Amendment No. CA3

Conference Committee Amendment to Senate Bill No. 161 Second Reprint (BDR 38-811)

Proposed by: Conference Committee

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

Adoption of this amendment will ADD an unfunded mandate not requested by the affected local government to S.B. 161 R2 (§ 15 & NRS 287.010).

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

EWR/AAK Date: 6/5/2023

S.B. No. 161—Establishes programs to facilitate the purchase of menstrual products. (BDR 38-811)

SENATE BILL NO. 161–SENATORS SCHEIBLE, D. HARRIS, SPEARMAN, CANNIZZARO, SEEVERS GANSERT; DALY, DONATE, DONDERO LOOP, FLORES, GOICOECHEA, HANSEN, KRASNER, NEAL, NGUYEN, OHRENSCHALL, PAZINA AND STONE

FEBRUARY 15, 2023

Referred to Committee on Health and Human Services

SUMMARY—~~[Establishes programs to facilitate the purchase of menstrual products.]~~ **Makes revisions relating to personal health and wellness.** (BDR 38-811)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: Yes.

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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 ~~[public assistance;]~~ **personal health; expanding required insurance coverage of contraception;** providing for the use of benefits under certain federal programs for persons with low incomes to purchase menstrual products; authorizing the establishment of a program to assist certain recipients of public assistance in the purchase of menstrual products; **authorizing certain persons and entities to acquire controlled substances and dangerous drugs directly from an outsourcing facility; revising requirements governing the dispensing of a drug used for contraception; enacting the Interstate Massage Compact; increasing the number of members of the Board of Massage Therapy required to constitute a quorum for the purposes of transacting the business of the Board; clarifying that a pharmacy benefit manager is subject to certain provisions of law governing an insurer for which the pharmacy benefit manager manages prescription drug coverage;** and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires public and private policies of insurance regulated under Nevada law to include coverage for up to a 12-month supply of contraceptive drugs. (NRS 287.010, 287.04335, 422.27172, 689A.0418, 689B.0378, 689C.1676, 695A.1865, 695B.1919, 695C.1696, 695G.1715) Sections 1, 11 and 14-20 of this bill prohibit an insurer from requiring an insured to obtain prior authorization before receiving a contraceptive drug. Sections 1 and 14-20 also require an insurer to: (1) cover certain contraceptive services when provided by a pharmacist to the same extent as if the services were provided by another provider of health care in certain circumstances; and (2) reimburse a pharmacist 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. Sections 1 and 14-20 additionally prescribe certain limitations on the imposition of a copayment or coinsurance for a drug for contraception. Section 10 of this bill requires an insurer to: (1) demonstrate the capacity to adequately deliver family planning services provided by pharmacists to covered persons; and (2) make available to covered persons a notice of pharmacists and pharmacies that are available to provide family planning services to covered persons through the network of the insurer. Sections 12 and 13 of this bill make conforming changes to indicate the proper placement of section 10 in the Nevada Revised Statutes.

Existing law imposes certain duties on a pharmacy benefit manager. (NRS 683A.178) Section 9 of this bill clarifies that a pharmacy benefit manager that manages prescription drug benefits for an insurer is required to comply with the same provisions of the Nevada Insurance Code as are applicable to the insurer.

Existing law authorizes the Department of Health and Human Services to enter into a contract with a pharmacy benefit manager or a health maintenance organization to manage, direct and coordinate all payments and rebates for prescription drugs and all other services and payments relating to the provision of prescription drugs under the State Plan for Medicaid and the Children's Health Insurance Program. (NRS 422.4053) Section 2 of this bill requires such a contract to require the pharmacy benefit manager or health maintenance organization to comply with certain provisions of law regarding the provision of prescription drugs under the State Plan for Medicaid and the Children's Health Insurance Program.

Existing federal law establishes the Supplemental Nutrition Assistance Program, which provides assistance to certain low-income families for the purchase of food. (7 U.S.C. §§ 2011 et seq.) Existing federal law also establishes the Special Supplemental Nutrition Program for Women, Infants and Children, which provides, through eligible local agencies, nutrition education and supplemental foods to pregnant women, mothers, infants and children less than 5 years of age with low household incomes. (42 U.S.C. § 1786) Existing law requires the Department of Health and Human Services to administer these programs within this State. (NRS 422A.338) ~~[This]~~ **Section 3 of this** bill requires the Department to authorize recipients of benefits provided under those programs to use such benefits to purchase menstrual products: (1) to the extent authorized by federal law; and (2) to the extent that federal funding is available. This bill also authorizes the Department to: (1) establish and administer a program to provide assistance for the purpose of purchasing menstrual products to recipients of benefits provided through programs for which the Division of Welfare and Supportive Services of the Department is responsible; and (2) accept gifts, grants and donations for the purposes of establishing such a program.

Existing law imposes certain requirements governing the purchase and sale of controlled substances and dangerous drugs. (NRS 639.268) Existing regulations prescribe certain requirements concerning the operation of outsourcing facilities, which are federally registered facilities that engage in the compounding of drugs. (NAC 639.691-639.6916) Those requirements include requirements that an outsourcing facility: (1) be licensed by the State Board of Pharmacy as a manufacturer; and (2) comply with regulatory requirements governing manufacturers. (NAC 639.6915) Section 5 of this bill authorizes a person or entity authorized to dispense controlled substances and dangerous drugs to purchase or otherwise acquire controlled substances and dangerous drugs compounded or repackaged by an outsourcing facility directly from the outsourcing facility. Section 4 of this bill makes a conforming change to update an internal reference changed by section 5.

Existing law requires a pharmacist to dispense up to a 12-month supply of contraceptives or therapeutic equivalent or any amount which covers the remainder of the plan year, whichever is less, pursuant to a valid prescription or order if: (1) the patient has previously received a 3-month supply of the same drug; (2) the patient has previously received a 9-month supply of the same drug or a supply of the same drug for the balance of the plan year in which the 3-month supply was prescribed or ordered, whichever is less; (3) the patient is insured by the same health insurance plan; and (4) a provider of health care has not specified in the prescription or order that a different supply of the drug is necessary. (NRS 639.28075) If a patient is not currently using a

contraceptive or therapeutic equivalent, section 6 of this bill requires a pharmacist to dispense a full 3-month supply or the amount designated by the prescription or order, whichever is less, pursuant to a valid prescription or order unless the patient is unable or unwilling to pay the applicable charge, copayment or coinsurance. If the patient is currently using the contraceptive or therapeutic equivalent, section 6 requires a pharmacist to dispense a full 9-month supply or a full 12-month supply, as applicable, any amount designated by the prescription or order or any amount which covers the remainder of the plan year, whichever is less, pursuant to a valid prescription or order unless the patient is unable or unwilling to pay the applicable charge, copayment or coinsurance.

Existing law authorizes the Board of Massage Therapy to issue a license to practice massage therapy and sets forth the requirements that an applicant for a license must satisfy in order to become licensed. (NRS 640C.580) Section 7 of this bill adopts the Interstate Massage Compact, creating a multistate license with uniform licensing requirements, including a national licensing examination, for use by licensees in all member states.

The Compact requires that, in order to be eligible to join the Compact and maintain eligibility as a member state, a state must: (1) license and regulate the practice of massage therapy; (2) have a mechanism or entity in place to receive and investigate complaints from the public, regulatory or law enforcement agencies or the Interstate Massage Compact Commission about licensees practicing in that state; (3) accept passage of a national licensing examination as a criterion for massage therapy licensure in that state; (4) require that licensees satisfy educational requirements before being licensed; (5) implement procedures for requiring background checks for a multistate license and other reporting requirements; (6) have continuing competence requirements; (7) participate in the Compact's data system; (8) notify the Commission and other member states of any disciplinary action taken against a licensee practicing under a multistate license; (9) comply with any rules of the Commission; and (10) accept licensees with valid multistate licenses from other member states. An applicant for a multistate license must: (1) hold a license to practice massage therapy in a member state; (2) complete 625 hours of massage therapy education or the substantial equivalent; (3) pass a national licensing examination or the substantial equivalent; (4) submit to and pass a background check; and (5) pay all required fees.

