

Amendment No. 280

Senate Amendment to Senate Bill No. 280	(BDR 40-40)
<b>Proposed by:</b> Senate Committee on Health and Human Services	
<b>Amends:</b> Summary: No Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes	

Adoption of this amendment will MAINTAIN the unfunded mandate not requested by the affected local government to S.B. 280 (§ 11).

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

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

DAN/EWR



Date: 4/21/2023

S.B. No. 280—Revises provisions governing contraception. (BDR 40-40)





## SENATE BILL NO. 280—SENATOR NGUYEN

MARCH 15, 2023

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions governing contraception. (BDR 40-40)

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

CONTAINS UNFUNDED MANDATE (§ 11)  
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

AN ACT relating to health care; requiring a hospital to provide for the insertion of certain ~~intrauterine contraceptive devices~~ long-acting reversible contraception if requested by a patient giving birth at a hospital; limiting the amount a hospital or provider of health care may require an insurer to pay for long-acting reversible contraception under such circumstances; prohibiting an insurer from refusing to cover the insertion of certain ~~intrauterine~~ contraceptive devices at a hospital immediately after an insured gives birth; and providing other matters properly relating thereto.

**Legislative Counsel's Digest:**

Existing law prescribes certain requirements governing the operation of hospitals and other medical facilities. (NRS 449.029-449.2488) **Section 1** of this bill requires a hospital, upon the request of a patient giving birth at the hospital, to provide for the insertion of ~~certain intrauterine contraceptive devices~~ long-acting reversible contraception unless: (1) the ~~device~~ contraception is contraindicated for the patient; (2) a physician, physician assistant or advanced practice registered nurse determines that inserting the ~~device~~ contraception would create an unreasonable risk of harm to the patient; or (3) the hospital is a religiously affiliated institution that objects to the insertion of such ~~a device~~ contraception on religious grounds. **Section 1** requires a religiously affiliated hospital that objects to the insertion of such ~~a device~~ contraception on religious grounds to notify maternity patients of that objection. **Section 1** also prohibits a hospital from requiring a provider of health care who objects to the insertion of such ~~a device~~ contraception on religious grounds to participate in the insertion of such ~~a device~~ contraception. **Section 1** requires such a provider at a hospital to refer a patient who requests the insertion of such ~~a device~~ contraception to a provider who is willing to provide that service. **Section 1 restricts the amount that a provider of health care or hospital is authorized to require a third party insurer to pay for such contraception, the insertion of such contraception or testing associated with such contraception.** **Sections 2-7 and 9** of this bill make conforming changes to provide for the administration and enforcement of the requirements of **section 1** in the same manner as other requirements imposed by existing law on medical facilities.

Existing law requires certain public and private insurers, including, without limitation, Medicaid, to cover certain types of contraception, including certain implantable rods and

intrauterine contraceptive devices. (NRS 287.010, 287.04335, 422.27172, 689A.0418, 689B.0378, 689C.1676, 695A.1865, 695B.1919, 695C.1696, 695G.1715) **Sections 8 and 10-16** of this bill prohibit such an insurer from refusing to cover the insertion of such a device at a hospital immediately after an insured gives birth.

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

**Section 1.** Chapter 449 of NRS is hereby amended by adding thereto a new section to read as follows:

*1. Except as otherwise provided in subsection 2, if a patient giving birth at a hospital requests the insertion of ~~a copper-based intrauterine device or progesterone-based intrauterine device,~~ long-acting reversible contraception, the hospital shall provide for the insertion of ~~such a device~~ the long-acting reversible contraception immediately after the birth unless:*

*(a) The use of the ~~device~~ long-acting reversible contraception is contraindicated for the patient; or*

*(b) A physician, physician assistant or advanced practice registered nurse determines that inserting the ~~device~~ long-acting reversible contraception would create an unreasonable risk of harm to the patient.*

*2. A hospital that is affiliated with a religious organization is not required to provide the service described in subsection 1 if the hospital objects on religious grounds. Before scheduling a patient for maternity care or, if such scheduling does not occur, upon admitting a patient to the hospital for maternity care, the hospital shall provide to the patient written notice that the hospital refuses to provide the service required by subsection 1.*

*3. A hospital shall not require a provider of health care who objects to the service described in subsection 1 on religious grounds to participate in the provision of that service. If such a provider of health care at a hospital, other than a hospital described in subsection 2, receives a request for that service, the provider shall refer the patient to a provider of health care who is willing to provide the service.*

*4. A hospital or provider of health care may not require a third party to pay more for:*

*(a) Long-acting reversible contraception inserted pursuant to subsection 1 than the lowest rate prescribed in a contract between the third party and a hospital or a provider of the same type as the provider of health care, as applicable, for the same type of long-acting reversible contraception.*

*(b) The insertion of long-acting reversible contraception pursuant to subsection 1 than the lowest rate prescribed in a contract between the third party and a hospital or a provider of the same type as the provider of health care, as applicable, for insertion of the same type of long-acting reversible contraception.*

*(c) Any testing associated with the insertion of long-acting reversible contraception pursuant to subsection 1 than the lowest rate prescribed in a contract between the third party and a hospital or a provider of health care of the same type as the provider of health care, as applicable, for the same test.*

*5. As used in this section:*

*(a) "Long-acting reversible contraception" means a method of contraception that requires administration less than once per month, including, without limitation:*

*(I) An intrauterine device; and*

(2) A contraceptive implant.

