26 contraception and any necessary follow-up after initiating such use;

27 ~~(f)~~ (f) Management of side effects relating to contraception; and

28 ~~(g)~~ (g) Voluntary sterilization for women.

29 2. An insurer must ensure that the benefits required by subsection 1 are made  
30 available to an insured through a provider of health care who participates in the  
31 network plan of the insurer.

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

36 4. Except as otherwise provided in subsections 8, 9 and 11, an insurer that  
37 offers or issues a policy of health insurance shall not:

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

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

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

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

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

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

1        5. Coverage pursuant to this section for the covered dependent of an insured  
2 must be the same as for the insured.

3        6. Except as otherwise provided in subsection 7, a policy subject to the  
4 provisions of this chapter that is delivered, issued for delivery or renewed on or  
5 after January 1, 2018, has the legal effect of including the coverage required by  
6 subsection 1, and any provision of the policy or the renewal which is in conflict  
7 with this section is void.

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

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

17        9. For each of the 18 methods of contraception listed in subsection 10 that  
18 have been approved by the Food and Drug Administration, a policy of health  
19 insurance must include at least one drug or device for contraception within each  
20 method for which no deductible, copayment or coinsurance may be charged to the  
21 insured, but the insurer may charge a deductible, copayment or coinsurance for any  
22 other drug or device that provides the same method of contraception.

23        10. The following 18 methods of contraception must be covered pursuant to  
24 this section:

- 25        (a) Voluntary sterilization for women;
- 26        (b) Surgical sterilization implants for women;
- 27        (c) Implantable rods;
- 28        (d) Copper-based intrauterine devices;
- 29        (e) Progesterone-based intrauterine devices;
- 30        (f) Injections;
- 31        (g) Combined estrogen- and progestin-based drugs;
- 32        (h) Progestin-based drugs;
- 33        (i) Extended- or continuous-regimen drugs;
- 34        (j) Estrogen- and progestin-based patches;
- 35        (k) Vaginal contraceptive rings;
- 36        (l) Diaphragms with spermicide;
- 37        (m) Sponges with spermicide;
- 38        (n) Cervical caps with spermicide;
- 39        (o) Female condoms;
- 40        (p) Spermicide;
- 41        (q) Combined estrogen- and progestin-based drugs for emergency  
42 contraception or progestin-based drugs for emergency contraception; and
- 43        (r) Ulipristal acetate for emergency contraception.

44        11. Except as otherwise provided in this section and federal law, an insurer  
45 may use medical management techniques, including, without limitation, any  
46 available clinical evidence, to determine the frequency of or treatment relating to  
47 any benefit required by this section or the type of provider of health care to use for  
48 such treatment.

49        12. An insurer shall not use medical management techniques to require an  
50 insured to use a method of contraception other than the method prescribed or  
51 ordered by a provider of health care.

52        13. An insurer must provide an accessible, transparent and expedited process  
53 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.

14. 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.

(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.** NRS 689B.0378 is hereby amended to read as follows:

689B.0378 1. Except as otherwise provided in subsection 7, 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:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with NRS 639.28075;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 11;

(c) ~~Contraceptive supplies prescribed or ordered and~~ Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to section 4.5 of this act;

(d) Insertion 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 group health insurance;

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

~~(f)~~ (f) Management of side effects relating to contraception; and

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

1       4. Except as otherwise provided in subsections 9, 10 and 12, an insurer that  
2 offers or issues a policy of group health insurance shall not:

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

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

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

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

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

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

19       5. Coverage pursuant to this section for the covered dependent of an insured  
20 must be the same as for the insured.

21       6. Except as otherwise provided in subsection 7, a policy subject to the  
22 provisions of this chapter that is delivered, issued for delivery or renewed on or  
23 after January 1, 2018, has the legal effect of including the coverage required by  
24 subsection 1, and any provision of the policy or the renewal which is in conflict  
25 with this section is void.

26       7. An insurer that offers or issues a policy of group health insurance and  
27 which is affiliated with a religious organization is not required to provide the  
28 coverage required by subsection 1 if the insurer objects on religious grounds. Such  
29 an insurer shall, before the issuance of a policy of group health insurance and  
30 before the renewal of such a policy, provide to the group policyholder or  
31 prospective insured, as applicable, written notice of the coverage that the insurer  
32 refuses to provide pursuant to this subsection.

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

36       9. An insurer may require an insured to pay a higher deductible, copayment or  
37 coinsurance for a drug for contraception if the insured refuses to accept a  
38 therapeutic equivalent of the drug.

39       10. For each of the 18 methods of contraception listed in subsection 11 that  
40 have been approved by the Food and Drug Administration, a policy of group health  
41 insurance must include at least one drug or device for contraception within each  
42 method for which no deductible, copayment or coinsurance may be charged to the  
43 insured, but the insurer may charge a deductible, copayment or coinsurance for any  
44 other drug or device that provides the same method of contraception.