The Compact: (1) establishes the Interstate Massage Compact Commission as a joint governmental agency whose membership consists of all member states; and (2) provides for the Commission's rules and governance. The Compact also establishes a data system, provided for by the Commission, and requires member states to submit uniform data to the data system on all individuals to whom the Compact is applicable.

The Compact provides additional provisions to carry out the Compact, including providing procedures for the taking of adverse actions against licensees, provisions for active military members or their spouses, provisions for rulemaking by the Commission, provisions for oversight and dispute resolution and procedures for amendments and withdrawals. The Compact takes effect on the date on which the Compact is enacted into law by the seventh member state.

Existing law provides that four members of the Board of Massage Therapy constitute a quorum for the purposes of transacting the business of the Board. (NRS 640C.180) Section 8 of this bill increases the number of board members needed to constitute a quorum from four to five.

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

Section 1. **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.

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. ***If the Plan requires a person enrolled in Medicaid to pay a copayment or coinsurance for a drug for contraception, the Plan may only require the person to pay the copayment or coinsurance:***

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

6. ***The Plan must provide for the reimbursement of a pharmacist for providing services described in subsection 1 that are within the scope of practice of the pharmacist to the same extent as if the services were provided by another provider of health care. The Plan must not limit:***

(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, physician assistant or advanced practice registered nurse.

7. 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.

8. As used in this section:

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

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

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

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

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

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

Sec. 2. **NRS 422.4053 is hereby amended to read as follows:**

422.4053 1. Except as otherwise provided in subsection 2, the Department shall directly manage, direct and coordinate all payments and rebates for prescription drugs and all other services and payments relating to the provision of prescription drugs under the State Plan for Medicaid and the Children's Health Insurance Program.

2. The Department may enter into a contract with:

(a) A pharmacy benefit manager for the provision of any services described in subsection 1.

(b) A health maintenance organization pursuant to NRS 422.273 for the provision of any of the services described in subsection 1 for recipients of Medicaid or recipients of insurance through the Children's Health Insurance Program who receive coverage through a Medicaid managed care program.

(c) One or more public or private entities from this State, the District of Columbia or other states or territories of the United States for the collaborative purchasing of prescription drugs in accordance with subsection 3 of NRS 277.110.

3. A contract entered into pursuant to paragraph (a) or (b) of subsection 2 must:

(a) Include the provisions required by NRS 422.4056; ~~[and]~~

(b) Require the pharmacy benefit manager or health maintenance organization, as applicable, to disclose to the Department any information relating to the services covered by the contract, including, without limitation, information concerning dispensing fees, measures for the control of costs, rebates collected and paid and any fees and charges imposed by the pharmacy benefit manager or health maintenance organization pursuant to the contract.~~.~~ ~~]~~ ***; and***

(c) Require the pharmacy benefit manager or health maintenance organization to comply with the provisions of this chapter regarding the provision of prescription drugs under the State Plan for Medicaid and the Children's Health Insurance Program to the same extent as the Department.

4. In addition to meeting the requirements of subsection 3, a contract entered into pursuant to:

(a) Paragraph (a) of subsection 2 may require the pharmacy benefit manager to provide the entire amount of any rebates received for the purchase of prescription drugs, including, without limitation, rebates for the purchase of prescription drugs by an entity other than the Department, to the Department.

(b) Paragraph (b) of subsection 2 must require the health maintenance organization to provide to the Department the entire amount of any rebates received for the purchase of prescription drugs, including, without limitation, rebates for the purchase of prescription drugs by an entity other than the Department, less an administrative fee in an amount prescribed by the contract. The Department shall adopt policies prescribing the maximum amount of such an administrative fee.

~~[Section 1.]~~ ***Sec. 3.*** Chapter 422A of NRS is hereby amended by adding thereto a new section to read as follows:

1. To the extent authorized by federal law and to the extent that federal funding is available, the Department shall authorize recipients of benefits provided under Supplemental Nutrition Assistance or the Special Supplemental

Nutrition Program for Women, Infants and Children established by 42 U.S.C. § 1786 to use such benefits to purchase menstrual products.

2. The Department shall take any action necessary to obtain federal authorization and federal funding to carry out the provisions of subsection 1, including, without limitation, applying for any necessary federal waiver.

3. To the extent that money is available for this purpose, the Department, through the Division, may establish and administer a program to provide assistance for the purpose of purchasing menstrual products to recipients of benefits provided through programs for which the Division is responsible. The Department may accept gifts, grants and donations from any source for the purpose of establishing and administering such a program.

4. As used in this section, "menstrual products" includes, without limitation, sanitary napkins, tampons or similar products used in connection with the menstrual cycle.

Sec. 4. **NRS 454.221 is hereby amended to read as follows:**

454.221 1. A person who furnishes any dangerous drug except upon the prescription of a practitioner is guilty of a category D felony and shall be punished as provided in NRS 193.130, unless the dangerous drug was obtained originally by a legal prescription.

2. The provisions of this section do not apply to the furnishing of any dangerous drug by:

(a) A practitioner to his or her patients;

(b) A physician assistant licensed pursuant to chapter 630 or 633 of NRS if authorized by the Board;

(c) A registered nurse while participating in a public health program approved by the Board, or an advanced practice registered nurse who holds a certificate from the State Board of Pharmacy permitting him or her to dispense dangerous drugs;

(d) A manufacturer or wholesaler or pharmacy to each other or to a practitioner or to a laboratory under records of sales and purchases that correctly give the date, the names and addresses of the supplier and the buyer, the drug and its quantity;

(e) A hospital pharmacy or a pharmacy so designated by a county health officer in a county whose population is 100,000 or more, or by a district health officer in any county within its jurisdiction or, in the absence of either, by the Chief Medical Officer or the Chief Medical Officer's designated Medical Director of Emergency Medical Services, to a person or agency described in subsection ~~[3]~~ ***4*** of NRS 639.268 to stock ambulances or other authorized vehicles or replenish the stock; or

(f) A pharmacy in a correctional institution to a person designated by the Director of the Department of Corrections to administer a lethal injection to a person who has been sentenced to death.

Sec. 5. **NRS 639.268 is hereby amended to read as follows:**

639.268 1. A practitioner may purchase supplies of controlled substances, poisons, dangerous drugs and devices from a pharmacy by:

(a) Making an oral order to the pharmacy or transmitting an oral order through his or her agent, except an order for a controlled substance in schedule II; or

(b) If the order is for a controlled substance, presenting to the pharmacy a written order signed by the practitioner which contains his or her registration number issued by the Drug Enforcement Administration.

2. ***Any person or entity authorized to dispense controlled substances and dangerous drugs, including, without limitation, a pharmacy, institutional pharmacy or practitioner, may:***

(a) Purchase or otherwise acquire controlled substances and dangerous drugs compounded or repackaged by an outsourcing facility directly from the outsourcing facility without an order from a practitioner other than, where applicable, the practitioner purchasing or acquiring the controlled substance or dangerous drug; and

(b) Administer and dispense controlled substances and dangerous drugs purchased or acquired pursuant to paragraph (a) to the same extent as controlled substances and dangerous drugs acquired through other authorized means.

