Amendment No. 272

retained in this amendment.

Assembly Amendment to Assembly Bill No. 383	(BDR 40-116)				
Proposed by: Assembly Committee on Health and Human Services					
Amends: Summary: No Title: Yes Preamble: No Joint Sponsorship: No	Digest: Yes				
Adoption of this amendment will REMOVE the unfunded mandate from A.B. 383.					
ASSEMBLY ACTION Initial and Date SENATE ACTION In	nitial and Date				
Adopted Lost Lost Lost]				
Concurred In Not Concurred In Not Not]				
Receded Not]				
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) <u>orange double underlining</u> is deleted language in the original bill proposed to be					

DAN/EWR Date: 4/21/2023

A.B. No. 383—Revises provisions relating to health care. (BDR 40-116)

ASSEMBLY BILL NO. 383—ASSEMBLYMEN TORRES, PETERS, GORELOW, GONZÁLEZ; ANDERSON, BILBRAY-AXELROD, BROWN-MAY, CONSIDINE, D'SILVA, DURAN, JAUREGUI, C.H. MILLER, NEWBY, SUMMERS-ARMSTRONG, THOMAS AND WATTS

MARCH 22, 2023

JOINT SPONSORS: SENATOR D. HARRIS

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to health care. (BDR 40-116)

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

Effect on the State: Yes.

[CONTAINS UNFUNDED MANDATE (§ 14 & NRS 287.010) (Not Requested by Affected Local Government)]

EXPLANATION - Matter in bolded italics is new; matter between brackets [omitted material] is material to be omitted.

AN ACT relating to health care; prohibiting a governmental entity from substantially burdening certain activity relating to [contraception] reproductive health services under certain circumstances; authorizing a person whose engagement in such activity has been so burdened to assert the violation as a claim or defense in a judicial proceeding; authorizing a court to award damages against a governmental entity that substantially burdens such activity in certain circumstances; expanding required [insurance] coverage of contraception [1] under the State Plan for Medicaid; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law prescribes certain rights for a patient of a medical facility or a facility for the dependent. (NRS 449A.100-449A.124) Sections 2-7 of this bill establish the Right to [Contraception] Reproductive Health Care Act. Sections [4 and 5] 4-5.5 of this bill define certain terms for purposes of the Act. Section 6 of this bill applies the provisions of the Act to [all] certain state laws and all local laws and ordinances and the implementation of those laws and ordinances, regardless of when those laws or ordinances were enacted. Section 7 of this bill generally prohibits a governmental entity from enacting or implementing any limitation or requirement that singles out [contraception] reproductive health services and substantially burdens: (1) the access of a person to [contraceptives, contraception] reproductive health services or information related to [contraception] reproductive health services or information related to a provide [contraceptives, contraception] reproductive health services or information related to [contraception] reproductive health services or information related to [cont

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experience. Section 7 creates an exception to such prohibitions if the governmental entity demonstrates by clear and convincing evidence that the burden, as applied to the person or provider of health care who is subject to the burden: (1) furthers a compelling interest; and (2) is the least restrictive means of furthering that interest. Section 7 authorizes a person whose ability to obtain or provide [contraceptives, contraception] reproductive health services, drugs or devices related to reproductive health services or information related to [contraception] reproductive health services is burdened to bring or defend an action in court and obtain appropriate relief. Section 7 requires a court to award costs and attorney's fees to a person who prevails on such a claim.

Existing law requires [public and private policies of insurance regulated under Nevada the State Plan for Medicaid to include coverage for certain contraceptive drugs and devices, including: (1) up to a 12-month supply of contraceptive drugs; (2) certain devices for contraception; and (3) voluntary sterilization for women. (NRS [287.010, 287.04335,] 422.27172 [, 689A.0418, 689B.0378, 689C.1676, 695A.1865, 695B.1919, 695C.1696, 695G.1715) Sections]) Section 8 [and 13-19] of this bill additionally [require such policies of insurance requires the State Plan for Medicaid to cover: (1) voluntary sterilization for men; (2) clinical services relating to covered contraceptive drugs, devices and services; and (3) a portion of the cost of language translation services provided to facilitate the provision of covered contraceptive drugs, devices and services. [Sections 8, 10 and 13-19 of this bill prohibit an insurer from requiring an insured to obtain prior authorization before receiving a contraceptive drug. Sections Section 8 [and 13-19] also [require an insurer] requires the State Plan to: (1) cover certain contraceptive services when provided by [a pharmacist; and] any provider of health care for whom the services are within his or her scope of practice, training and experience; (2) reimburse a [pharmaeist] provider of health care, other than a physician, physician assistant or advanced practice registered nurse, for providing such services at a rate that is not less than the rate provided to a physician, physician assistant or advanced practice registered nurse [. Section 9 of this bill requires an insurer to demonstrate the capacity to adequately deliver family planning services provided by pharmacists to covered persons. Sections 11 and 12 of this bill make conforming changes to indicate the proper placement of section 9 in the Nevada Revised Statutes.]; and (3) cover such services regardless of whether the services are provided in an inpatient or outpatient setting.

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

- Section 1. Chapter 449A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 7, inclusive, of this act.
- Sec. 2. Sections 2 to 7, inclusive, of this act may be cited as the Right to [Contraception] Reproductive Health Care Act.
- Sec. 3. As used in sections 2 to 7, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 4, [and] 5 and 5.5 of this act have the meanings ascribed to them in those sections.
- Sec. 4. "Governmental entity" means the State of Nevada or any of its agencies or political subdivisions.
- Sec. 5. "Provider of health care" has the meaning ascribed to it in NRS *629.031*.
- Sec. 5.5. "Reproductive health services" means medical, surgical, counseling or referral services relating to the human reproductive system, including, without limitation, services relating to pregnancy, contraception, miscarriage, in-vitro fertilization or any procedure or care found by a competent medical professional to be appropriate based upon the wishes of a patient and in accordance with the laws of this State.
- Sec. 6. 1. [The] Except as otherwise provided in this subsection, the provisions of sections 2 to 7, inclusive, of this act apply to all state and local laws

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and ordinances and the implementation of those laws and ordinances, whether statutory or otherwise, and whether enacted before, on or after January 1, 2024. The provisions of sections 2 to 7, inclusive, of this act do not apply to NRS 442.250 or the implementation of NRS 442.250. State laws that are enacted on or after January 1, 2024, are subject to the

provisions of sections 2 to 7, inclusive, of this act unless the law explicitly

excludes such application by reference to this section.

3. The provisions of sections 2 to 7, inclusive, of this act do not:

(a) Authorize a governmental entity to burden:

(1) The access of any person to [contraceptive] reproductive health services, information related to [contraception] reproductive health services or any [contraceptive] drug or device [;] related to reproductive health services; or

(2) The ability of a provider of health care to provide [contraceptive] reproductive health services or information related to [contraception] reproductive health services or to provide, administer, dispense or prescribe any [contraceptive] drug or device related to reproductive health services within the scope of practice, training and experience of the provider of health care.