(b) "Third party" means:

(1) An insurer, as that term is defined in NRS 679B.540;

(2) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for prescription drugs;

(3) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; or

(4) Any other insurer or organization that provides health coverage or benefits in accordance with state or federal law.

**Sec. 2.** NRS 449.029 is hereby amended to read as follows:

449.029 As used in NRS 449.029 to 449.240, inclusive, *and section 1 of this act*, unless the context otherwise requires, "medical facility" has the meaning ascribed to it in NRS 449.0151 and includes a program of hospice care described in NRS 449.196.

**Sec. 3.** NRS 449.0301 is hereby amended to read as follows:

449.0301 The provisions of NRS 449.029 to 449.2428, inclusive, *and section 1 of this act* do not apply to:

1. Any facility conducted by and for the adherents of any church or religious denomination for the purpose of providing facilities for the care and treatment of the sick who depend solely upon spiritual means through prayer for healing in the practice of the religion of the church or denomination, except that such a facility shall comply with all regulations relative to sanitation and safety applicable to other facilities of a similar category.

2. Foster homes as defined in NRS 424.014.

3. Any medical facility, facility for the dependent or facility which is otherwise required by the regulations adopted by the Board pursuant to NRS 449.0303 to be licensed that is operated and maintained by the United States Government or an agency thereof.

**Sec. 4.** NRS 449.0302 is hereby amended to read as follows:

449.0302 1. The Board shall adopt:

(a) Licensing standards for each class of medical facility or facility for the dependent covered by NRS 449.029 to 449.2428, inclusive, *and section 1 of this act* and for programs of hospice care.

(b) Regulations governing the licensing of such facilities and programs.

(c) Regulations governing the procedure and standards for granting an extension of the time for which a natural person may provide certain care in his or her home without being considered a residential facility for groups pursuant to NRS 449.017. The regulations must require that such grants are effective only if made in writing.

(d) Regulations establishing a procedure for the indemnification by the Division, from the amount of any surety bond or other obligation filed or deposited by a facility for refractive surgery pursuant to NRS 449.068 or 449.069, of a patient of the facility who has sustained any damages as a result of the bankruptcy of or any breach of contract by the facility.

(e) Regulations that prescribe the specific types of discrimination prohibited by NRS 449.101.

(f) Regulations requiring a hospital or independent center for emergency medical care to provide training to each employee who provides care to victims of sexual assault or attempted sexual assault concerning appropriate care for such

persons, including, without limitation, training concerning the requirements of NRS 449.1885.

(g) Any other regulations as it deems necessary or convenient to carry out the provisions of NRS 449.029 to 449.2428, inclusive ~~(f)~~, *and section 1 of this act*.

2. The Board shall adopt separate regulations governing the licensing and operation of:

(a) Facilities for the care of adults during the day; and

(b) Residential facilities for groups, which provide care to persons with Alzheimer's disease or other severe dementia, as described in paragraph (a) of subsection 2 of NRS 449.1845.

3. The Board shall adopt separate regulations for:

(a) The licensure of rural hospitals which take into consideration the unique problems of operating such a facility in a rural area.

(b) The licensure of facilities for refractive surgery which take into consideration the unique factors of operating such a facility.

(c) The licensure of mobile units which take into consideration the unique factors of operating a facility that is not in a fixed location.

4. The Board shall require that the practices and policies of each medical facility or facility for the dependent provide adequately for the protection of the health, safety and physical, moral and mental well-being of each person accommodated in the facility.

5. In addition to the training requirements prescribed pursuant to NRS 449.093, the Board shall establish minimum qualifications for administrators and employees of residential facilities for groups. In establishing the qualifications, the Board shall consider the related standards set by nationally recognized organizations which accredit such facilities.

6. The Board shall adopt separate regulations regarding the assistance which may be given pursuant to NRS 453.375 and 454.213 to an ultimate user of controlled substances or dangerous drugs by employees of residential facilities for groups. The regulations must require at least the following conditions before such assistance may be given:

(a) The ultimate user's physical and mental condition is stable and is following a predictable course.

(b) The amount of the medication prescribed is at a maintenance level and does not require a daily assessment.

(c) A written plan of care by a physician or registered nurse has been established that:

(1) Addresses possession and assistance in the administration of the medication; and

(2) Includes a plan, which has been prepared under the supervision of a registered nurse or licensed pharmacist, for emergency intervention if an adverse condition results.

(d) Except as otherwise authorized by the regulations adopted pursuant to NRS 449.0304, the prescribed medication is not administered by injection or intravenously.

(e) The employee has successfully completed training and examination approved by the Division regarding the authorized manner of assistance.

7. The Board shall adopt separate regulations governing the licensing and operation of residential facilities for groups which provide assisted living services. The Board shall not allow the licensing of a facility as a residential facility for groups which provides assisted living services and a residential facility for groups shall not claim that it provides "assisted living services" unless:

1 (a) Before authorizing a person to move into the facility, the facility makes a  
2 full written disclosure to the person regarding what services of personalized care  
3 will be available to the person and the amount that will be charged for those  
4 services throughout the resident's stay at the facility.