3. A hospital pharmacy or a pharmacy designated for this purpose by a county health officer in a county whose population is 100,000 or more, or by a district health officer in any county within its jurisdiction or, in the absence of either, by the Chief Medical Officer or his or her designated medical director of emergency medical services, may sell to a person or agency described in subsection ~~[3]~~ ***4*** supplies of controlled substances to stock the ambulances or other authorized vehicles of such a person or agency or replenish the stock if:

(a) The person or agency is registered with the Drug Enforcement Administration pursuant to 21 C.F.R. Part 1301;

(b) The person in charge of the controlled substances is:

(1) A paramedic appropriately certified by the health authority;

(2) A registered nurse licensed by the State Board of Nursing; or

(3) A person who holds equivalent certification or licensure issued by another state; and

(c) Except as otherwise provided in this paragraph, the purchase order is countersigned by a physician or initiated by an oral order and may be made by the person or agency or transmitted by an agent of such a person or agency. An order for a controlled substance listed in schedule II must be made pursuant to NRS 453.251.

~~[3.]~~ ***4.*** A pharmacy, institutional pharmacy or other person licensed by the Board to furnish controlled substances and dangerous drugs may sell to:

(a) The holder of a permit issued pursuant to the provisions of NRS 450B.200 or 450B.210;

(b) The holder of a permit issued by another state which is substantially similar to a permit issued pursuant to the provisions of NRS 450B.200 or 450B.210; and

(c) An agency of the Federal Government that provides emergency care or transportation and is registered with the Drug Enforcement Administration pursuant to 21 C.F.R. Part 1301.

~~[4.]~~ ***5.*** A pharmacy, institutional pharmacy ***, outsourcing facility*** or other person licensed by the Board to furnish dangerous drugs who sells supplies pursuant to this section shall maintain a record of each sale which must contain:

(a) The date of sale;

(b) The name, address and signature of the purchaser or the person receiving the delivery;

(c) The name of the dispensing pharmacist ~~[;]~~ ***, where applicable;***

(d) The name and address of the authorizing practitioner ~~[;]~~ ***, where applicable;*** and

(e) The name, strength and quantity of each drug sold.

~~[5.]~~ ***6.*** A pharmacy, institutional pharmacy or other person licensed by the Board to furnish dangerous drugs who supplies the initial stock for an ambulance or other emergency vehicle shall comply with any applicable regulations adopted by the State Board of Health, or a district board of health, pursuant to NRS 450B.120.

~~[6.]~~ ***7.*** The Board shall adopt regulations regarding the records a pharmacist shall keep of any purchase made pursuant to this section.

8. As used in this section:

(a) "Compounding" includes, without limitation, the combining, admixing, mixing, pooling, reconstituting or other altering of a drug or bulk drug substance, as defined in 21 C.F.R. § 207.3, to create a drug.

(b) "Outsourcing facility" means a manufacturer at one geographic location or address that:

(1) Is engaged in the compounding of sterile or nonsterile drugs for use by humans; and

(2) Has registered with the Secretary of Health and Human Services as an outsourcing facility pursuant to 21 U.S.C. § 353b.

Sec. 6. **NRS 639.28075 is hereby amended to read as follows:**

639.28075 1. Except as otherwise provided in ~~[subsections]~~ ***subsection*** 2 ***,*** ~~[and 3,]~~ pursuant to a valid prescription or order for a drug to be used for contraception or its therapeutic equivalent which has been approved by the Food and Drug Administration ***,*** a pharmacist shall:

(a) ~~[The first time dispensing the drug or therapeutic equivalent to]~~ ***If*** the patient ~~[,]~~ ***is not currently using the drug or its therapeutic equivalent,*** dispense up to a 3-month supply of the drug or therapeutic equivalent ~~[,]~~ ***or any amount designated by the prescription or order, whichever is less.***

(b) ~~[The second time dispensing]~~ ***If*** the drug or therapeutic equivalent ***has only been dispensed*** to the patient ~~[,]~~ ***once pursuant to paragraph (a),*** dispense up to a 9-month supply of the drug or therapeutic equivalent, ***any amount designated by the prescription or order*** or any amount which covers the remainder of the plan year if the patient is covered by a health care plan, whichever is less.

(c) For a refill in a plan year following the initial dispensing of a drug or therapeutic equivalent pursuant to paragraphs (a) and (b), dispense ~~[up to]~~ a 12-month supply of the drug or therapeutic equivalent ***, any amount designated by the prescription or order*** or any amount which covers the remainder of the plan year if the patient is covered by a health care plan, whichever is less.

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

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

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

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

~~4.]~~ ***A pharmacist is not required to dispense an amount of a drug to be used for contraception or its therapeutic equivalent for which the patient is unable or unwilling to pay any applicable charge, copayment or coinsurance due to the pharmacy.***

3. As used in this section:

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

(b) "Plan year" means the year designated in the evidence of coverage of a health care plan in which a person is covered by such plan.

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

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

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

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

Sec. 7. **Chapter 640C of NRS is hereby amended by adding thereto a new section to read as follows:**

INTERSTATE MASSAGE COMPACT

ARTICLE 1-PURPOSE

The purpose of this Compact is to reduce the burdens on State governments and to facilitate the interstate practice and regulation of Massage Therapy with the goal of improving public access to, and the safety of, Massage Therapy Services. Through this Compact, the Member States seek to establish a regulatory framework which provides for a new multistate licensing program. Through this additional licensing pathway, the Member States seek to provide increased value and mobility to licensed massage therapists in the Member States, while ensuring the provision of safe, competent, and reliable services to the public.

This Compact is designed to achieve the following objectives, and the Member States hereby ratify the same intentions by subscribing hereto:

A. Increase public access to Massage Therapy Services by providing for a multistate licensing pathway;

B. Enhance the Member States' ability to protect the public's health and safety;

C. Enhance the Member States' ability to prevent human trafficking and licensure fraud;

D. Encourage the cooperation of Member States in regulating the multistate Practice of Massage Therapy;

E. Support relocating military members and their spouses;

F. Facilitate and enhance the exchange of licensure, investigative, and disciplinary information between the Member States;

G. Create an Interstate Commission that will exist to implement and administer the Compact;

H. Allow a Member State to hold a Licensee accountable, even where that Licensee holds a Multistate License;

I. Create a streamlined pathway for Licensees to practice in Member States, thus increasing the mobility of duly licensed massage therapists; and

J. Serve the needs of licensed massage therapists and the public receiving their services; however,

K. Nothing in this Compact is intended to prevent a State from enforcing its own laws regarding the Practice of Massage Therapy.

ARTICLE 2-DEFINITIONS

As used in this Compact, except as otherwise provided and subject to clarification by the Rules of the Commission, the following definitions shall govern the terms herein:

A. "Active Military Member" - any person with full-time duty status in the armed forces of the United States, including members of the National Guard and Reserve.

B. "Adverse Action" - any administrative, civil, equitable, or criminal action permitted by a Member State's laws which is imposed by a Licensing Authority or other regulatory body against a Licensee, including actions against an individual's Authorization to Practice such as revocation, suspension, probation, surrender in lieu of discipline, monitoring of the Licensee, limitation of the Licensee's practice, or any other Encumbrance on licensure affecting an individual's ability to practice Massage Therapy, including the issuance of a cease and desist order.

C. "Alternative Program" - a non-disciplinary monitoring or prosecutorial diversion program approved by a Member State's Licensing Authority.

D. "Authorization to Practice" - a legal authorization by a Remote State pursuant to a Multistate License permitting the Practice of Massage Therapy in that Remote State, which shall be subject to the enforcement jurisdiction of the Licensing Authority in that Remote State.

E. "Background Check" - the submission of an applicant's criminal history record information, as further defined in 28 C.F.R. § 20.3(d), as amended from the Federal Bureau of Investigation and the agency responsible for retaining State criminal records in the applicant's Home State.

F. "Charter Member States" - Member States who have enacted legislation to adopt this Compact where such legislation predates the effective date of this Compact as defined in Article 12.