(b) Authorize or sanction any sterilization procedure without the voluntary

and informed consent of the patient.

Sec. 7. 1. Except as otherwise provided in this section, a governmental

entity shall not enact or implement any limitation or requirement that:

(a) Expressly, effectively, implicitly or, as implemented, singles out [contraceptives, contraception] reproductive health services, drugs or devices related to reproductive health services or information related to feontraception reproductive health services or any providers of health care or facilities that provide [contraceptives, contraception] reproductive health services, drugs or devices related to reproductive health services or information related to [contraception;] reproductive health services; and

(b) Substantially burdens:

(1) The access of a person to feontraceptives, contraception? reproductive health services, drugs or devices related to reproductive health services or information related to [contraception;] reproductive health services; or

(2) The ability of a provider of health care to provide [contraceptives, contraception] reproductive health services, drugs or devices related to reproductive health services or information related to feontraception? reproductive health services within the scope of practice, training and experience

of the provider of health care.

- 2. A governmental entity may enact a requirement or limitation described in subsection 1 if the governmental entity demonstrates by clear and convincing evidence that the burden imposed by the requirement or limitation on the activity described in paragraph (b) of subsection 1, as applied to the person or provider of health care who is subject to the burden:
 - (a) Furthers a compelling interest; and

(b) Is the least restrictive means of furthering that interest.

- 3. Notwithstanding any provision of NRS 41.0305 to 41.039, inclusive, but subject to the limitation on damages set forth in NRS 41.035 when applicable, a person or provider of health care who has been substantially burdened in violation of this section may assert that violation as a claim or defense in a judicial proceeding and obtain appropriate relief. A court shall award costs and attorney's fees to a person who prevails on such a claim or defense pursuant to this section.
- 4. A court may find that a person is a vexatious litigant if the person makes a claim within the scope of sections 2 to 7, inclusive, of this act which is without

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merit, fraudulent or otherwise intended to harass or annoy a person. If a court finds that a person is a vexatious litigant pursuant to this subsection, the court may deny standing to that person to bring further claims which allege a violation of this section.

Sec. 8. 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) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078:

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

- (e) Education and counseling relating to the initiation of the use of contraceptives and any necessary follow-up after initiating such use;
 - (f) Management of side effects relating to contraception; [and]

(g) Voluntary sterilization [for women.]; and

- (h) Any clinical services relating to the drugs, devices and services described in paragraphs (a) to (g), inclusive. Such clinical services, include, without limitation, services to monitor the use and effectiveness of contraception.
- 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.

- 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. The Plan must [provide]:

- (a) Provide for the reimbursement of a [pharmaeist] provider of health care for providing services described in subsection 1 [that] if the services are within the scope of practice, training and experience of the [pharmacist. The Plan must
- (a) Coverage for such services provided by a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.
- (b) Reimbursement for such services provided by a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician,

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- physician assistant or advanced practice registered nurse.] provider of health care.
- (b) Provide coverage for the services described in subsection 1 regardless of whether those services are provided in an inpatient or outpatient setting.
- The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:
- (a) One-quarter of the costs of any language translation services provided to facilitate the provision of any drug, device or service described in subsection 1 to a recipient of Medicaid who is eligible for the Children's Health Insurance Program: and
- (b) One-half of the costs of any language translation services provided to facilitate the provision of any drug, device or service described in subsection 1 to a recipient of Medicaid who is not eligible for the Children's Health Insurance Program.
- 8. [The Plan must not require a recipient of Medicaid to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1. 4. 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. 9. [Chapter 687B of NRS is hereby amended by adding thereto a new section to read as follows:
- 1. A health carrier which offers or issues a network plan must demonstrate the capacity to adequately deliver family planning services provided by pharmacists to covered persons in accordance with the regulations adopted pursuant to subsection 2.
- 2. The Commissioner shall adopt regulations to carry out the provisions of this section, including, without limitation, regulations prescribing requirements for a health carrier to demonstrate compliance with subsection 1. Those regulations must not allow a health earrier to demonstrate the capacity to adequately deliver family planning services to covered persons by demonstrating that the health carrier has entered into a network contract with one or more pharmacies for the sole purpose of dispensing prescription drugs to covered persons.] (Deleted by amendment.)
 - Sec. 10. [NRS 687B.225 is hereby amended to read as follows
- 1. Except as otherwise provided in NRS 689A.0405, 689A.0412, 689A.0413, 689A.0418, 689A.044, 689A.0445, 689B.031, 689B.0313, 689B.0315, 689B.0317, 689B.0374, 689B.0378, 689C.1675, 689C.1676, 695A.1856, 695A.1865, 695B.1912, 695B.1913, 695B.1914, 695B.1919, 695B.1925, 695B.1942, 695C.1696, 695C.1713, 695C.1735, 695C.1737, 695C.1745, 695C.1751, 695G.170, 695G.171, 695G.1714 , 695G.1715 and 695G.177, any contract for group, blanket or individual health incurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the incured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:
- (a) File its procedure for obtaining approval of care pursuant to this section for approval by the Commissioner; and

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(b) Respond to any request for approval by the insured or member pursuant to
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       this section within 20 days after it receives the request.
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           2. The procedure for prior authorization may not discriminate among persons
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       <del>licensed to provide the covered care.]</del> (Deleted by amendment.)
           Sec. 11. [NRS 687B.600 is hereby amended to read as follows:
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           687B.600 As used in NRS 687B.600 to 687B.850, inclusive, and section 9 of
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       this act, unless the context otherwise requires, the words and terms defined in NRS
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       687B.602 to 687B.665, inclusive, have the meanings ascribed to them in those
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       sections.] (Deleted by amendment.)
           Sec. 12. [NRS 687B.670 is hereby amended to read as follows:
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           687B.670 If a health carrier offers or issues a network plan, the health carrier
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       shall, with regard to that network plan:
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          1. Comply with all applicable requirements set forth in NRS 687B.600 to
       687B.850, inclusive [;], and section 9 of this act;
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       2. As applicable, ensure that each contract entered into for the purposes of the
       network plan between a participating provider of health care and the health earrier
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       complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive
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       [:] and section 9 of this act: and
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           3. As applicable, ensure that the network plan complies with the requirements
       set forth in NRS 687B.600 to 687B.850, inclusive [.], and section 9 of this act.]
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       (Deleted by amendment.)
           Sec. 13. [NRS 689A.0418 is hereby amended to read as follows:
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           689A.0418
                      1. Except as otherwise provided in subsection [7,] 8, an insurer
       that offers or issues a policy of health insurance shall include in the policy coverage
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       for:
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          (a) Up to a 12 month supply, per prescription, of any type of drug for
       contraception or its therapeutic equivalent which is:
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               (1) Lawfully prescribed or ordered;
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               (2) Approved by the Food and Drug Administration;
               (3) Listed in subsection [10;] 11; and
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               (4) Dispensed in accordance with NRS 639.28075;
           (b) Any type of device for contraception which is:
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               (1) Lawfully prescribed or ordered;
(2) Approved by the Food and Drug Administration; and
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               (3) Listed in subsection [10:] 11:
           (c) Solf administered hormonal contraceptives dispensed by a pharmacist
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       pursuant to NRS 639.28078:
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           (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 health
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       insurance:
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           (e) Education and counseling relating to the initiation of the use
       contraception and any necessary follow up after initiating such use;
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           (f) Management of side effects relating to contraception; [and]
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           (g) Voluntary sterilization [for women.];
           (h) Any clinical service relating to the drugs, devices and services described
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       in paragraphs (a) to (g), inclusive, including, without limitation, services to
       monitor the use and effectiveness of such drugs, devices and services; and
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           (i) One quarter of the costs of any language translation services provided to
       facilitate the provision of any item or service described in paragraphs (a) to (h),
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       inclusive.
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           2. An insured is entitled to reimbursement for services listed in subsection 1
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       which are within the authorized scope of practice of a pharmacist when such
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services are provided by a pharmacist who participates in the network plan of the insurer. The terms of the policy must not limit: (a) Coverage for services listed in subsection 1 and provided by such a

pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.

(b) Reimbursement for services listed in subsection 1 and provided by such a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.

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.] 4. 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.

[4.] 5. Except as otherwise provided in subsections [8,] 9, 10 and [11,] 12, an insurer that offers or issues a policy of health insurance shall not:

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

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

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

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

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

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

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

[6.] 7. Except as otherwise provided in subsection [7,] 8, a policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, [2022,] 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void

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

[8.] 9. An insurer 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.] 10. For each of the 18 methods of contraception listed in subsection [10] 11 that have been approved by the Food and Drug Administration, a policy of health insurance must include at least one drug or device for contraception within

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each method for which no deductible, copayment or coinsurance may be charged to
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       the insured, but the insurer may charge a deductible, copayment or coinsurance for
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       any other drug or device that provides the same method of contraception.
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           [10.] H. The following 18 methods of contraception must be covered
       pursuant to this section:
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           (a) Voluntary sterilization ; [for women;]
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    (b) Surgical sterilization implants for women;

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           (e) Implantable rods;
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           (d) Copper-based intrauterine devices;
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           (e) Progesterone-based intrauterine devices:
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           (f) Injections;
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           (g) Combined estrogen- and progestin-based drugs;
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           (h) Procestin-based drugs:
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           (i) Extended- or continuous-regimen drugs;
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           (i) Estrogen- and progestin-based patches;
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           (k) Vaginal contraceptive rings;
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           (1) Diaphragms with spermicide;
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           (m) Sponges with spermicide;
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           (n) Cervical caps with spermicide;
           (o) Female condoms;
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           (p) Spermieide;
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       contraception or progestin based drugs for emergency contraception; and
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           (r) Ulipristal acetate for emergency contraception.
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           [11.] 12. Except as otherwise provided in this section and federal law.
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       insurer may use medical management techniques, including, without limitation, any
       available clinical evidence, to determine the frequency of or treatment relating to
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       any benefit required by this section or the type of provider of health care to use for
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       such treatment.
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           [12.] 13. An insurer shall not [use]:
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           (a) Use medical management techniques to require an insured to use a method
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       of contraception other than the method prescribed or ordered by a provider of
       health care [.
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           13.] ; or
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           (b) Require an insured to obtain prior authorization for the benefits
       described in paragraphs (a) and (c) of subsection 1.
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           14. An insurer must provide an accessible, transparent and expedited process
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       which is not unduly burdensome by which an insured, or the authorized
       representative of the insured, may request an exception relating to any medical
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       management technique used by the insurer to obtain any benefit required by this
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       section without a higher deductible, copayment or coinsurance.
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           [14.] 15. As used in this section:
           (a) "Medical management technique" means a practice which is used to control
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       the cost or utilization of health care services or prescription drug use. The term
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       includes, without limitation, the use of step therapy, prior authorization or
       categorizing drugs and devices based on cost, type or method of administration.
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           (b) "Network plan" means a policy of health insurance offered by an insurer
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       under which the financing and delivery of medical care, including items and
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       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
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       an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.
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           (d) "Therapeutic equivalent" means a drug which:
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(1) Contains an identical amount of the same active incredients in the same 2 dosage and method of administration as another drug: 3 (2) Is expected to have the same clinical effect when administered to a 4 patient pursuant to a prescription or order as another drug; and 5 (3) Meets any other criteria required by the Food and Drug Administration 6 for classification as a therapeutic equivalent.] (Deleted by amendment.) Sec. 14. [NRS 689B.0378 is hereby amended to read as follows: 7 8 1. Except as otherwise provided in subsection [7,] 8, an insurer 9 that offers or issues a policy of group health insurance shall include in the policy 10 coverage for: 11 (a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is: 12 13 (1) Lawfully prescribed or ordered; (2) Approved by the Food and Drug Administration; 14 15 (3) Listed in subsection [11;] 12; and (4) Dispensed in accordance with NRS 639.28075; 16 17 (b) Any type of device for contraception which is: 18 (1) Lawfully prescribed or ordered: 19 (2) Approved by the Food and Drug Administration; and 20 (3) Listed in subsection [11;] 12; 21 (e) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078; 22 23 (d) Insertion of a device for contraception or removal of such a device if the 24 device was inserted while the insured was covered by the same policy of group 2.5 health insurance; 26 (e) Education and counseling relating to the initiation of the use of contraception and any necessary follow up after initiating such use: 27 (f) Management of side effects relating to contraception; [and] 28 (g) Voluntary sterilization [for women.]; 29 30 (h) Any clinical service relating to the drugs, devices and services described 31 in paragraphs (a) to (g), inclusive, including, without limitation, services to 32 monitor the use and effectiveness of such drugs, devices and services; and 33 (i) One quarter of the costs of any language translation services provided to 34 facilitate the provision of any item or service described in paragraphs (a) to (h), 35 inclusive. 2. An insured is entitled to reimbursement for services listed in subsection 1 36 37 which are within the authorized scope of practice of a pharmacist when such 38 services are provided by a pharmacist who participates in the network plan of the insurer. The terms of the policy must not limit: 39 40 (a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services 41 when provided by another provider of health care. 42 (b) Reimbursement for services listed in subsection 1 and provided by such a 43 pharmacist to an amount less than the amount reimbursed for similar services 44 45 provided by a physician, physician assistant or advanced practice registered 46 nurse. An insurer must ensure that the benefits required by subsection 1 are made 47 48 available to an insured through a provider of health care who participates in the 49 network plan of the insurer. 50 [3.] A. If a covered therapeutic equivalent listed in subsection 1 is not 51 available or a provider of health care deems a covered therapeutic equivalent to be 52 medically inappropriate, an alternate therapeutic equivalent prescribed by a 53 provider of health care must be covered by the insurer.