5 (b) The residents of the facility reside in their own living units which:

6 (1) Except as otherwise provided in subsection 8, contain toilet facilities;

7 (2) Contain a sleeping area or bedroom; and

8 (3) Are shared with another occupant only upon consent of both occupants.

9 (c) The facility provides personalized care to the residents of the facility and  
10 the general approach to operating the facility incorporates these core principles:

11 (1) The facility is designed to create a residential environment that actively  
12 supports and promotes each resident's quality of life and right to privacy;

13 (2) The facility is committed to offering high-quality supportive services  
14 that are developed by the facility in collaboration with the resident to meet the  
15 resident's individual needs;

16 (3) The facility provides a variety of creative and innovative services that  
17 emphasize the particular needs of each individual resident and the resident's  
18 personal choice of lifestyle;

19 (4) The operation of the facility and its interaction with its residents  
20 supports, to the maximum extent possible, each resident's need for autonomy and  
21 the right to make decisions regarding his or her own life;

22 (5) The operation of the facility is designed to foster a social climate that  
23 allows the resident to develop and maintain personal relationships with fellow  
24 residents and with persons in the general community;

25 (6) The facility is designed to minimize and is operated in a manner which  
26 minimizes the need for its residents to move out of the facility as their respective  
27 physical and mental conditions change over time; and

28 (7) The facility is operated in such a manner as to foster a culture that  
29 provides a high-quality environment for the residents, their families, the staff, any  
30 volunteers and the community at large.

31 8. The Division may grant an exception from the requirement of subparagraph  
32 (1) of paragraph (b) of subsection 7 to a facility which is licensed as a residential  
33 facility for groups on or before July 1, 2005, and which is authorized to have 10 or  
34 fewer beds and was originally constructed as a single-family dwelling if the  
35 Division finds that:

36 (a) Strict application of that requirement would result in economic hardship to  
37 the facility requesting the exception; and

38 (b) The exception, if granted, would not:

39 (1) Cause substantial detriment to the health or welfare of any resident of  
40 the facility;

41 (2) Result in more than two residents sharing a toilet facility; or

42 (3) Otherwise impair substantially the purpose of that requirement.

43 9. The Board shall, if it determines necessary, adopt regulations and  
44 requirements to ensure that each residential facility for groups and its staff are  
45 prepared to respond to an emergency, including, without limitation:

46 (a) The adoption of plans to respond to a natural disaster and other types of  
47 emergency situations, including, without limitation, an emergency involving fire;

48 (b) The adoption of plans to provide for the evacuation of a residential facility  
49 for groups in an emergency, including, without limitation, plans to ensure that  
50 nonambulatory patients may be evacuated;

51 (c) Educating the residents of residential facilities for groups concerning the  
52 plans adopted pursuant to paragraphs (a) and (b); and

(d) Posting the plans or a summary of the plans adopted pursuant to paragraphs (a) and (b) in a conspicuous place in each residential facility for groups.

10. The regulations governing the licensing and operation of facilities for transitional living for released offenders must provide for the licensure of at least three different types of facilities, including, without limitation:

(a) Facilities that only provide a housing and living environment;

(b) Facilities that provide or arrange for the provision of supportive services for residents of the facility to assist the residents with reintegration into the community, in addition to providing a housing and living environment; and

(c) Facilities that provide or arrange for the provision of programs for alcohol and other substance use disorders, in addition to providing a housing and living environment and providing or arranging for the provision of other supportive services.

➤ The regulations must provide that if a facility was originally constructed as a single-family dwelling, the facility must not be authorized for more than eight beds.

11. The Board shall adopt regulations applicable to providers of community-based living arrangement services which:

(a) Except as otherwise provided in paragraph (b), require a natural person responsible for the operation of a provider of community-based living arrangement services and each employee of a provider of community-based living arrangement services who supervises or provides support to recipients of community-based living arrangement services to complete training concerning the provision of community-based living arrangement services to persons with mental illness and continuing education concerning the particular population served by the provider;

(b) Exempt a person licensed or certified pursuant to title 54 of NRS from the requirements prescribed pursuant to paragraph (a) if the Board determines that the person is required to receive training and continuing education substantially equivalent to that prescribed pursuant to that paragraph;

(c) Require a natural person responsible for the operation of a provider of community-based living arrangement services to receive training concerning the provisions of title 53 of NRS applicable to the provision of community-based living arrangement services; and

(d) Require an applicant for a license to provide community-based living arrangement services to post a surety bond in an amount equal to the operating expenses of the applicant for 2 months, place that amount in escrow or take another action prescribed by the Division to ensure that, if the applicant becomes insolvent, recipients of community-based living arrangement services from the applicant may continue to receive community-based living arrangement services for 2 months at the expense of the applicant.

12. The Board shall adopt separate regulations governing the licensing and operation of freestanding birthing centers. Such regulations must:

(a) Align with the standards established by the American Association of Birth Centers, or its successor organization, the accrediting body of the Commission for the Accreditation of Birth Centers, or its successor organization, or another nationally recognized organization for accrediting freestanding birthing centers; and

(b) Allow the provision of supervised training to providers of health care, as appropriate, at a freestanding birthing center.

13. As used in this section, "living unit" means an individual private accommodation designated for a resident within the facility.