G. "Commission" - the government agency whose membership consists of all States that have enacted this Compact, which is known as the Interstate Massage Compact Commission, as defined in Article 8, and which shall operate as an instrumentality of the Member States.

H. "Continuing Competence" - a requirement, as a condition of license renewal, to provide evidence of participation in, and completion of, educational or professional activities that maintain, improve, or enhance Massage Therapy fitness to practice.

I. "Current Significant Investigative Information" - Investigative Information that a Licensing Authority, after an inquiry or investigation that complies with a Member State's due process requirements, has reason to believe is not groundless and, if proved true, would indicate a violation of that State's laws regarding the Practice of Massage Therapy.

J. "Data System" - a repository of information about Licensees who hold Multistate Licenses, which may include but is not limited to license status, Investigative Information, and Adverse Actions.

K. "Disqualifying Event" - any event which shall disqualify an individual from holding a Multistate License under this Compact, which the Commission may by Rule specify.

L. "Encumbrance" - a revocation or suspension of, or any limitation or condition on, the full and unrestricted Practice of Massage Therapy by a Licensing Authority.

M. "Executive Committee" - a group of delegates elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

N. "Home State" - means the Member State which is a Licensee's primary state of residence where the Licensee holds an active Single-State License.

O. "Investigative Information" - information, records, or documents received or generated by a Licensing Authority pursuant to an investigation or other inquiry.

P. "Licensing Authority" - a State's regulatory body responsible for issuing Massage Therapy licenses or otherwise overseeing the Practice of Massage Therapy in that State.

Q. "Licensee" - an individual who currently holds a license from a Member State to fully practice Massage Therapy, whose license is not a student, provisional, temporary, inactive, or other similar status.

R. "Massage Therapy", "Massage Therapy Services", and the "Practice of Massage Therapy" - the care and services provided by a Licensee as set forth in the Member State's statutes and regulations in the State where the services are being provided.

S. "Member State" - any State that has adopted this Compact.

T. "Multistate License" - a license that consists of Authorizations to Practice Massage Therapy in all Remote States pursuant to this Compact, which shall be subject to the enforcement jurisdiction of the Licensing Authority in a Licensee's Home State.

U. "National Licensing Examination" - A national examination developed by a national association of Massage Therapy regulatory boards, as defined by Commission Rule, that is derived from a practice analysis and is consistent with generally accepted psychometric principles of fairness, validity and reliability, and is administered under secure and confidential examination protocols.

V. "Remote State" - any Member State, other than the Licensee's Home State.

W. "Rule" - any opinion or regulation promulgated by the Commission under this Compact, which shall have the force of law.

X. "Single-State License" - a current, valid authorization issued by a Member State's Licensing Authority allowing an individual to fully practice Massage Therapy, that is not a restricted, student, provisional, temporary, or inactive practice authorization and authorizes practice only within the issuing State.

Y. "State" - a state, territory, possession of the United States, or the District of Columbia.

ARTICLE 3-MEMBER STATE REQUIREMENTS

A. To be eligible to join this Compact, and to maintain eligibility as a Member State, a State must:

1. License and regulate the Practice of Massage Therapy;

2. Have a mechanism or entity in place to receive and investigate complaints from the public, regulatory or law enforcement agencies, or the Commission about Licensees practicing in that State;

3. Accept passage of a National Licensing Examination as a criterion for Massage Therapy licensure in that State;

4. Require that Licensees satisfy educational requirements prior to being licensed to provide Massage Therapy Services to the public in that State;

5. Implement procedures for requiring the Background Check of applicants for a Multistate License, and for the reporting of any Disqualifying Events, including but not limited to obtaining and submitting, for each Licensee holding a Multistate License and each applicant for a Multistate License, fingerprint or other biometric-based information to the Federal Bureau of Investigation for Background Checks; receiving the results of the Federal Bureau of Investigation record search on Background Checks and considering the results of such a Background Check in making licensure decisions;

6. Have Continuing Competence requirements as a condition for license renewal;

7. Participate in the Data System, including through the use of unique identifying numbers as described herein;

8. Notify the Commission and other Member States, in compliance with the terms of the Compact and Rules of the Commission, of any disciplinary action taken by the State against a Licensee practicing under a Multistate License in that State, or of the existence of Investigative Information or Current Significant Investigative Information regarding a Licensee practicing in that State pursuant to a Multistate License;

9. Comply with the Rules of the Commission;

10. Accept Licensees with valid Multistate Licenses from other Member States as established herein;

B. Individuals not residing in a Member State shall continue to be able to apply for a Member State's Single-State License as provided under the laws of each Member State. However, the Single-State License granted to those individuals shall not be recognized as granting a Multistate License for Massage Therapy in any other Member State;

C. Nothing in this Compact shall affect the requirements established by a Member State for the issuance of a Single-State License; and

D. A Multistate License issued to a Licensee shall be recognized by each Remote State as an Authorization to Practice Massage Therapy in each Remote State.

ARTICLE 4-MULTISTATE LICENSE REQUIREMENTS

A. To qualify for a Multistate License under this Compact, and to maintain eligibility for such a license, an applicant must:

1. Hold an active Single-State License to practice Massage Therapy in the applicant's Home State;

2. Have completed at least six hundred and twenty-five (625) clock hours of Massage Therapy education or the substantial equivalent which the Commission may approve by Rule.

3. Have passed a National Licensing Examination or the substantial equivalent which the Commission may approve by Rule;

4. Submit to a Background Check;

5. Have not been convicted or found guilty, or have entered into an agreed disposition, of a felony offense under applicable State or federal criminal law, within five (5) years prior to the date of their application, where such a time period shall not include any time served for the offense, and provided that the applicant has completed any and all requirements arising as a result of any such offense;

6. Have not been convicted or found guilty, or have entered into an agreed disposition, of a misdemeanor offense related to the Practice of Massage Therapy under applicable State or federal criminal law, within two (2) years prior to the date of their application where such a time period shall not include any time served for the offense, and provided that the applicant has completed any and all requirements arising as a result of any such offense;

7. Have not been convicted or found guilty, or have entered into an agreed disposition, of any offense, whether a misdemeanor or a felony, under State or federal law, at any time, relating to any of the following:

a. Kidnapping;

b. Human trafficking;
c. Human smuggling;
d. Sexual battery, sexual assault, or any related offenses; or
e. Any other category of offense which the Commission may by Rule designate.
8. Have not previously held a Massage Therapy license which was revoked by, or surrendered in lieu of discipline to an applicable Licensing Authority;
9. Have no history of any Adverse Action on any occupational or professional license within two (2) years prior to the date of their application; and
10. Pay all required fees.
B. A Multistate License granted pursuant to this Compact may be effective for a definite period of time concurrent with the renewal of the Home State license.
C. A Licensee practicing in a Member State is subject to all scope of practice laws governing Massage Therapy Services in that State.
D. The Practice of Massage Therapy under a Multistate License granted pursuant to this Compact will subject the Licensee to the jurisdiction of the Licensing Authority, the courts, and the laws of the Member State in which the Massage Therapy Services are provided.