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 - (f) Injections;

- [4.] 5. Except as otherwise provided in subsections [9,] 10, 11 and [12,] 13, an insurer that offers or issues a policy of group health insurance shall not:
- (a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit included in the policy pursuant to subsection 1;
- (b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;
- (e) 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.] 6. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.
- [6.] 7. Except as otherwise provided in subsection [7,] 8, a policy subject to provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, [2022,] 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.
- [7.] 8. An insurer that offers or issues a policy of group health insurance and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of group health insurance and before the renewal of such a policy, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection.
- [8.] 9. If an insurer refuses, pursuant to subsection [7,] 8, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.
- [9.] 10. An insurer 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.
- [10.] II. For each of the 18 methods of contraception listed in subsection [11] 12 that have been approved by the Food and Drug Administration, a policy of group health insurance 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 insurer may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.
- [11.] 12. 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;

(g) Combined estrogen- and progestin-based drugs; 2 (h) Procestin-based drugs: 3 (i) Extended- or continuous-regimen drugs; 4 (j) Estrogen- and progestin-based patches; 5 (k) Vaginal contraceptive rings; 6 (l) Diaphragms with spermicide; 7 (m) Sponges with spermicide; 8 (n) Cervical caps with spermicide; 9 (o) Female condoms; (p) Spermicide; 10 11 (a) Combined estrogen- and progestin-based drugs for 12 contraception or progestin-based drugs for emergency contraception; and 13 (r) Ulipristal acetate for emergency contraception. 14 [12.] 13. Except as otherwise provided in this section and federal law, an 15 insurer may use medical management techniques, including, without limitation, any 16 available clinical evidence, to determine the frequency of or treatment relating to 17 any benefit required by this section or the type of provider of health care to use for 18 such treatment. 19 -[13.] 14. An insurer shall not [use] : 20 (a) Use medical management techniques to require an insured to use a method 21 of contraception other than the method prescribed or ordered by a provider of health care [. 22 14.] ; or 23 24 (b) Require an insured to obtain prior authorization for the benefits 2.5 described in paragraphs (a) and (c) of subsection 1. 26 15. An insurer must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized 27 representative of the insured, may request an exception relating to any medical 28 29 management technique used by the insurer to obtain any benefit required by this section without a higher deductible, copayment or coinsurance. 30 31 [15.] 16. As used in this section: (a) "Medical management technique" means a practice which is used to control 32 the cost or utilization of health care services or prescription drug use. The term 33 includes, without limitation, the use of step therapy, prior authorization or 34 categorizing drugs and devices based on cost, type or method of administration. 35 (b) "Network plan" means a policy of group health insurance offered by an 36 37 insurer under which the financing and delivery of medical care, including items and 38 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 39 40 an arrangement for the financing of premiums. "Provider of health care" has the meaning ascribed to it in NRS 629.031. 41 (d) "Therapeutic equivalent" means a drug which: 42 43 (1) Contains an identical amount of the same active incredients in the same 44 dosage and method of administration as another drug; (2) Is expected to have the same clinical effect when administered to a 45 patient pursuant to a prescription or order as another drug; and 46 (3) Moots any other criteria required by the Food and Drug Administration 47 48 for classification as a therapeutic equivalent.] (Deleted by amendment.) Sec. 15. [NRS 689C.1676 is hereby amended to read as follows: 49 689C.1676 1. Except as otherwise provided in subsection [7,] 8, a carrier 50 51 that offers or issues a health benefit plan shall include in the plan coverage for: 52 (a) Up to a 12 month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is: 53

(1) Lawfully prescribed or ordered; 2 (2) Approved by the Food and Drug Administration; 3 (3) Listed in subsection [10:] H: and (4) Dispensed in accordance with NRS 639.28075: 4 5 (b) Any type of device for contraception which is: 6 (1) Lawfully prescribed or ordered; 7 (2) Approved by the Food and Drug Administration; and 8 (3) Listed in subsection [10;] H; 9 (e) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078: 10 11 (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; 12 13 (e) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use; 14 15 (f) Management of side effects relating to contraception; [and] 16 (g) Voluntary sterilization [for women.]; (h) Any clinical service relating to the drugs, devices and services described 17 in paragraphs (a) to (g), inclusive, including, without limitation, services to 18 19 monitor the use and effectiveness of such drugs, devices and services; and 20 (i) One-quarter of the costs of any language translation services provided to 21 facilitate the provision of any item or service described in paragraphs (a) to (h). 22 inclusive. 23 2. An insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such 24 services are provided by a pharmacist who participates in the network plan of the 2.5 carrier. The terms of the health benefit plan must not limit: 26 (a) Coverage for services listed in subsection 1 and provided by such a 27 pharmacist to a number of occasions less than the coverage for such services 28 when provided by another provider of health care. 29 30 (b) Reimbursement for services listed in subsection 1 and provided by such a 31 pharmacist to an amount less than the amount reimbursed for similar services 32 provided by a physician, physician assistant or advanced practice recistered 33 nurse. 34 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 35 36 network plan of the carrier. 37 [3.] 4. If a covered therapeutic equivalent listed in subsection 1 is not 38 available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a 39 provider of health care must be covered by the carrier. 40 41 [4.] 5. Except as otherwise provided in subsections [8,] 9, 10 and [11,] 12, a 42 carrier that offers or issues a health benefit plan shall not: 43 (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 44 benefit included in the health benefit plan pursuant to subsection 1; 45 46 (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 47 48 benefit: (c) Offer or pay any type of material inducement or financial incentive to an 49 insured to discourage the insured from obtaining any such benefit; 50 51 (d) Penalize a provider of health care who provides any such benefit to an 52 insured, including, without limitation, reducing the reimbursement to the provider

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of health care;

(e) Offer or pay any type of material inducement, bonus or other financial 2 incentive to a provider of health care to deny, reduce, withhold, limit or delay 3 access to any such benefit to an insured; or 4 (f) Impose any other restrictions or delays on the access of an insured to any such benefit. 5 6 [5.] 6. Coverage pursuant to this section for the covered dependent of an 7 insured must be the same as for the insured. 8 [6.] 7. Except as otherwise provided in subsection [7,] 8, a health benefit plan 9 subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, [2022,] 2024, has the legal effect of including the 10 11 coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void. 12 13 [7.] 8. A carrier that offers or issues a health benefit plan and which is 14 affiliated with a religious organization is not required to provide the coverage 15 required by subsection 1 if the carrier objects on religious grounds. Such a carrier 16 shall, before the issuance of a health benefit plan and before the renewal of such a 17 plan, provide to the prospective insured written notice of the coverage that the carrier refuses to provide pursuant to this subsection. 18 19 [8.] 9. A carrier may require an insured to pay a higher deductible, 20 copayment or coinsurance for a drug for contraception if the insured refuses to 21 accept a therapeutic equivalent of the drug. [9.] 10. For each of the 18 methods of contraception listed in subsection [10] 22 11 that have been approved by the Food and Drug Administration, a health benefit 23 24 plan must include at least one drug or device for contraception within each method 2.5 for which no deductible, copayment or coinsurance may be charged to the insured, 26 but the carrier may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception. 27 [10.] 11. The following 18 methods of contraception must be covered 28 29 pursuant to this section: 30 (a) Voluntary sterilization : [for women;] 31 (b) Surgical sterilization implants for women; 32 (c) Implantable rods: 33 (d) Copper based intrauterine devices; 34 (e) Progesterone based intrauterine devices: 35 (f) Injections: (g) Combined estrogen and progestin based drugs; 36 37 (h) Progestin based drugs: (i) Extended or continuous regimen drugs; 38 (j) Estrogen and progestin based patches; 39 40 (k) Vaginal contraceptive rings; (1) Diaphragms with spermicide; 41 42 (m) Sponges with spermicide; 43 (n) Cervical caps with spermicide; 44 (o) Female condoms; (p) Spermicide; 45 (q) Combined progestin based 46 and estrogen contraception or progestin based drugs for emergency contraception; and 47 48 (r) Ulipristal acetate for emergency contraception. 49 [11.] 12. 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 50 51