**Sec. 5.** NRS 449.160 is hereby amended to read as follows:

449.160 1. The Division may deny an application for a license or may suspend or revoke any license issued under the provisions of NRS 449.029 to 449.2428, inclusive, *and section 1 of this act* upon any of the following grounds:



1 (a) Violation by the applicant or the licensee of any of the provisions of NRS  
2 439B.410 or 449.029 to 449.245, inclusive, *and section 1 of this act* or of any other  
3 law of this State or of the standards, rules and regulations adopted thereunder.

4 (b) Aiding, abetting or permitting the commission of any illegal act.

5 (c) Conduct inimical to the public health, morals, welfare and safety of the  
6 people of the State of Nevada in the maintenance and operation of the premises for  
7 which a license is issued.

8 (d) Conduct or practice detrimental to the health or safety of the occupants or  
9 employees of the facility.

10 (e) Failure of the applicant to obtain written approval from the Director of the  
11 Department of Health and Human Services as required by NRS 439A.100 or as  
12 provided in any regulation adopted pursuant to NRS 449.001 to 449.430, inclusive,  
13 *and section 1 of this act* and 449.435 to 449.531, inclusive, and chapter 449A of  
14 NRS if such approval is required.

15 (f) Failure to comply with the provisions of NRS 441A.315 and any  
16 regulations adopted pursuant thereto or NRS 449.2486.

17 (g) Violation of the provisions of NRS 458.112.

18 2. In addition to the provisions of subsection 1, the Division may revoke a  
19 license to operate a facility for the dependent if, with respect to that facility, the  
20 licensee that operates the facility, or an agent or employee of the licensee:

21 (a) Is convicted of violating any of the provisions of NRS 202.470;

22 (b) Is ordered to but fails to abate a nuisance pursuant to NRS 244.360,  
23 244.3603 or 268.4124; or

24 (c) Is ordered by the appropriate governmental agency to correct a violation of  
25 a building, safety or health code or regulation but fails to correct the violation.

26 3. The Division shall maintain a log of any complaints that it receives relating  
27 to activities for which the Division may revoke the license to operate a facility for  
28 the dependent pursuant to subsection 2. The Division shall provide to a facility for  
29 the care of adults during the day:

30 (a) A summary of a complaint against the facility if the investigation of the  
31 complaint by the Division either substantiates the complaint or is inconclusive;

32 (b) A report of any investigation conducted with respect to the complaint; and

33 (c) A report of any disciplinary action taken against the facility.

34 ➤ The facility shall make the information available to the public pursuant to NRS  
35 449.2486.

36 4. On or before February 1 of each odd-numbered year, the Division shall  
37 submit to the Director of the Legislative Counsel Bureau a written report setting  
38 forth, for the previous biennium:

39 (a) Any complaints included in the log maintained by the Division pursuant to  
40 subsection 3; and

41 (b) Any disciplinary actions taken by the Division pursuant to subsection 2.

42 **Sec. 6.** NRS 449.163 is hereby amended to read as follows:

43 449.163 1. In addition to the payment of the amount required by NRS  
44 449.0308, if a medical facility, facility for the dependent or facility which is  
45 required by the regulations adopted by the Board pursuant to NRS 449.0303 to be  
46 licensed violates any provision related to its licensure, including any provision of  
47 NRS 439B.410 or 449.029 to 449.2428, inclusive, *and section 1 of this act* or any  
48 condition, standard or regulation adopted by the Board, the Division, in accordance  
49 with the regulations adopted pursuant to NRS 449.165, may:

50 (a) Prohibit the facility from admitting any patient until it determines that the  
51 facility has corrected the violation;

(b) Limit the occupancy of the facility to the number of beds occupied when the violation occurred, until it determines that the facility has corrected the violation;

(c) If the license of the facility limits the occupancy of the facility and the facility has exceeded the approved occupancy, require the facility, at its own expense, to move patients to another facility that is licensed;

(d) Impose an administrative penalty of not more than \$5,000 per day for each violation, together with interest thereon at a rate not to exceed 10 percent per annum; and

(e) Appoint temporary management to oversee the operation of the facility and to ensure the health and safety of the patients of the facility, until:

(1) It determines that the facility has corrected the violation and has management which is capable of ensuring continued compliance with the applicable statutes, conditions, standards and regulations; or

(2) Improvements are made to correct the violation.

2. If the facility fails to pay any administrative penalty imposed pursuant to paragraph (d) of subsection 1, the Division may:

(a) Suspend the license of the facility until the administrative penalty is paid; and

(b) Collect court costs, reasonable attorney's fees and other costs incurred to collect the administrative penalty.

3. The Division may require any facility that violates any provision of NRS 439B.410 or 449.029 to 449.2428, inclusive, *and section 1 of this act* or any condition, standard or regulation adopted by the Board to make any improvements necessary to correct the violation.

4. Any money collected as administrative penalties pursuant to paragraph (d) of subsection 1 must be accounted for separately and used to administer and carry out the provisions of NRS 449.001 to 449.430, inclusive, *and section 1 of this act*, 449.435 to 449.531, inclusive, and chapter 449A of NRS to protect the health, safety, well-being and property of the patients and residents of facilities in accordance with applicable state and federal standards or for any other purpose authorized by the Legislature.