ARTICLE 5-AUTHORITY OF INTERSTATE MASSAGE COMPACT COMMISSION AND MEMBER STATE LICENSING AUTHORITIES

A. Nothing in this Compact, nor any Rule of the Commission, shall be construed to limit, restrict, or in any way reduce the ability of a Member State to enact and enforce laws, regulations, or other rules related to the Practice of Massage Therapy in that State, where those laws, regulations, or other rules are not inconsistent with the provisions of this Compact.
B. Nothing in this Compact, nor any Rule of the Commission, shall be construed to limit, restrict, or in any way reduce the ability of a Member State to take Adverse Action against a Licensee's Single-State License to practice Massage Therapy in that State.
C. Nothing in this Compact, nor any Rule of the Commission, shall be construed to limit, restrict, or in any way reduce the ability of a Remote State to take Adverse Action against a Licensee's Authorization to Practice in that State.
D. Nothing in this Compact, nor any Rule of the Commission, shall be construed to limit, restrict, or in any way reduce the ability of a Licensee's Home State to take Adverse Action against a Licensee's Multistate License based upon information provided by a Remote State.
E. Insofar as practical, a Member State's Licensing Authority shall cooperate with the Commission and with each entity exercising independent regulatory authority over the Practice of Massage Therapy according to the provisions of this Compact.

ARTICLE 6-ADVERSE ACTIONS

A. A Licensee's Home State shall have exclusive power to impose an Adverse Action against a Licensee's Multistate License issued by the Home State.
B. A Home State may take Adverse Action on a Multistate License based on the Investigative Information, Current Significant Investigative Information, or Adverse Action of a Remote State.

C. A Home State shall retain authority to complete any pending investigations of a Licensee practicing under a Multistate License who changes their Home State during the course of such an investigation. The Licensing Authority shall also be empowered to report the results of such an investigation to the Commission through the Data System as described herein.

D. Any Member State may investigate actual or alleged violations of the scope of practice laws in any other Member State for a massage therapist who holds a Multistate License.

E. A Remote State shall have the authority to:

1. Take Adverse Actions against a Licensee's Authorization to Practice.

2. Issue cease and desist orders or impose an Encumbrance on a Licensee's Authorization to Practice in that State.

3. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses, as well as the production of evidence. Subpoenas issued by a Licensing Authority in a Member State for the attendance and testimony of witnesses or the production of evidence from another Member State shall be enforced in the latter State by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings before it. The issuing Licensing Authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the State in which the witnesses or evidence are located.

4. If otherwise permitted by State law, recover from the affected Licensee the costs of investigations and disposition of cases resulting from any Adverse Action taken against that Licensee.

5. Take Adverse Action against the Licensee's Authorization to Practice in that State based on the factual findings of another Member State.

F. If an Adverse Action is taken by the Home State against a Licensee's Multistate License or Single-State License to practice in the Home State, the Licensee's Authorization to Practice in all other Member States shall be deactivated until all Encumbrances have been removed from such license. All Home State disciplinary orders that impose an Adverse Action against a Licensee shall include a statement that the Massage Therapist's Authorization to Practice is deactivated in all Member States during the pendency of the order.

G. If Adverse Action is taken by a Remote State against a Licensee's Authorization to Practice, that Adverse Action applies to all Authorizations to Practice in all Remote States. A Licensee whose Authorization to Practice in a Remote State is removed for a specified period of time is not eligible to apply for a new Multistate License in any other State until the specific time for removal of the Authorization to Practice has passed and all encumbrance requirements are satisfied.

H. Nothing in this Compact shall override a Member State's authority to accept a Licensee's participation in an Alternative Program in lieu of Adverse Action. A Licensee's Multistate License shall be suspended for the duration of the Licensee's participation in any Alternative Program.

I. Joint Investigations

1. In addition to the authority granted to a Member State by its respective scope of practice laws or other applicable State law, a Member State may participate with other Member States in joint investigations of Licensees.

2. Member States shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

ARTICLE 7-ACTIVE MILITARY MEMBERS AND THEIR SPOUSES

Active Military Members, or their spouses, shall designate a Home State where the individual has a current license to practice Massage Therapy in good standing. The individual may retain their Home State designation during any period of service when that individual or their spouse is on active duty assignment.

ARTICLE 8-ESTABLISHMENT AND OPERATION OF INTERSTATE MASSAGE COMPACT COMMISSION

A. The Compact Member States hereby create and establish a joint government agency whose membership consists of all Member States that have enacted the Compact known as the Interstate Massage Compact Commission. The Commission is an instrumentality of the Compact States acting jointly and not an instrumentality of any one State. The Commission shall come into existence on or after the effective date of the Compact as set forth in Article 12.

B. Membership, Voting, and Meetings

1. Each Member State shall have and be limited to one (1) delegate selected by that Member State's State Licensing Authority.

2. The delegate shall be the primary administrative officer of the State Licensing Authority or their designee.

3. The Commission shall by Rule or bylaw establish a term of office for delegates and may by Rule or bylaw establish term limits.

4. The Commission may recommend removal or suspension of any delegate from office.

5. A Member State's State Licensing Authority shall fill any vacancy of its delegate occurring on the Commission within 60 days of the vacancy.

6. Each delegate shall be entitled to one vote on all matters that are voted on by the Commission.

7. The Commission shall meet at least once during each calendar year. Additional meetings may be held as set forth in the bylaws. The Commission may meet by telecommunication, video conference or other similar electronic means.

C. The Commission shall have the following powers:

1. Establish the fiscal year of the Commission;

2. Establish code of conduct and conflict of interest policies;

3. Adopt Rules and bylaws;

4. Maintain its financial records in accordance with the bylaws;

5. Meet and take such actions as are consistent with the provisions of this Compact, the Commission's Rules, and the bylaws;

6. Initiate and conclude legal proceedings or actions in the name of the Commission, provided that the standing of any State Licensing Authority to sue or be sued under applicable law shall not be affected;

7. Maintain and certify records and information provided to a Member State as the authenticated business records of the Commission, and designate an agent to do so on the Commission's behalf;

8. Purchase and maintain insurance and bonds;

9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Member State;

10. Conduct an annual financial review;

11. Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of

the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

12. Assess and collect fees;

13. Accept any and all appropriate gifts, donations, grants of money, other sources of revenue, equipment, supplies, materials, and services, and receive, utilize, and dispose of the same; provided that at all times the Commission shall avoid any appearance of impropriety or conflict of interest;

14. Lease, purchase, retain, own, hold, improve, or use any property, real, personal, or mixed, or any undivided interest therein;

15. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property real, personal, or mixed;

16. Establish a budget and make expenditures;

17. Borrow money;

18. Appoint committees, including standing committees, composed of members, State regulators, State legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;

19. Accept and transmit complaints from the public, regulatory or law enforcement agencies, or the Commission, to the relevant Member State(s) regarding potential misconduct of Licensees;

20. Elect a Chair, Vice Chair, Secretary and Treasurer and such other officers of the Commission as provided in the Commission's bylaws;

21. Establish and elect an Executive Committee, including a chair and a vice chair;

22. Adopt and provide to the Member States an annual report;

23. Determine whether a State's adopted language is materially different from the model Compact language such that the State would not qualify for participation in the Compact; and

24. Perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact.

D. The Executive Committee

1. The Executive Committee shall have the power to act on behalf of the Commission according to the terms of this Compact. The powers, duties, and responsibilities of the Executive Committee shall include:

a. Overseeing the day-to-day activities of the administration of the Compact including compliance with the provisions of the Compact, the Commission's Rules and bylaws, and other such duties as deemed necessary;

b. Recommending to the Commission changes to the Rules or bylaws, changes to this Compact legislation, fees charged to Compact Member States, fees charged to Licensees, and other fees;

c. Ensuring Compact administration services are appropriately provided, including by contract;

d. Preparing and recommending the budget;

e. Maintaining financial records on behalf of the Commission;

f. Monitoring Compact compliance of Member States and providing compliance reports to the Commission;

g. Establishing additional committees as necessary;

h. Exercise the powers and duties of the Commission during the interim between Commission meetings, except for adopting or amending Rules, adopting or amending bylaws, and exercising any other powers and duties expressly reserved to the Commission by Rule or bylaw; and

i. Other duties as provided in the Rules or bylaws of the Commission.