any benefit required by this section or the type of provider of health care to use for

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such treatment.

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- [12.] 13. A carrier shall not [use] :
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           (a) Use medical management techniques to require an insured to use a method
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       of contraception other than the method prescribed or ordered by a provider of
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       health care f.
          13.] ; or
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           (b) Require an insured to obtain prior authorization for the benefits
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       described in paragraphs (a) and (c) of subsection 1.
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          14. A carrier must provide an accessible, transparent and expedited process
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       which is not unduly burdensome by which an insured, or the authorized
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       representative of the insured, may request an exception relating to any medical
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       management technique used by the carrier to obtain any benefit required by this
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       section without a higher deductible, copayment or coinsurance.
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           [14.] 15. As used in this section:
           (a) "Medical management technique" means a practice which is used to control
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       the cost or utilization of health care services or prescription drug use. The term
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       includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.
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           (b) "Network plan" means a health benefit plan offered by a carrier under
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       which the financing and delivery of medical care, including items and services paid
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       for as medical care, are provided, in whole or in part, through a defined set of
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       providers under contract with the carrier. The term does not include an arrangement
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       for the financing of premiums.
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               "Provider of health care" has the meaning ascribed to it in NRS 629.031.
           (d) "Therapeutic equivalent" means a drug which:
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               (1) Contains an identical amount of the same active ingredients in the same
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       dosage and method of administration as another drug;
               (2) Is expected to have the same clinical effect when administered to a
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       patient pursuant to a prescription or order as another drug; and
               (3) Meets any other criteria required by the Food and Drug Administration
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       for classification as a therapeutic equivalent.] (Deleted by amendment.)
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           Sec. 16. NRS 695A.1865 is hereby amended to read as follows:
           695A.1865 1. Except as otherwise provided in subsection [7,] 8, a society
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       that offers or issues a benefit contract which provides coverage for prescription
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       drugs or devices shall include in the contract coverage for:
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           (a) Up to a 12 month supply, per prescription, of any type of drug for
       contraception or its therapeutic equivalent which is:
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               (1) Lawfully prescribed or ordered;
               (2) Approved by the Food and Drug Administration;
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               (3) Listed in subsection [10;] 11; and
               (4) Dispensed in accordance with NRS 639.28075;
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               Any type of device for contraception which is:
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    Lawfully prescribed or ordered;

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               (2) Approved by the Food and Drug Administration; and
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               (3) Listed in subsection [10;] 11;
           (c) Self administered hormonal contraceptives dispensed by a pharmacist
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       pursuant to NRS 639.28078;
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           (d) Insertion of a device for contraception or removal of such a device if the
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       device was inserted while the insured was covered by the same benefit contract:
           (e) Education and counseling relating to the initiation of the use
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       contraception and any necessary follow up after initiating such use;

(f) Management of side effects relating to contraception; [and]
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           (g) Voluntary sterilization [for women.];
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- (h) Any clinical service relating to the drugs, devices and services described in paragraphs (a) to (g), inclusive, including, without limitation, services to monitor the use and effectiveness of such drugs, devices and services; and
- (i) One-quarter of the costs of any language translation services provided to facilitate the provision of any item or service described in paragraphs (a) to (h), inclusive.
- 2. An insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who participates in the network plan of the society. The terms of the benefit contract must not limit:
- (a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.
- (b) Reimbursement for services listed in subsection 1 and provided by such a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.
- 3. 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.] 4. 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.] 5. Except as otherwise provided in subsections [8,] 9, 10 and [11,] 12, a society that offers or issues a benefit contract shall not:
- (a) Require an insured to pay a higher deductible, any copayment or coincurance 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
- (f) Impose any other restrictions or delays on the access of an insured to any such benefit.
- [5.] 6. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.
- [6.] 7. Except as otherwise provided in subsection [7,] 8, a benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, [2022,] 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.
- [7.] 8. A society that offers or issues a benefit contract and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the society objects on religious grounds. Such a society shall, before the issuance of a benefit contract and before the renewal of such a contract, provide