**Sec. 7.** NRS 449.240 is hereby amended to read as follows:

449.240 The district attorney of the county in which the facility is located shall, upon application by the Division, institute and conduct the prosecution of any action for violation of any provisions of NRS 449.029 to 449.245, inclusive ~~§~~, *and section 1 of this act*.

**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 ~~§~~, *including, without limitation, the insertion of such a ~~copper-based intrauterine device or progesterone-based intrauterine~~ device at a hospital immediately after a person gives birth;*

(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.

2. Except as otherwise provided in subsections 4 and 5, to obtain any benefit provided in the Plan pursuant to subsection 1, a person enrolled in Medicaid must not be required to:

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

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

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

4. The Plan may require a person enrolled in Medicaid to pay a higher deductible, copayment or coinsurance for a drug for contraception if the person refuses to accept a therapeutic equivalent of the contraceptive drug.

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

6. As used in this section:

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

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

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

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

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

**Sec. 9.** NRS 654.190 is hereby amended to read as follows:

654.190 1. The Board may, after notice and an opportunity for a hearing as required by law, impose an administrative fine of not more than \$10,000 for each violation on, recover reasonable investigative fees and costs incurred from, suspend, revoke, deny the issuance or renewal of or place conditions on the license of, and place on probation or impose any combination of the foregoing on any licensee who:

(a) Is convicted of a felony relating to the practice of administering a nursing facility or residential facility or of any offense involving moral turpitude.

(b) Has obtained his or her license by the use of fraud or deceit.

(c) Violates any of the provisions of this chapter.

(d) Aids or abets any person in the violation of any of the provisions of NRS 449.029 to 449.2428, inclusive, *and section 1 of this act*, as those provisions pertain to a facility for skilled nursing, facility for intermediate care or residential facility for groups.

(e) Violates any regulation of the Board prescribing additional standards of conduct for licensees, including, without limitation, a code of ethics.

(f) Engages in conduct that violates the trust of a patient or resident or exploits the relationship between the licensee and the patient or resident for the financial or other gain of the licensee.

2. If a licensee requests a hearing pursuant to subsection 1, the Board shall give the licensee written notice of a hearing pursuant to NRS 233B.121 and 241.034. A licensee may waive, in writing, his or her right to attend the hearing.

3. The Board may compel the attendance of witnesses or the production of documents or objects by subpoena. The Board may adopt regulations that set forth a procedure pursuant to which the Chair of the Board may issue subpoenas on behalf of the Board. Any person who is subpoenaed pursuant to this subsection may request the Board to modify the terms of the subpoena or grant additional time for compliance.

4. An order that imposes discipline and the findings of fact and conclusions of law supporting that order are public records.

5. The expiration of a license by operation of law or by order or decision of the Board or a court, or the voluntary surrender of a license, does not deprive the Board of jurisdiction to proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

**Sec. 10.** NRS 689A.0418 is hereby amended to read as follows:

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

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

- (1) Lawfully prescribed or ordered;
- (2) Approved by the Food and Drug Administration;
- (3) Listed in subsection 10; and
- (4) Dispensed in accordance with NRS 639.28075;

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

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

(c) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078;

(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 insurance;

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

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

(g) Voluntary sterilization for women.

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

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

4. Except as otherwise provided in subsections 8, 9 and 11, 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;

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

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

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

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

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

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

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

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

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

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

35 (a) Voluntary sterilization for women;

36 (b) Surgical sterilization implants for women;

37 (c) Implantable rods;

38 (d) Copper-based intrauterine devices;

39 (e) Progesterone-based intrauterine devices;

40 (f) Injections;

41 (g) Combined estrogen- and progestin-based drugs;

42 (h) Progestin-based drugs;

43 (i) Extended- or continuous-regimen drugs;

44 (j) Estrogen- and progestin-based patches;

45 (k) Vaginal contraceptive rings;

46 (l) Diaphragms with spermicide;

47 (m) Sponges with spermicide;

48 (n) Cervical caps with spermicide;

49 (o) Female condoms;

50 (p) Spermicide;

51 (q) Combined estrogen- and progestin-based drugs for emergency  
52 contraception or progestin-based drugs for emergency contraception; and

53 (r) Ulipristal acetate for emergency contraception.

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

12. An insurer shall not ~~use~~ :

(a) *Use* medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care ~~or~~ ; *or*

(b) *Refuse to cover the insertion of a device described in paragraph (c), (d) or (e) of subsection 10 at a hospital immediately after an insured gives birth.*

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

14. As used in this section:

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

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

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

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

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

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

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

**Sec. 11.** NRS 689B.0378 is hereby amended to read as follows:

689B.0378 1. Except as otherwise provided in subsection 7, an insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 11;

(c) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078;

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

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

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

4 (g) Voluntary sterilization for women.

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

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

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

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

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

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

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

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

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

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

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

37 7. An insurer that offers or issues a policy of group health insurance and  
38 which is affiliated with a religious organization is not required to provide the  
39 coverage required by subsection 1 if the insurer objects on religious grounds. Such  
40 an insurer shall, before the issuance of a policy of group health insurance and  
41 before the renewal of such a policy, provide to the group policyholder or  
42 prospective insured, as applicable, written notice of the coverage that the insurer  
43 refuses to provide pursuant to this subsection.