45       11. The following 18 methods of contraception must be covered pursuant to  
46 this section:

47       (a) Voluntary sterilization for women;

48       (b) Surgical sterilization implants for women;

49       (c) Implantable rods;

50       (d) Copper-based intrauterine devices;

51       (e) Progesterone-based intrauterine devices;

52       (f) Injections;

53       (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) Ulipristal acetate for emergency contraception.

12. 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.

13. 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.

14. 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.

15. 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.

(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. 14.** NRS 689C.1676 is hereby amended to read as follows:

689C.1676 1. Except as otherwise provided in subsection 7, 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:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with NRS 639.28075;

(b) Any type of device for contraception which is:

- (1) Lawfully prescribed or ordered;
- (2) Approved by the Food and Drug Administration; and
- (3) Listed in subsection 10;

(c) ~~{Contraceptive supplies prescribed or ordered and}~~ Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to section ~~44~~ 4.5 of this act;

(d) Insertion 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;

~~{(e)}~~ (e) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use;

~~{(e)}~~ (f) Management of side effects relating to contraception; and

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

4. Except as otherwise provided in subsections 8, 9 and 11, a carrier that offers or issues a health benefit plan shall not:

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

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

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

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

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

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

5. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.

6. Except as otherwise provided in subsection 7, 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.

7. 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.

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

9. For each of the 18 methods of contraception listed in subsection 10 that have been approved by the Food and Drug Administration, a health benefit plan must include at least one drug or device for contraception within each method 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 drug or device that provides the same method of contraception.

10. 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) Ulipristal acetate for emergency contraception.

11. 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.

12. 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.

13. 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.

14. 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.

(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. 15.** NRS 695A.1865 is hereby amended to read as follows:

695A.1865 1. Except as otherwise provided in subsection 7, 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:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with NRS 639.28075;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 10;

(c) ~~Contraceptive supplies prescribed or ordered and~~ Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to section 4.5 of this act;

(d) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same benefit contract;

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

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

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

4. Except as otherwise provided in subsections 8, 9 and 11, a society that offers or issues a benefit contract shall not:

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

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

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

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

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

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

3 5. Coverage pursuant to this section for the covered dependent of an insured  
4 must be the same as for the insured.

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

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

16 8. A society may require an insured to pay a higher deductible, copayment or  
17 coinsurance for a drug for contraception if the insured refuses to accept a  
18 therapeutic equivalent of the drug.

19 9. For each of the 18 methods of contraception listed in subsection 10 that  
20 have been approved by the Food and Drug Administration, a benefit contract must  
21 include at least one drug or device for contraception within each method for which  
22 no deductible, copayment or coinsurance may be charged to the insured, but the  
23 society may charge a deductible, copayment or coinsurance for any other drug or  
24 device that provides the same method of contraception.

25 10. The following 18 methods of contraception must be covered pursuant to  
26 this section:

- 27 (a) Voluntary sterilization for women;
- 28 (b) Surgical sterilization implants for women;
- 29 (c) Implantable rods;
- 30 (d) Copper-based intrauterine devices;
- 31 (e) Progesterone-based intrauterine devices;
- 32 (f) Injections;
- 33 (g) Combined estrogen- and progestin-based drugs;
- 34 (h) Progestin-based drugs;
- 35 (i) Extended- or continuous-regimen drugs;
- 36 (j) Estrogen- and progestin-based patches;
- 37 (k) Vaginal contraceptive rings;
- 38 (l) Diaphragms with spermicide;
- 39 (m) Sponges with spermicide;
- 40 (n) Cervical caps with spermicide;
- 41 (o) Female condoms;
- 42 (p) Spermicide;
- 43 (q) Combined estrogen- and progestin-based drugs for emergency  
44 contraception or progestin-based drugs for emergency contraception; and  
45 (r) Ulipristal acetate for emergency contraception.

46 11. Except as otherwise provided in this section and federal law, a society  
47 may use medical management techniques, including, without limitation, any  
48 available clinical evidence, to determine the frequency of or treatment relating to  
49 any benefit required by this section or the type of provider of health care to use for  
50 such treatment.

51 12. A society shall not use medical management techniques to require an  
52 insured to use a method of contraception other than the method prescribed or  
53 ordered by a provider of health care.

13. 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.

14. 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. 16.** NRS 695B.1919 is hereby amended to read as follows:

695B.1919 1. Except as otherwise provided in subsection 7, 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:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with NRS 639.28075;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 11;

(c) ~~Contraceptive supplies prescribed or ordered and~~ Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to section 4.5 of this act;

(d) Insertion of a device for contraception 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;

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

~~(f)~~ (f) Management of side effects relating to contraception; and

~~(g)~~ (g) Voluntary sterilization for women.