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to the prospective insured written notice of the coverage that the society refuses to
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       provide pursuant to this subsection.
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          [8.] A society may require an insured to pay a higher deductible,
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       copayment or coinsurance for a drug for contraception if the insured refuses to
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       accept a therapeutic equivalent of the drug.
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           9.1 10. For each of the 18 methods of contraception listed in subsection [10]
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       11 that have been approved by the Food and Drug Administration, a benefit
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       contract must include at least one drug or device for contraception within each
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       method for which no deductible, copayment or coinsurance may be charged to the
       insured, but the society may charge a deductible, copayment or coinsurance for any
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       other drug or device that provides the same method of contraception.
         [10.] 11. The following 18 methods of contraception must be covered
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       pursuant to this section:
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           (a) Voluntary sterilization : [for women;]
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          (b) Surgical sterilization implants for women;
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          (c) Implantable rods;
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           (d) Copper-based intrauterine devices;
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          (e) Progesterone-based intrauterine devices;
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          (f) Injections:
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           (g) Combined estrogen- and progestin-based drugs;
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           (h) Procestin-based drugs:
22
           (i) Extended or continuous regimen drugs;
23
           (i) Estrogen and progestin based patches;
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           (k) Vaginal contraceptive rings;
           (1) Diaphragms with spermicide;
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           (m) Sponges with spermicide:
           (n) Cervical caps with spermicide;
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           (o) Female condoms;
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           (p) Spermicide:
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                                      and progestin based
                           estrogen
       contraception or progestin based drugs for emergency contraception; and
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           (r) Ulipristal acetate for emergency contraception.
           [11.] 12. Except as otherwise provided in this section and federal law,
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       society may use medical management techniques, including, without limitation, any
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       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
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       such treatment.
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           [12.] 13. A society shall not [use]:
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           (a) Use medical management techniques to require an insured to use a method
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       of contraception other than the method prescribed or ordered by a provider of
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       health care f.
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           13.1 : or
           (b) Require an insured to obtain prior authorization for the benefits
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       described in paragraphs (a) and (c) of subsection 1.
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           14. A society must provide an accessible, transparent and expedited process
       which is not unduly burdensome by which an insured, or the authorized
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       representative of the insured, may request an exception relating to any medical
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       management technique used by the society to obtain any benefit required by this
       section without a higher deductible, copayment or coinsurance.
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           [14.] 15. As used in this section:
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           (a) "Medical management technique" means a practice which is used to control
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       the cost or utilization of health care services or prescription drug use. The term
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includes, without limitation, the use of step therapy, prior authorization categorizing drugs and devices based on cost, type or method of administration. prior authorization 2 3 (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 4 5 medical care, are provided, in whole or in part, through a defined set of providers 6 under contract with the society. The term does not include an arrangement for the 7 financing of premiums. (c) "Provider of health care" has the meaning ascribed to it in NRS 629.031. 8 9 (d) "Therapeutic equivalent" means a drug which: 10 (1) Contains an identical amount of the same active ingredients in the same 11 dosage and method of administration as another drug; 12 (2) Is expected to have the same clinical effect when administered to a 13 patient pursuant to a prescription or order as another drug; and 14 (3) Meets any other criteria required by the Food and Drug Administration 15 for classification as a therapeutic equivalent.] (Deleted by amendment.) 16 Sec. 17. [NRS 695B.1919 is hereby amended to read as follows: 17 695B.1919 1. Except as otherwise provided in subsection [7,] 8, an insurer 18 that offers or issues a contract for hospital or medical service shall include in the 19 contract coverage for: 20 (a) Up to a 12-month supply, per prescription, of any type of drug for 21 contraception or its therapeutic equivalent which is: 22 (1) Lawfully prescribed or ordered; 23 (2) Approved by the Food and Drug Administration; (3) Listed in subsection [11:] 12: and 24 (4) Dispensed in accordance with NRS 639.28075; 25 26 (b) Any type of device for contraception which is: (1) Lawfully prescribed or ordered;
(2) Approved by the Food and Drug Administration; and 27 28 29 (3) Listed in subsection [11:] 12: (c) Self administered hormonal contraceptives dispensed by a pharmacist 30 31 pursuant to NRS 639.28078: (d) Insertion of a device for contraception or removal of such a device if the 32 device was inserted while the insured was covered by the same contract for hospital 33 or medical service; 34 35 (e) Education and counseling relating to the initiation of the use contraception and any necessary follow up after initiating such use: 36 (f) Management of side effects relating to contraception; [and] 37 38 (g) Voluntary sterilization [for women.]; (h) Any clinical service relating to the drugs, devices and services described 39 in paragraphs (a) to (g), inclusive, including, without limitation, services to 40 41 monitor the use and effectiveness of such drugs, devices and services; and 42 (i) One quarter of the costs of any language translation services provided to 43 facilitate the provision of any item or service described in paragraphs (a) to (h), 44 inclusive. 2. An insured is entitled to reimbursement for services listed in subsection 1 45 which are within the authorized scope of practice of a pharmacist when such 46 services are provided by a pharmacist who participates in the network plan of the 47 48 hospital or medical services corporation. The terms of the policy must not limit: (a) Coverage for services listed in subsection 1 and provided by such a 49 pharmacist to a number of occasions less than the coverage for such services 50 51 when provided by another provider of health care. 52 (b) Reimbursement for services listed in subsection 1 and provided by such a 53 pharmacist to an amount less than the amount reimbursed for similar services

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provided by a physician, physician assistant or advanced practice registered nurse.

- 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.] 4. 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.
- [4.] 5. Except as otherwise provided in subsections [9,] 10, 11 and [12,] 13, an insurer that offers or issues a contract for hospital or medical service shall not:
- (a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit included in the contract for hospital or medical service pursuant to subsection 1:
- (b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use any such benefit;
- (e) 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.] 6. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.
- [6.] 7. Except as otherwise provided in subsection [7,] 8, a contract for hospital or medical service subject to the provisions of this chapter that is delivered. issued for delivery or renewed on or after January 1, [2022,] 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.
- [7.] 8. An insurer that offers or issues a contract for hospital or medical service and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the insurer objects on religious grounds. Such an incurer shall, before the issuance of a contract for hospital or medical service and before the renewal of such a contract, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.
- [8.] 9. If an insurer refuses, pursuant to subsection [7,] 8, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.
- [9.] 10. An insurer 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.
- [10.] 11. For each of the 18 methods of contraception listed in subsection [11] 12 that have been approved by the Food and Drug Administration, a contract for hospital or medical service 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 insurer may charge a deductible. 2 copayment or coinsurance for any other drug or device that provides the same 3 method of contraception. [11.] 12. The following 18 methods of contraception must be covered 4 pursuant to this section: 5 6 (a) Voluntary sterilization ; [for women;] 7 (b) Surgical sterilization implants for women; 8 (e) Implantable rods; 9 (d) Copper-based intrauterine devices; 10 (e) Progesterone-based intrauterine devices: 11 (f) Injections; 12 (g) Combined estrogen- and progestin-based drugs; 13 (h) Procestin-based drugs: 14 (i) Extended- or continuous-regimen drugs; 15 (i) Estrogen- and progestin-based patches; 16 (k) Vaginal contraceptive rings; 17 (1) Diaphragms with spermicide; 18 (m) Sponges with spermicide; 19 (n) Cervical caps with spermicide; 20 (o) Female condoms; 21 (p) Spermieide: progestin based 22 (q) Combined contraception or progestin based drugs for emergency contraception; and 23 (r) Ulipristal acetate for emergency contraception. 24 2.5 [12.] 13. Except as otherwise provided in this section and federal law, an 26 insurer that offers or issues a contract for hospital or medical services may use medical management techniques, including, without limitation, any available 27 clinical evidence, to determine the frequency of or treatment relating to any benefit 28 required by this section or the type of provider of health care to use for such 29 30 treatment. 31 [13.] 14. An insurer shall not [use]: (a) Use medical management techniques to require an insured to use a method 32 33 of contraception other than the method prescribed or ordered by a provider of health care f. 34 14.] ; or 35 (b) Require an insured to obtain prior authorization for the benefits 36 37 described in paragraphs (a) and (c) of subsection 1. 38 15. An insurer must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized 39 representative of the insured, may request an exception relating to any medical 40 41 management technique used by the insurer to obtain any benefit required by this 42 section without a higher deductible, copayment or coinsurance. 43 [15.] 16. As used in this section: (a) "Medical management technique" means a practice which is used to control 44 the cost or utilization of health care services or prescription drug use. The term 45 46 includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration. 47 48 (b) "Network plan" means a contract for hospital or medical service offered by 49 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 50 51 defined set of providers under contract with the insurer. The term does not include 52 an arrangement for the financing of premiums. 53 (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 2 3 dosage and method of administration as another drug: 4 (2) Is expected to have the same clinical effect when administered to a 5 patient pursuant to a prescription or order as another drug; and 6 (3) Meets any other criteria required by the Food and Drug Administration 7 for classification as a therapeutic equivalent.] (Deleted by amendment.) 8 Sec. 18. [NRS 695C.1696 is hereby amended to read as follows: 9 695C.1696 1. Except as otherwise provided in subsection [7,] 9, a health 10 maintenance organization that offers or issues a health care plan shall include in the 11 plan coverage for: 12 (a) Up to a 12-month supply, per prescription, of any type of drug for 13 contraception or its therapeutic equivalent which is: 14 (1) Lawfully prescribed or ordered; 15 (2) Approved by the Food and Drug Administration; 16 (3) Listed in subsection [11;] 13; and (4) Dispensed in accordance with NRS 639.28075; 17 (b) Any type of device for contraception which is: 18 19 (1) Lawfully prescribed or ordered: 20 (2) Approved by the Food and Drug Administration; and 21 (3) Listed in subsection [11:] 13: (c) Self administered hormonal contraceptives dispensed by a pharmacist 22 pursuant to NRS 639.28078; 23 24 (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; 2.5 26 (e) Education and counseling relating to the initiation of the use contraception and any necessary follow up after initiating such use;