2. The Executive Committee shall be composed of seven voting members and up to two ex-officio members as follows:

a. The chair and vice chair of the Commission and any other members of the Commission who serve on the Executive Committee shall be voting members of the Executive Committee.

b. Other than the chair, vice-chair, secretary and treasurer, the Commission shall elect three voting members from the current membership of the Commission.

c. The Commission may elect ex-officio, nonvoting members as necessary as follows:

i. One ex-officio member who is a representative of the national association of State Massage Therapy regulatory boards.

ii. One ex-officio member as specified in the Commission's bylaws.

3. The Commission may remove any member of the Executive Committee as provided in the Commission's bylaws.

4. The Executive Committee shall meet at least annually.

a. Executive Committee meetings shall be open to the public, except that the Executive Committee may meet in a closed, non-public session of a public meeting when dealing with any of the matters covered under subsection F.4.

b. The Executive Committee shall give five business days advance notice of its public meetings, posted on its website and as determined to provide notice to persons with an interest in the public matters the Executive Committee intends to address at those meetings.

5. The Executive Committee may hold an emergency meeting when acting for the Commission to:

a. Meet an imminent threat to public health, safety, or welfare;

b. Prevent a loss of Commission or Participating State funds; or

c. Protect public health and safety.

E. The Commission shall adopt and provide to the Member States an annual report.

F. Meetings of the Commission

1. All meetings of the Commission that are not closed pursuant to this subsection shall be open to the public. Notice of public meetings shall be posted on the Commission's website at least thirty (30) days prior to the public meeting.

2. Notwithstanding subsection F.1 of this Article, the Commission may convene an emergency public meeting by providing at least twenty-four (24) hours prior notice on the Commission's website, and any other means as provided in the Commission's Rules, for any of the reasons it may dispense with notice of proposed rulemaking under Article 10.L. The Commission's legal counsel shall certify that one of the reasons justifying an emergency public meeting has been met.

3. Notice of all Commission meetings shall provide the time, date, and location of the meeting, and if the meeting is to be held or accessible via telecommunication, video conference, or other electronic means, the notice shall include the mechanism for access to the meeting.

4. The Commission may convene in a closed, non-public meeting for the Commission to discuss:

a. Non-compliance of a Member State with its obligations under the Compact;

b. The employment, compensation, discipline or other matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current or threatened discipline of a Licensee by the Commission or by a Member State's Licensing Authority;

d. Current, threatened, or reasonably anticipated litigation;

e. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;

f. Accusing any person of a crime or formally censuring any person;

g. Trade secrets or commercial or financial information that is privileged or confidential;

h. Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

i. Investigative records compiled for law enforcement purposes;

j. Information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the Compact;

k. Legal advice;

l. Matters specifically exempted from disclosure to the public by federal or Member State law; or

m. Other matters as promulgated by the Commission by Rule.

5. If a meeting, or portion of a meeting, is closed, the presiding officer shall state that the meeting will be closed and reference each relevant exempting provision, and such reference shall be recorded in the minutes.

6. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

G. Financing of the Commission

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate sources of revenue, donations, and grants of money, equipment, supplies, materials, and services.

3. The Commission may levy on and collect an annual assessment from each Member State and impose fees on Licensees of Member States to whom it grants a Multistate License to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount for Member States shall be allocated based upon a formula that the Commission shall promulgate by Rule.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any Member States, except by and with the authority of the Member State.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the financial review and accounting procedures established under its bylaws. All receipts and disbursements of funds handled by the Commission shall be subject to an annual financial review by a certified or licensed public

accountant, and the report of the financial review shall be included in and become part of the annual report of the Commission.

H. Qualified Immunity, Defense, and Indemnification

1. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, both personally and in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person. The procurement of insurance of any type by the Commission shall not in any way compromise or limit the immunity granted hereunder.

2. The Commission shall defend any member, officer, executive director, employee, and representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or as determined by the Commission that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining their own counsel at their own expense; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, and representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

4. Nothing herein shall be construed as a limitation on the liability of any Licensee for professional malpractice or misconduct, which shall be governed solely by any other applicable State laws.

5. Nothing in this Compact shall be interpreted to waive or otherwise abrogate a Member State's State action immunity or State action affirmative defense with respect to antitrust claims under the Sherman Act, Clayton Act, or any other State or federal antitrust or anticompetitive law or regulation.

6. Nothing in this Compact shall be construed to be a waiver of sovereign immunity by the Member States or by the Commission.

ARTICLE 9-DATA SYSTEM

A. The Commission shall provide for the development, maintenance, operation, and utilization of a coordinated database and reporting system.

B. The Commission shall assign each applicant for a Multistate License a unique identifier, as determined by the Rules of the Commission.

C. Notwithstanding any other provision of State law to the contrary, a Member State shall submit a uniform data set to the Data System on all individuals to whom this Compact is applicable as required by the Rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Adverse Actions against a license and information related thereto;

4. Non-confidential information related to Alternative Program participation, the beginning and ending dates of such participation, and other information related to such participation;

5. Any denial of application for licensure, and the reason(s) for such denial (excluding the reporting of any criminal history record information where prohibited by law);

6. The existence of Investigative Information;

7. The existence presence of Current Significant Investigative Information; and

8. Other information that may facilitate the administration of this Compact or the protection of the public, as determined by the Rules of the Commission.

D. The records and information provided to a Member State pursuant to this Compact or through the Data System, when certified by the Commission or an agent thereof, shall constitute the authenticated business records of the Commission, and shall be entitled to any associated hearsay exception in any relevant judicial, quasi-judicial or administrative proceedings in a Member State.

E. The existence of Current Significant Investigative Information and the existence of Investigative Information pertaining to a Licensee in any Member State will only be available to other Member States.

F. It is the responsibility of the Member States to report any Adverse Action against a Licensee who holds a Multistate License and to monitor the database to determine whether Adverse Action has been taken against such a Licensee or License applicant. Adverse Action information pertaining to a Licensee or License applicant in any Member State will be available to any other Member State.

G. Member States contributing information to the Data System may designate information that may not be shared with the public without the express permission of the contributing State.

H. Any information submitted to the Data System that is subsequently expunged pursuant to federal law or the laws of the Member State contributing the information shall be removed from the Data System.

ARTICLE 10-RULEMAKING

A. The Commission shall promulgate reasonable Rules in order to effectively and efficiently implement and administer the purposes and provisions of the Compact. A Rule shall be invalid and have no force or effect only if a court of competent jurisdiction holds that the Rule is invalid because the Commission exercised its rulemaking authority in a manner that is beyond the scope and purposes of the Compact, or the powers granted hereunder, or based upon another applicable standard of review.

B. The Rules of the Commission shall have the force of law in each Member State, provided however that where the Rules of the Commission conflict with the laws of the Member State that establish the Member State's scope of

practice as held by a court of competent jurisdiction, the Rules of the Commission shall be ineffective in that State to the extent of the conflict.

C. The Commission shall exercise its Rulemaking powers pursuant to the criteria set forth in this article and the Rules adopted thereunder. Rules shall become binding as of the date specified by the Commission for each Rule.

D. If a majority of the legislatures of the Member States rejects a Rule or portion of a Rule, by enactment of a statute or resolution in the same manner used to adopt the Compact within four (4) years of the date of adoption of the Rule, then such Rule shall have no further force and effect in any Member State or to any State applying to participate in the Compact.

E. Rules shall be adopted at a regular or special meeting of the Commission.

F. Prior to adoption of a proposed Rule, the Commission shall hold a public hearing and allow persons to provide oral and written comments, data, facts, opinions, and arguments.