2. An insurer that offers or issues a contract for hospital or medical services 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. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically

1 inappropriate, an alternate therapeutic equivalent prescribed by a provider of health  
2 care must be covered by the insurer.

3 4. Except as otherwise provided in subsections 9, 10 and 12, an insurer that  
4 offers or issues a contract for hospital or medical service shall not:

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

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

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

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

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

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

22 5. Coverage pursuant to this section for the covered dependent of an insured  
23 must be the same as for the insured.

24 6. Except as otherwise provided in subsection 7, a contract for hospital or  
25 medical service subject to the provisions of this chapter that is delivered, issued for  
26 delivery or renewed on or after January 1, 2018, has the legal effect of including the  
27 coverage required by subsection 1, and any provision of the contract or the renewal  
28 which is in conflict with this section is void.

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

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

38 9. An insurer may require an insured to pay a higher deductible, copayment or  
39 coinsurance for a drug for contraception if the insured refuses to accept a  
40 therapeutic equivalent of the drug.

41 10. For each of the 18 methods of contraception listed in subsection 11 that  
42 have been approved by the Food and Drug Administration, a contract for hospital or  
43 medical service must include at least one drug or device for contraception within  
44 each method for which no deductible, copayment or coinsurance may be charged to  
45 the insured, but the insurer may charge a deductible, copayment or coinsurance for  
46 any other drug or device that provides the same method of contraception.

47 11. The following 18 methods of contraception must be covered pursuant to  
48 this section:

49 (a) Voluntary sterilization for women;

50 (b) Surgical sterilization implants for women;

51 (c) Implantable rods;

52 (d) Copper-based intrauterine devices;

53 (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) Ulipristal acetate for emergency contraception.

12. Except as otherwise provided in this section and federal law, an insurer that offers or issues a contract for hospital or medical services 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.

13. 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.

14. 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.

15. 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.

(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. 17.** NRS 695C.1696 is hereby amended to read as follows:

695C.1696 1. Except as otherwise provided in subsection 7, 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:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;



- (3) Listed in subsection 11; and  
(4) Dispensed in accordance with NRS 639.28075;  
(b) Any type of device for contraception which is:  
(1) Lawfully prescribed or ordered;  
(2) Approved by the Food and Drug Administration; and  
(3) Listed in subsection 11;

(c) ~~Contraceptive supplies prescribed or ordered and~~ Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to section 4.5 of this act;

(d) Insertion 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;

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

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

~~(e)~~ (g) 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. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the health maintenance organization.

4. Except as otherwise provided in subsections 9, 10 and 12, a health maintenance organization that offers or issues a health care plan shall not:

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

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

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

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

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

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

5. Coverage pursuant to this section for the covered dependent of an enrollee must be the same as for the enrollee.

6. Except as otherwise provided in subsection 7, 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.

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

1 written notice of the coverage that the health maintenance organization refuses to  
2 provide pursuant to this subsection.

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

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

9 10. For each of the 18 methods of contraception listed in subsection 11 that  
10 have been approved by the Food and Drug Administration, a health care plan must  
11 include at least one drug or device for contraception within each method for which  
12 no deductible, copayment or coinsurance may be charged to the enrollee, but the  
13 health maintenance organization may charge a deductible, copayment or  
14 coinsurance for any other drug or device that provides the same method of  
15 contraception.

16 11. The following 18 methods of contraception must be covered pursuant to  
17 this section:

- 18 (a) Voluntary sterilization for women;
- 19 (b) Surgical sterilization implants for women;
- 20 (c) Implantable rods;
- 21 (d) Copper-based intrauterine devices;
- 22 (e) Progesterone-based intrauterine devices;
- 23 (f) Injections;
- 24 (g) Combined estrogen- and progestin-based drugs;
- 25 (h) Progestin-based drugs;
- 26 (i) Extended- or continuous-regimen drugs;
- 27 (j) Estrogen- and progestin-based patches;
- 28 (k) Vaginal contraceptive rings;
- 29 (l) Diaphragms with spermicide;
- 30 (m) Sponges with spermicide;
- 31 (n) Cervical caps with spermicide;
- 32 (o) Female condoms;
- 33 (p) Spermicide;
- 34 (q) Combined estrogen- and progestin-based drugs for emergency  
35 contraception or progestin-based drugs for emergency contraception; and
- 36 (r) Ulipristal acetate for emergency contraception.

37 12. Except as otherwise provided in this section and federal law, a health  
38 maintenance organization may use medical management techniques, including,  
39 without limitation, any available clinical evidence, to determine the frequency of or  
40 treatment relating to any benefit required by this section or the type of provider of  
41 health care to use for such treatment.