(f) Management of side effects relating to contraception; [and] 27 28 (g) Voluntary sterilization [for women.]; 29 30 (h) Any clinical service relating to the drugs, devices and services described 31 in paragraphs (a) to (g), inclusive, including, without limitation, services to 32 monitor the use and effectiveness of such drugs, devices and services; and (i) Except as otherwise provided in subsection 2, one quarter of the costs of 33 34 any language translation services provided to facilitate the provision of any item 35 or service described in paragraphs (a) to (h), inclusive. 2. A health maintenance organization that provides health care services 36 37 through managed care to recipients of Medicaid under the State Plan for 38 Medicaid shall include in a health care plan that covers such services coverage 39 for: 40 (a) One quarter of the costs of any language translation services provided to 41 facilitate the provision of any item or service described in paragraphs (a) to (h), inclusive, of subsection 1 to a recipient of Medicaid who is eligible for the 42 43 Children's Health Insurance Program: and (b) One half of the costs of any language translation services provided to 44 facilitate the provision of any item or service described in paragraphs (a) to (h), 45 inclusive, of subsection 1 to a recipient of Medicaid who is not eligible for the 46 Children's Health Insurance Program. 47 48 3. An enrollee is entitled to reimbursement for services listed in subsection 1 49 which are within the authorized scope of practice of a pharmacist when such 50 services are provided by a pharmacist who participates in the network plan of the 51 health maintenance organization. The terms of the evidence of coverage must not 52 limit:

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- (a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.
- (b) Reimbursement for services listed in subsection 1 and provided by such a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.
- A health maintenance organization must ensure that the benefits required by [subsection] subsections 1 and 2 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.
- [3.] 5. 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.] 6. Except as otherwise provided in subsections [9, 10] 11, 12 and [12,] 14, 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 [;] or 2;
- (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.] 7. Coverage pursuant to this section for the covered dependent of an enrollee must be the same as for the enrollee.
- [6.] 8. Except as otherwise provided in subsection [7,] 9, a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, [2022,] 2024, has the legal effect of including the coverage required by [subsection] subsections 1 [] and 2, and any provision of the plan or the renewal which is in conflict with this section is void.
- [7.] 9. 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 or 2 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 written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection.
- [8.] 10. If a health maintenance organization refuses, pursuant to subsection [7,] 9, to provide the coverage required by subsection 1 [,] or 2, an employer may otherwise provide for the coverage for the employees of the employer.

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[9.] 11. A health maintenance organization may require an enrollee to pay
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       higher deductible, copayment or coinsurance for a drug for contraception if the
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       enrollee refuses to accept a therapeutic equivalent of the drug.
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           [10.] 12. For each of the 18 methods of contraception listed in subsection
       [11] 13 that have been approved by the Food and Drug Administration, a health
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       care plan must include at least one drug or device for contraception within each
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       method for which no deductible, copayment or coinsurance may be charged to the
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       enrollee, but the health maintenance organization may charge a deductible,
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       copayment or coinsurance for any other drug or device that provides the same
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       method of contraception.
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          [11.] 13. The following 18 methods of contraception must be covered
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       pursuant to this section:
13
           (a) Voluntary sterilization ; [for women;]
14
           (b) Surgical sterilization implants for women;
15
          (c) Implantable rods;
16
           (d) Copper-based intrauterine devices;
17
           (e) Progesterone-based intrauterine devices;
18
           (f) Injections:
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           (g) Combined estrogen- and progestin-based drugs;
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           (h) Progestin-based drugs;
21
           (i) Extended- or continuous-regimen drugs;
22
              Estrogen and progestin based patches;
23
              Vaginal contraceptive rings;
           (1) Diaphragms with spermicide;
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2.5
           (m) Sponges with spermicide;
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           (n) Cervical caps with spermicide;
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           (o) Female condoms:
           (p) Spermicide;
28
           (q) Combined
29
                                       and
                                             procestin based
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       contraception or progestin based drugs for emergency contraception; and
31
           (r) Ulipristal acetate for emergency contraception.
           [12.] 14. Except as otherwise provided in this section and federal law, a
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       health maintenance organization may use medical management techniques.
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       including, without limitation, any available clinical evidence, to determine the
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       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.
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           [13.] 15. A health maintenance organization shall not [use]:
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           (a) Use medical management techniques to require an enrollee to use a method
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       of contraception other than the method prescribed or ordered by a provider of
       health care f.
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41
           14.] ; or
           (b) Require an enrollee to obtain prior authorization for the benefits
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       described in paragraphs (a) and (c) of subsection 1.
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           16. A health maintenance organization must provide an accessible,
       transparent and expedited process which is not unduly burdensome by which an
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       enrollee, or the authorized representative of the enrollee, may request an exception
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       relating to any medical management technique used by the health maintenance
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       organization to obtain any benefit required by this section without a higher
       deductible, copayment or coinsurance.
[15.] 17. As used in this section:
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           (a) "Medical management technique" means a practice which is used to control
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          cost or utilization of health care services or prescription drug use. The term
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includes, without limitation, the use of step therapy, prior authorization categorizing drugs and devices based on cost, type or method of administration.
                                                                  -prior authorization
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       (b) "Network plan" means a health care plan offered by a health maintenance
       organization under which the financing and delivery of medical care, including
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       items and services paid for as medical care, are provided, in whole or in part,
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       through a defined set of providers under contract with the health maintenance
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       organization. The term does not include an arrangement for the financing of
       premiums.
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 9
           (c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.
           (d) "Therapeutic equivalent" means a drug which:
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              (1) Contains an identical amount of the same active ingredients in the same
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       dosage and method of administration as another drug;
13
              (2) Is expected to have the same clinical effect when administered to a
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       patient pursuant to a prescription or order as another drug; and
15
              (3) Meets any other criteria required by the Food and Drug Administration
       for classification as a therapeutic equivalent.] (Deleted by amendment.)
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           Sec. 19. [NRS 695G.1715 is hereby amended to read as follows:
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           695G.1715 1. Except as otherwise provided in subsection [7,] 9, a managed
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       eare organization that offers or issues a health care plan shall include in the plan
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       coverage for:
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           (a) Up to a 12-month supply, per prescription, of any type of drug for
       contraception or its therapeutic equivalent which is:
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               (1) Lawfully prescribed or ordered;
               (2) Approved by the Food and Drug Administration;
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2.5
               (3) Listed in subsection [10;] 12; and
26
               (4) Dispensed in accordance with NRS 639.28075;
           (b) Any type of device for contraception which is:
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               (1) Lawfully prescribed or ordered;
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               (2) Approved by the Food and Drug Administration; and
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               (3) Listed in subsection [10:] 12:
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           (c) Solf administered hormonal contraceptives dispenses by a pharmacist
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       pursuant to NRS 639.28078:
           (d) Insertion of a device for contraception or removal of such a device if the
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34
       device was inserted while the insured was covered by the same health care plan;
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           (e) Education and counseling relating to the initiation of the
       contraception and any necessary follow up after initiating such use;
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           (f) Management of side effects relating to contraception; [and]
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           (g) Voluntary sterilization [for women.];
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           (h) Any clinical service relating to the drugs, devices and services described
       in paragraphs (a) to (g), inclusive, including, without limitation, services to
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       monitor the use and effectiveness of such drugs, devices and services; and
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           (i) Except as otherwise provided in subsection 2, one quarter of the costs of
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       any language translation services provided to facilitate the provision of any item
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       or service described in paragraphs (a) to (h), inclusive.
           2. A managed care organization that provides health care services through
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       managed care to recipients of Medicaid under the State Plan for Medicaid shall
       include in a health care plan that covers such services coverage for:
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           (a) One quarter of the costs of any language translation services provided to
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       facilitate the provision of any item or service described in paragraphs (a) to (h),
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       inclusive, of subsection 1 to a recipient of Medicaid who is cligible for the
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       Children's Health Insurance Program; and
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           (b) One half of the costs of any language translation services provided to
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facilitate the provision of any item or service described in paragraphs (a) to (h),