G. Prior to adoption of a proposed Rule by the Commission, and at least thirty (30) days in advance of the meeting at which the Commission will hold a public hearing on the proposed Rule, the Commission shall provide a Notice of Proposed Rulemaking:

1. On the website of the Commission or other publicly accessible platform;

2. To persons who have requested notice of the Commission's notices of proposed rulemaking, and

3. In such other way(s) as the Commission may by Rule specify.

H. The Notice of Proposed Rulemaking shall include:

1. The time, date, and location of the public hearing at which the Commission will hear public comments on the proposed Rule and, if different, the time, date, and location of the meeting where the Commission will consider and vote on the proposed Rule;

2. If the hearing is held via telecommunication, video conference, or other electronic means, the Commission shall include the mechanism for access to the hearing in the Notice of Proposed Rulemaking;

3. The text of the proposed Rule and the reason therefor;

4. A request for comments on the proposed Rule from any interested person; and

5. The manner in which interested persons may submit written comments.

I. All hearings will be recorded. A copy of the recording and all written comments and documents received by the Commission in response to the proposed Rule shall be available to the public.

J. Nothing in this article shall be construed as requiring a separate hearing on each Rule. Rules may be grouped for the convenience of the Commission at hearings required by this article.

K. The Commission shall, by majority vote of all Commissioners, take final action on the proposed Rule based on the Rulemaking record.

1. The Commission may adopt changes to the proposed Rule provided the changes do not enlarge the original purpose of the proposed Rule.

2. The Commission shall provide an explanation of the reasons for substantive changes made to the proposed Rule as well as reasons for substantive changes not made that were recommended by commenters.

3. The Commission shall determine a reasonable effective date for the Rule. Except for an emergency as provided in subsection L, the effective date of the Rule shall be no sooner than thirty (30) days after the Commission issuing the notice that it adopted or amended the Rule.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency Rule with 24 hours' notice, provided that the usual Rulemaking procedures provided in the Compact and in this article shall be retroactively applied to the Rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the Rule. For the purposes of this provision, an emergency Rule is one that must be adopted immediately to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or Member State funds;

3. Meet a deadline for the promulgation of a Rule that is established by federal law or rule; or

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted Rule for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a Rule. A challenge shall be made in writing and delivered to the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

N. No Member State's rulemaking requirements shall apply under this Compact.

ARTICLE 11-OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

A. Oversight

1. The executive and judicial branches of State government in each Member State shall enforce this Compact and take all actions necessary and appropriate to implement the Compact.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings. Nothing herein shall affect or limit the selection or propriety of venue in any action against a Licensee for professional malpractice, misconduct or any such similar matter.

3. The Commission shall be entitled to receive service of process in any proceeding regarding the enforcement or interpretation of the Compact and shall have standing to intervene in such a proceeding for all purposes. Failure to provide the Commission service of process shall render a judgment or order void as to the Commission, this Compact, or promulgated Rules.

B. Default, Technical Assistance, and Termination

1. If the Commission determines that a Member State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated Rules, the Commission shall provide written notice to the defaulting State. The notice of default shall describe the default, the proposed means of curing the default, and any other action that the Commission may take, and shall offer training and specific technical assistance regarding the default.

2. The Commission shall provide a copy of the notice of default to the other Member States.

C. If a State in default fails to cure the default, the defaulting State may be terminated from the Compact upon an affirmative vote of a majority of the delegates of the Member States, and all rights, privileges and benefits conferred on that State by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending State of obligations or liabilities incurred during the period of default.

D. Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting State's legislature, the defaulting State's State Licensing Authority and each of the Member States' State Licensing Authority.

E. A State that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

F. Upon the termination of a State's membership from this Compact, that State shall immediately provide notice to all Licensees who hold a Multistate License within that State of such termination. The terminated State shall continue to recognize all licenses granted pursuant to this Compact for a minimum of one hundred eighty (180) days after the date of said notice of termination.

G. The Commission shall not bear any costs related to a State that is found to be in default or that has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting State.

H. The defaulting State may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees.

I. Dispute Resolution

1. Upon request by a Member State, the Commission shall attempt to resolve disputes related to the Compact that arise among Member States and between Member and non-Member States.

2. The Commission shall promulgate a Rule providing for both mediation and binding dispute resolution for disputes as appropriate.

J. Enforcement

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions of this Compact and the Commission's Rules.

2. By majority vote as provided by Commission Rule, the Commission may initiate legal action against a Member State in default in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices to enforce compliance with the provisions of the Compact and its promulgated Rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or the defaulting Member State's law.

3. A Member State may initiate legal action against the Commission in the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices to enforce compliance with the provisions of

the Compact and its promulgated Rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees.

4. No individual or entity other than a Member State may enforce this Compact against the Commission.

ARTICLE 12-EFFECTIVE DATE, WITHDRAWAL, AND AMENDMENT

A. The Compact shall come into effect on the date on which the Compact statute is enacted into law in the seventh Member State.

1. On or after the effective date of the Compact, the Commission shall convene and review the enactment of each of the Charter Member States to determine if the statute enacted by each such Charter Member State is materially different than the model Compact statute.

a. A Charter Member State whose enactment is found to be materially different from the model Compact statute shall be entitled to the default process set forth in Article 11.

b. If any Member State is later found to be in default, or is terminated or withdraws from the Compact, the Commission shall remain in existence and the Compact shall remain in effect even if the number of Member States should be less than seven (7).

2. Member States enacting the Compact subsequent to the Charter Member States shall be subject to the process set forth in Article 8.C.23 to determine if their enactments are materially different from the model Compact statute and whether they qualify for participation in the Compact.

3. All actions taken for the benefit of the Commission or in furtherance of the purposes of the administration of the Compact prior to the effective date of the Compact or the Commission coming into existence shall be considered to be actions of the Commission unless specifically repudiated by the Commission.

4. Any State that joins the Compact shall be subject to the Commission's Rules and bylaws as they exist on the date on which the Compact becomes law in that State. Any Rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that State.

B. Any Member State may withdraw from this Compact by enacting a statute repealing that State's enactment of the Compact.

1. A Member State's withdrawal shall not take effect until one hundred eighty (180) days after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing State's Licensing Authority to comply with the investigative and Adverse Action reporting requirements of this Compact prior to the effective date of withdrawal.

3. Upon the enactment of a statute withdrawing from this Compact, a State shall immediately provide notice of such withdrawal to all Licensees within that State. Notwithstanding any subsequent statutory enactment to the contrary, such withdrawing State shall continue to recognize all licenses granted pursuant to this Compact for a minimum of 180 days after the date of such notice of withdrawal.

C. Nothing contained in this Compact shall be construed to invalidate or prevent any licensure agreement or other cooperative arrangement between a

Member State and a non-Member State that does not conflict with the provisions of this Compact.

D. This Compact may be amended by the Member States. No amendment to this Compact shall become effective and binding upon any Member State until it is enacted into the laws of all Member States.

ARTICLE 13. CONSTRUCTION AND SEVERABILITY

A. This Compact and the Commission's rulemaking authority shall be liberally construed so as to effectuate the purposes, and the implementation and administration of the Compact. Provisions of the Compact expressly authorizing or requiring the promulgation of Rules shall not be construed to limit the Commission's rulemaking authority solely for those purposes.

B. The provisions of this Compact shall be severable and if any phrase, clause, sentence or provision of this Compact is held by a court of competent jurisdiction to be contrary to the constitution of any Member State, a State seeking participation in the Compact, or of the United States, or the applicability thereof to any government, agency, person or circumstance is held to be unconstitutional by a court of competent jurisdiction, the validity of the remainder of this Compact and the applicability thereof to any other government, agency, person or circumstance shall not be affected thereby.