42 13. A health maintenance organization shall not use medical management  
43 techniques to require an enrollee to use a method of contraception other than the  
44 method prescribed or ordered by a provider of health care.

45 14. A health maintenance organization must provide an accessible,  
46 transparent and expedited process which is not unduly burdensome by which an  
47 enrollee, or the authorized representative of the enrollee, may request an exception  
48 relating to any medical management technique used by the health maintenance  
49 organization to obtain any benefit required by this section without a higher  
50 deductible, copayment or coinsurance.

51 15. As used in this section:

52 (a) "Medical management technique" means a practice which is used to control  
53 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.

(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. 18.** NRS 695G.1715 is hereby amended to read as follows:

695G.1715 1. Except as otherwise provided in subsection 7, 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:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with NRS 639.28075;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 10;

(c) ~~Contraceptive supplies prescribed or ordered and~~ Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to section 4.5 of this act;

(d) Insertion 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 care plan;

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

~~(f)~~ (f) Management of side effects relating to contraception; and

~~(g)~~ (g) Voluntary sterilization for women.

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

4. Except as otherwise provided in subsections 8, 9 and 11, a managed care organization that offers or issues a health care plan shall not:

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

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

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

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

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

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

14 5. Coverage pursuant to this section for the covered dependent of an insured  
15 must be the same as for the insured.

16 6. Except as otherwise provided in subsection 7, a health care plan subject to  
17 the provisions of this chapter that is delivered, issued for delivery or renewed on or  
18 after January 1, 2018, has the legal effect of including the coverage required by  
19 subsection 1, and any provision of the plan or the renewal which is in conflict with  
20 this section is void.

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

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

31 9. For each of the 18 methods of contraception listed in subsection 10 that  
32 have been approved by the Food and Drug Administration, a health care plan must  
33 include at least one drug or device for contraception within each method for which  
34 no deductible, copayment or coinsurance may be charged to the insured, but the  
35 managed care organization may charge a deductible, copayment or coinsurance for  
36 any other drug or device that provides the same method of contraception.

37 10. The following 18 methods of contraception must be covered pursuant to  
38 this section:

- 39 (a) Voluntary sterilization for women;
- 40 (b) Surgical sterilization implants for women;
- 41 (c) Implantable rods;
- 42 (d) Copper-based intrauterine devices;
- 43 (e) Progesterone-based intrauterine devices;
- 44 (f) Injections;
- 45 (g) Combined estrogen- and progestin-based drugs;
- 46 (h) Progestin-based drugs;
- 47 (i) Extended- or continuous-regimen drugs;
- 48 (j) Estrogen- and progestin-based patches;
- 49 (k) Vaginal contraceptive rings;
- 50 (l) Diaphragms with spermicide;
- 51 (m) Sponges with spermicide;
- 52 (n) Cervical caps with spermicide;
- 53 (o) Female condoms;

1 (p) Spermicide;

2 (q) Combined estrogen- and progestin-based drugs for emergency  
3 contraception or progestin-based drugs for emergency contraception; and

4 (r) Ulipristal acetate for emergency contraception.

5 11. Except as otherwise provided in this section and federal law, a managed  
6 care organization may use medical management techniques, including, without  
7 limitation, any available clinical evidence, to determine the frequency of or  
8 treatment relating to any benefit required by this section or the type of provider of  
9 health care to use for such treatment.

10 12. A managed care organization shall not use medical management  
11 techniques to require an insured to use a method of contraception other than the  
12 method prescribed or ordered by a provider of health care.

13 13. A managed care organization must provide an accessible, transparent and  
14 expedited process which is not unduly burdensome by which an insured, or the  
15 authorized representative of the insured, may request an exception relating to any  
16 medical management technique used by the managed care organization to obtain  
17 any benefit required by this section without a higher deductible, copayment or  
18 coinsurance.

19 14. As used in this section:

20 (a) "Medical management technique" means a practice which is used to control  
21 the cost or utilization of health care services or prescription drug use. The term  
22 includes, without limitation, the use of step therapy, prior authorization or  
23 categorizing drugs and devices based on cost, type or method of administration.

24 (b) "Network plan" means a health care plan offered by a managed care  
25 organization under which the financing and delivery of medical care, including  
26 items and services paid for as medical care, are provided, in whole or in part,  
27 through a defined set of providers under contract with the managed care  
28 organization. The term does not include an arrangement for the financing of  
29 premiums.

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

31 (d) "Therapeutic equivalent" means a drug which:

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

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

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

38 **Sec. 19.** The provisions of NRS 354.599 do not apply to any additional  
39 expenses of a local government that are related to the provisions of this act.

40 **Sec. 20.** This act becomes effective:

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

44 2. On January 1, 2020, for all other purposes.