inclusive, of subsection 1 to a recipient of Medicaid who is not eligible for the Children's Health Insurance Program.

3. An insured is entitled to reimbursement for services listed in subsection 1

- which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who participates in the network plan of the managed care organization. The terms of the evidence of coverage must not limit:

 (a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.
- (b) Reimbursement for services listed in subsection 1 and provided by such a pharmacist to an amount less than the amount reimbursed for similar services provided by a physician, physician assistant or advanced practice registered nurse.
- 4. A managed care organization must ensure that the benefits required by [subsection] subsections 1 and 2 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization.
- [3,] 5. 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.] 6. Except as otherwise provided in subsections [8, 9] 10, 11 and [11,] 13, 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 [:] or 2;
- (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 benefits:
- (e) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefits:
- (d) Penalize a provider of health care who provides any such benefits to an insured, including, without limitation, reducing the reimbursement of the provider of health care;
- (e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefits to an insured; or
- (f) Impose any other restrictions or delays on the access of an insured to any such benefits.
 - [5.] 7. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.
 - [6.] 8. Except as otherwise provided in subsection [7,] 9, a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, [2022,] 2024, has the legal effect of including the coverage required by [subsection] subsections 1 [,] and 2, and any provision of the plan or the renewal which is in conflict with this section is void.
 - [7.] 9. A managed care organization that offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 or 2 if the managed care organization objects on religious grounds. Such an organization shall, before the issuance of a health care plan and before the renewal of such a plan, provide to the prospective insured written notice of the coverage that the managed care organization refuses to provide pursuant to this subsection.

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[8.] 10. A managed care organization may require an insured to pay a higher
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       deductible, consyment or coinsurance for a drug for contracention if the insured
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       refuses to accept a therapeutic equivalent of the drug.
          [9.] 11. For each of the 18 methods of contraception listed in subsection [10]
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       12 that have been approved by the Food and Drug Administration, a health care
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       plan must include at least one drug or device for contraception within each method
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       for which no deductible, copayment or coinsurance may be charged to the insured,
       but the managed care organization may charge a deductible, copayment or
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       coinsurance for any other drug or device that provides the same method of
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       contraception.
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          [10.] 12. The following 18 methods of contraception must be covered
       pursuant to this section:
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          (a) Voluntary sterilization ; [for women;]
14
          (b) Surgical sterilization implants for women;
15
         (c) Implantable rods;
16
          (d) Copper-based intrauterine devices;
17
          (e) Progesterone-based intrauterine devices;
18
          (f) Injections:
19
           (g) Combined estrogen- and progestin-based drugs;
20
           (h) Progestin-based drugs;
21
          (i) Extended- or continuous-regimen drugs;
22
             Estrogen and progestin based patches;
23
           (k) Vaginal contraceptive rings;
           (1) Diaphragms with spermicide;
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2.5
           (m) Sponges with spermicide;
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           (n) Cervical caps with spermicide;
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           (o) Female condoms:
           (p) Spermicide;
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           (q) Combined
29
                                       and procestin based
       contraception or progestin based drugs for emergency contraception; and
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           (r) Ulipristal acetate for emergency contraception.
           [11.] 13. Except as otherwise provided in this section and federal law, a
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       managed care organization may use medical management techniques, including,
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       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
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       health care to use for such treatment.
          [12.] 14. A managed care organization shall not [use]:
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           (a) Use medical management techniques to require an insured to use a method
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       of contraception other than the method prescribed or ordered by a provider of
       health care f.
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           13.] ; or
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           (b) Require an insured to obtain prior authorization for the benefits
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43
       described in paragraphs (a) and (c) of subsection 1.
44
          15. A managed care organization must provide an accessible, transparent and
       expedited process which is not unduly burdensome by which an insured, or the
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       authorized representative of the insured, may request an exception relating to any
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       medical management technique used by the managed care organization to obtain
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       any benefit required by this section without a higher deductible, copayment or
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       coinsurance.
           [14.] 16. As used in this section:
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           (a) "Medical management technique" means a practice which is used to control
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          cost or utilization of health care services or prescription drug use. The term
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- includes, without limitation, the use of step therapy, prior authorization or eategorizing drugs and devices based on cost, type or method of administration.

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

 Sec. 20. [The provisions of NRS 354.599 do not apply to any additional
 - Sec. 20. [The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.] (Deleted by amendment.)
 - **Sec. 21.** 1. This section becomes effective upon passage and approval.
 - 2. Sections 1 to 20, inclusive, of this act become effective:
 - (a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and
 - (b) On January 1, 2024, for all other purposes.