44 8. If an insurer refuses, pursuant to subsection 7, to provide the coverage  
45 required by subsection 1, an employer may otherwise provide for the coverage for  
46 the employees of the employer.

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

50 10. For each of the 18 methods of contraception listed in subsection 11 that  
51 have been approved by the Food and Drug Administration, a policy of group health  
52 insurance must include at least one drug or device for contraception within each  
53 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. The following 18 methods of contraception must be covered pursuant to this section:

- (a) Voluntary sterilization for women;
- (b) Surgical sterilization implants for women;
- (c) Implantable rods;
- (d) Copper-based intrauterine devices;
- (e) Progesterone-based intrauterine devices;
- (f) Injections;
- (g) Combined estrogen- and progestin-based drugs;
- (h) Progestin-based drugs;
- (i) Extended- or continuous-regimen drugs;
- (j) Estrogen- and progestin-based patches;
- (k) Vaginal contraceptive rings;
- (l) Diaphragms with spermicide;
- (m) Sponges with spermicide;
- (n) Cervical caps with spermicide;
- (o) Female condoms;
- (p) Spermicide;
- (q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
- (r) Ulipristal acetate for emergency contraception.

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

13. An insurer shall not ~~use~~:

(a) Use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care ~~to~~; or

(b) Refuse to cover the insertion of a device described in paragraph (c), (d) or (e) of subsection 11 at a hospital immediately after an insured gives birth.

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

15. As used in this section:

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

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

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

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

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



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

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

**Sec. 12.** NRS 689C.1676 is hereby amended to read as follows:

689C.1676 1. Except as otherwise provided in subsection 7, a carrier that offers or issues a health benefit plan shall include in the plan coverage for:

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 10;

(c) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078;

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

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

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

(g) Voluntary sterilization for women.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (a) Voluntary sterilization for women;
- (b) Surgical sterilization implants for women;
- (c) Implantable rods;
- (d) Copper-based intrauterine devices;
- (e) Progesterone-based intrauterine devices;
- (f) Injections;
- (g) Combined estrogen- and progestin-based drugs;
- (h) Progestin-based drugs;
- (i) Extended- or continuous-regimen drugs;
- (j) Estrogen- and progestin-based patches;
- (k) Vaginal contraceptive rings;
- (l) Diaphragms with spermicide;
- (m) Sponges with spermicide;
- (n) Cervical caps with spermicide;
- (o) Female condoms;
- (p) Spermicide;
- (q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
- (r) Ulipristal acetate for emergency contraception.

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

12. A carrier shall not ~~use~~ :

(a) Use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care ~~to~~ ; or

(b) Refuse to cover the insertion of a device described in paragraph (c), (d) or (e) of subsection 10 at a hospital immediately after an insured gives birth.

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

14. As used in this section:

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

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

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

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

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

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

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

**Sec. 13.** NRS 695A.1865 is hereby amended to read as follows:

695A.1865 1. Except as otherwise provided in subsection 7, a society that offers or issues a benefit contract which provides coverage for prescription drugs or devices shall include in the contract coverage for:

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 10;

(c) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078;

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

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

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

(g) Voluntary sterilization for women.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

43        (a) Voluntary sterilization for women;

44        (b) Surgical sterilization implants for women;

45        (c) Implantable rods;

46        (d) Copper-based intrauterine devices;

47        (e) Progesterone-based intrauterine devices;

48        (f) Injections;

49        (g) Combined estrogen- and progestin-based drugs;

50        (h) Progestin-based drugs;

51        (i) Extended- or continuous-regimen drugs;

52        (j) Estrogen- and progestin-based patches;

53        (k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;  
(m) Sponges with spermicide;  
(n) Cervical caps with spermicide;  
(o) Female condoms;  
(p) Spermicide;  
(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and  
(r) Ulipristal acetate for emergency contraception.

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

12. A society shall not ~~use~~ :

(a) *Use* medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care ~~to~~; *or*

(b) *Refuse to cover the insertion of a device described in paragraph (c), (d) or (e) of subsection 10 at a hospital immediately after an insured gives birth.*

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

14. As used in this section:

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

(b) “Network plan” means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the society. The term does not include an arrangement for the financing of premiums.

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

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

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

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

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

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

695B.1919 1. Except as otherwise provided in subsection 7, an insurer that offers or issues a contract for hospital or medical service shall include in the contract coverage for:

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with NRS 639.28075;

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

- 1 (1) Lawfully prescribed or ordered;
- 2 (2) Approved by the Food and Drug Administration; and
- 3 (3) Listed in subsection 11;
- 4 (c) Self-administered hormonal contraceptives dispensed by a pharmacist
- 5 pursuant to NRS 639.28078;
- 6 (d) Insertion of a device for contraception or removal of such a device if the
- 7 device was inserted while the insured was covered by the same contract for hospital
- 8 or medical service;
- 9 (e) Education and counseling relating to the initiation of the use of
- 10 contraception and any necessary follow-up after initiating such use;
- 11 (f) Management of side effects relating to contraception; and
- 12 (g) Voluntary sterilization for women.
- 13 2. An insurer that offers or issues a contract for hospital or medical services
- 14 must ensure that the benefits required by subsection 1 are made available to an
- 15 insured through a provider of health care who participates in the network plan of
- 16 the insurer.
- 17 3. If a covered therapeutic equivalent listed in subsection 1 is not available or
- 18 a provider of health care deems a covered therapeutic equivalent to be medically
- 19 inappropriate, an alternate therapeutic equivalent prescribed by a provider of health
- 20 care must be covered by the insurer.
- 21 4. Except as otherwise provided in subsections 9, 10 and 12, an insurer that
- 22 offers or issues a contract for hospital or medical service shall not:
- 23 (a) Require an insured to pay a higher deductible, any copayment or
- 24 coinsurance or require a longer waiting period or other condition to obtain any
- 25 benefit included in the contract for hospital or medical service pursuant to
- 26 subsection 1;
- 27 (b) Refuse to issue a contract for hospital or medical service or cancel a
- 28 contract for hospital or medical service solely because the person applying for or
- 29 covered by the contract uses or may use any such benefit;
- 30 (c) Offer or pay any type of material inducement or financial incentive to an
- 31 insured to discourage the insured from obtaining any such benefit;
- 32 (d) Penalize a provider of health care who provides any such benefit to an
- 33 insured, including, without limitation, reducing the reimbursement to the provider
- 34 of health care;
- 35 (e) Offer or pay any type of material inducement, bonus or other financial
- 36 incentive to a provider of health care to deny, reduce, withhold, limit or delay
- 37 access to any such benefit to an insured; or
- 38 (f) Impose any other restrictions or delays on the access of an insured to any
- 39 such benefit.
- 40 5. Coverage pursuant to this section for the covered dependent of an insured
- 41 must be the same as for the insured.
- 42 6. Except as otherwise provided in subsection 7, a contract for hospital or
- 43 medical service subject to the provisions of this chapter that is delivered, issued for
- 44 delivery or renewed on or after January 1, ~~2022,~~ 2024, has the legal effect of
- 45 including the coverage required by subsection 1, and any provision of the contract
- 46 or the renewal which is in conflict with this section is void.
- 47 7. An insurer that offers or issues a contract for hospital or medical service
- 48 and which is affiliated with a religious organization is not required to provide the
- 49 coverage required by subsection 1 if the insurer objects on religious grounds. Such
- 50 an insurer shall, before the issuance of a contract for hospital or medical service and
- 51 before the renewal of such a contract, provide to the prospective insured written
- 52 notice of the coverage that the insurer refuses to provide pursuant to this subsection.

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

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.

10. For each of the 18 methods of contraception listed in subsection 11 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, copayment or coinsurance for any other drug or device that provides the same method of contraception.

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

- (a) Voluntary sterilization for women;
- (b) Surgical sterilization implants for women;
- (c) Implantable rods;
- (d) Copper-based intrauterine devices;
- (e) Progesterone-based intrauterine devices;
- (f) Injections;
- (g) Combined estrogen- and progestin-based drugs;
- (h) Progestin-based drugs;
- (i) Extended- or continuous-regimen drugs;
- (j) Estrogen- and progestin-based patches;
- (k) Vaginal contraceptive rings;
- (l) Diaphragms with spermicide;
- (m) Sponges with spermicide;
- (n) Cervical caps with spermicide;
- (o) Female condoms;
- (p) Spermicide;
- (q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
- (r) Ulipristal acetate for emergency contraception.

12. Except as otherwise provided in this section and federal law, an insurer that offers or issues a contract for hospital or medical services may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

13. An insurer shall not ~~use~~ :

(a) *Use* medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care ~~to~~; *or*

(b) *Refuse to cover the insertion of a device described in paragraph (c), (d) or (e) of subsection 11 at a hospital immediately after an insured gives birth.*

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

15. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term

includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a contract for hospital or medical service offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

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

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

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

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

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

**Sec. 15.** NRS 695C.1696 is hereby amended to read as follows:

695C.1696 1. Except as otherwise provided in subsection 7, a health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

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

(3) Listed in subsection 11;

(c) Self-administered hormonal contraceptives dispensed by a pharmacist pursuant to NRS 639.28078;

(d) Insertion of a device for contraception or removal of such a device if the device was inserted while the enrollee was covered by the same health care plan;

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

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

(g) Voluntary sterilization for women.

2. A health maintenance organization must ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

- (a) Voluntary sterilization for women;
- (b) Surgical sterilization implants for women;
- (c) Implantable rods;
- (d) Copper-based intrauterine devices;
- (e) Progesterone-based intrauterine devices;
- (f) Injections;
- (g) Combined estrogen- and progestin-based drugs;
- (h) Progestin-based drugs;
- (i) Extended- or continuous-regimen drugs;
- (j) Estrogen- and progestin-based patches;
- (k) Vaginal contraceptive rings;
- (l) Diaphragms with spermicide;
- (m) Sponges with spermicide;
- (n) Cervical caps with spermicide;

(o) Female condoms;  
(p) Spermicide;  
(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and  
(r) Ulipristal acetate for emergency contraception.

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

13. A health maintenance organization shall not ~~use~~ :

(a) *Use* medical management techniques to require an enrollee to use a method of contraception other than the method prescribed or ordered by a provider of health care ~~to~~; *or*

(b) *Refuse to cover the insertion of a device described in paragraph (c), (d) or (e) of subsection 11 at a hospital immediately after an enrollee gives birth.*

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

15. As used in this section:

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

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

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

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

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

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

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

**Sec. 16.** NRS 695G.1715 is hereby amended to read as follows:

695G.1715 1. Except as otherwise provided in subsection 7, a managed care organization that offers or issues a health care plan shall include in the plan coverage for:

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

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with NRS 639.28075;

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

(1) Lawfully prescribed or ordered;

1 (2) Approved by the Food and Drug Administration; and  
2 (3) Listed in subsection 10;  
3 (c) Self-administered hormonal contraceptives dispensed by a pharmacist  
4 pursuant to NRS 639.28078;  
5 (d) Insertion of a device for contraception or removal of such a device if the  
6 device was inserted while the insured was covered by the same health care plan;  
7 (e) Education and counseling relating to the initiation of the use of  
8 contraception and any necessary follow-up after initiating such use;  
9 (f) Management of side effects relating to contraception; and  
10 (g) Voluntary sterilization for women.  
11 2. A managed care organization must ensure that the benefits required by  
12 subsection 1 are made available to an insured through a provider of health care who  
13 participates in the network plan of the managed care organization.  
14 3. If a covered therapeutic equivalent listed in subsection 1 is not available or  
15 a provider of health care deems a covered therapeutic equivalent to be medically  
16 inappropriate, an alternate therapeutic equivalent prescribed by a provider of health  
17 care must be covered by the managed care organization.  
18 4. Except as otherwise provided in subsections 8, 9 and 11, a managed care  
19 organization that offers or issues a health care plan shall not:  
20 (a) Require an insured to pay a higher deductible, any copayment or  
21 coinsurance or require a longer waiting period or other condition to obtain any  
22 benefit included in the health care plan pursuant to subsection 1;  
23 (b) Refuse to issue a health care plan or cancel a health care plan solely  
24 because the person applying for or covered by the plan uses or may use any such  
25 benefits;  
26 (c) Offer or pay any type of material inducement or financial incentive to an  
27 insured to discourage the insured from obtaining any such benefits;  
28 (d) Penalize a provider of health care who provides any such benefits to an  
29 insured, including, without limitation, reducing the reimbursement of the provider  
30 of health care;  
31 (e) Offer or pay any type of material inducement, bonus or other financial  
32 incentive to a provider of health care to deny, reduce, withhold, limit or delay  
33 access to any such benefits to an insured; or  
34 (f) Impose any other restrictions or delays on the access of an insured to any  
35 such benefits.  
36 5. Coverage pursuant to this section for the covered dependent of an insured  
37 must be the same as for the insured.  
38 6. Except as otherwise provided in subsection 7, a health care plan subject to  
39 the provisions of this chapter that is delivered, issued for delivery or renewed on or  
40 after January 1, ~~2022~~, 2024, has the legal effect of including the coverage required  
41 by subsection 1, and any provision of the plan or the renewal which is in conflict  
42 with this section is void.  
43 7. A managed care organization that offers or issues a health care plan and  
44 which is affiliated with a religious organization is not required to provide the  
45 coverage required by subsection 1 if the managed care organization objects on  
46 religious grounds. Such an organization shall, before the issuance of a health care  
47 plan and before the renewal of such a plan, provide to the prospective insured  
48 written notice of the coverage that the managed care organization refuses to provide  
49 pursuant to this subsection.  
50 8. A managed care organization may require an insured to pay a higher  
51 deductible, copayment or coinsurance for a drug for contraception if the insured  
52 refuses to accept a therapeutic equivalent of the drug.

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

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

- (a) Voluntary sterilization for women;
- (b) Surgical sterilization implants for women;
- (c) Implantable rods;
- (d) Copper-based intrauterine devices;
- (e) Progesterone-based intrauterine devices;
- (f) Injections;
- (g) Combined estrogen- and progestin-based drugs;
- (h) Progestin-based drugs;
- (i) Extended- or continuous-regimen drugs;
- (j) Estrogen- and progestin-based patches;
- (k) Vaginal contraceptive rings;
- (l) Diaphragms with spermicide;
- (m) Sponges with spermicide;
- (n) Cervical caps with spermicide;
- (o) Female condoms;
- (p) Spermicide;
- (q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and
- (r) Ulipristal acetate for emergency contraception.

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

12. A managed care organization shall not ~~use~~:

(a) *Use* medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care ~~to~~; *or*

(b) *Refuse to cover the insertion of a device described in paragraph (c), (d) or (e) of subsection 10 at a hospital immediately after an insured gives birth.*

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

14. As used in this section:

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

(b) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the managed care

1 organization. The term does not include an arrangement for the financing of  
2 premiums.

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

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

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

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

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

11 **Sec. 17.** The provisions of NRS 354.599 do not apply to any additional  
12 expenses of a local government that are related to the provisions of this act.

13 **Sec. 18.** 1. This section becomes effective upon passage and approval.

14 2. Sections 1 to 7, inclusive, and 9 of this act become effective on October 1,  
15 2023.

16 3. Sections 8 and 10 to 17, inclusive, of this act become effective:

17 (a) Upon passage and approval for the purpose of adopting any regulations or  
18 performing any other preparatory administrative tasks that are necessary to carry  
19 out the provisions of this act; and

20 (b) On January 1, 2024, for all other purposes.