C. Notwithstanding subsection B of this article, the Commission may deny a State's participation in the Compact or, in accordance with the requirements of Article 11.B, terminate a Member State's participation in the Compact, if it determines that a constitutional requirement of a Member State is a material departure from the Compact. Otherwise, if this Compact shall be held to be contrary to the constitution of any Member State, the Compact shall remain in full force and effect as to the remaining Member States and in full force and effect as to the Member State affected as to all severable matters.

ARTICLE 14. CONSISTENT EFFECT AND CONFLICT WITH OTHER STATE LAWS

Nothing herein shall prevent or inhibit the enforcement of any other law of a Member State that is not inconsistent with the Compact.

Any laws, statutes, regulations, or other legal requirements in a Member State in conflict with the Compact are superseded to the extent of the conflict.

All permissible agreements between the Commission and the Member States are binding in accordance with their terms.

Sec. 8. **NRS 640C.180 is hereby amended to read as follows:**

640C.180 1. At the first meeting of each fiscal year, the members of the Board shall elect a Chair, Vice Chair and Secretary-Treasurer from among the members.

2. The Board shall meet at least quarterly and may meet at other times at the call of the Chair or upon the written request of a majority of the members of the Board.

3. The Board shall alternate the location of its meetings between the southern district of Nevada and the northern district of Nevada. For the purposes of this subsection:

(a) The southern district of Nevada consists of all that portion of the State lying within the boundaries of the counties of Clark, Esmeralda, Lincoln and Nye.

(b) The northern district of Nevada consists of all that portion of the State lying within the boundaries of Carson City and the counties of Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lyon, Mineral, Pershing, Storey, Washoe and White Pine.

4. A meeting of the Board may be conducted telephonically or by videoconferencing. A meeting conducted telephonically or by videoconferencing must meet the requirements of chapter 241 of NRS and any other applicable provisions of law.

5. ~~[Four]~~ ***Five*** members of the Board constitute a quorum for the purposes of transacting the business of the Board, including, without limitation, issuing, renewing, suspending, revoking or reinstating a license issued pursuant to this chapter.

Sec. 9. **NRS 683A.178 is hereby amended to read as follows:**

683A.178 1. A pharmacy benefit manager has an obligation of good faith and fair dealing toward a third party or pharmacy when performing duties pursuant to a contract to which the pharmacy benefit manager is a party. Any provision of a contract that waives or limits that obligation is against public policy, void and unenforceable.

2. A pharmacy benefit manager shall notify a third party with which it has entered into a contract in writing of any activity, policy or practice of the pharmacy benefit manager that presents a conflict of interest that interferes with the obligations imposed by subsection 1.

3. A pharmacy benefit manager that manages prescription drug benefits for an insurer licensed pursuant to this title shall comply with the provisions of this title which are applicable to the insurer when managing such benefits for the insurer.

Sec. 10. **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:

(a) Must demonstrate the capacity to adequately deliver family planning services provided by pharmacists or pharmacies to covered persons in accordance with the regulations adopted pursuant to subsection 2.

(b) Shall make available to each covered person in this State a notice that meets the requirements prescribed by the regulations adopted pursuant to subsection 2 of each pharmacist or pharmacy that has entered into a provider network contract with the carrier to provide family planning services to covered persons who participate in the relevant network plan.

2. The Commissioner shall adopt regulations to carry out the provisions of this section, including, without limitation, regulations prescribing requirements for:

(a) A health carrier to demonstrate compliance with paragraph (a) of subsection 1. Those regulations must not allow a health carrier 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.

(b) The form and contents of the notice required by paragraph (b) of subsection 1.

Sec. 11. **NRS 687B.225 is hereby amended to read as follows:**

687B.225 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 insurance 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 insured 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

(b) Respond to any request for approval by the insured or member pursuant to this section within 20 days after it receives the request.

2. The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

Sec. 12. **NRS 687B.600 is hereby amended to read as follows:**

687B.600 As used in NRS 687B.600 to 687B.850, inclusive, ***and section 11 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 687B.602 to 687B.665, inclusive, have the meanings ascribed to them in those sections.

Sec. 13. **NRS 687B.670 is hereby amended to read as follows:**

687B.670 If a health carrier offers or issues a network plan, the health carrier shall, with regard to that network plan:

1. Comply with all applicable requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~[,]~~ ***, and section 11 of this act;***

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 carrier complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~[,]~~ ***, and section 11 of this act;*** and

3. As applicable, ensure that the network plan complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~[,]~~ ***, and section 11 of this act.***

Sec. 14. **NRS 689A.0418 is hereby amended to read as follows:**

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 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;]~~ ***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 ~~[10;]~~ ***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 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 shall provide coverage for any 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 is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the applicable provider network contract. Such coverage must be provided to the same extent as if the services were provided by another provider of health care, as applicable to the services being provided. 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.

3. 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,]~~ ***this section,*** 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 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of health insurance and before the renewal of

such a policy, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

~~[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 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. ***If the insurer charges a copayment or coinsurance for a drug for contraception, the insurer may only require an insured to pay the copayment or coinsurance:***

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

~~[10.]~~ ***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.

~~[11.]~~ ***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.

~~[12.]~~ ***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 ~~[.]~~ ***; or***

(b) Require an insured to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1.

~~[13.]~~ ***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.

~~[14.]~~ ***15.*** As used in this section:

(a) ***"In-network pharmacy" means a pharmacy that has entered into a contract with an insurer to provide services to insureds through a network plan offered or issued by the insurer.***

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

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

~~[(c)]~~ ***(d) "Provider network contract" means a contract between an insurer and a provider of health care or pharmacy specifying the rights and responsibilities of the insurer and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.***

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

~~[(d)]~~ ***(f)*** "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 689B.0378 is hereby amended to read as follows:**

689B.0378 1. Except as otherwise provided in subsection ~~[7,]~~ ***8,*** 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;]~~ ***12;*** 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;]~~ ***12;***

(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;

(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 shall provide coverage for any 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 is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the***

applicable network contract. Such coverage must be provided to the same extent as if the services were provided by another provider of health care, as applicable to the services being provided. 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.

3. 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 ~~[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;

(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 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,]~~ ***this section,*** 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.]~~ ***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 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. ***If the insurer charges a copayment or coinsurance for a drug for contraception, the insurer may only require an insured to pay the copayment or coinsurance:***

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

~~[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;
(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.]~~ ***13.*** 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.]~~ ***14.*** 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***

(b) Require an insured to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1.

~~[14.]~~ ***15.*** 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.]~~ ***16.*** As used in this section:

(a) ***"In-network pharmacy" means a pharmacy that has entered into a contract with an insurer to provide services to insureds through a network plan offered or issued by the insurer.***

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

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

~~[(c)]~~ ***(d) "Provider network contract" means a contract between an insurer and a provider of health care or pharmacy specifying the rights and responsibilities of the insurer and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.***

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

~~[(d)]~~ ***(f)*** "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 689C.1676 is hereby amended to read as follows:**

689C.1676 1. Except as otherwise provided in subsection ~~[7,]~~ ***8,*** 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;]~~ ***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 ~~[10;]~~ ***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 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 shall provide coverage for any 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 is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the applicable provider network contract. Such coverage must be provided to the same extent as if the services were provided by another provider of health care, as applicable to the services being provided. 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.

3. 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.]~~ ***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 carrier.

~~[4.]~~ ***5.*** Except as otherwise provided in subsections ~~[8,]~~ 9 ***, 10*** and ~~[11,]~~ ***12,*** 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.]~~ ***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 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,]~~ ***this section,*** and any provision of the plan or the renewal which is in conflict with this section is void.

~~[7.]~~ ***8.*** 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.]~~ ***9.*** 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.]~~ ***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 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. ***If the carrier charges a copayment or coinsurance for a drug for contraception, the carrier may only require an insured to pay the copayment or coinsurance:***

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

~~[10.]~~ ***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.

~~[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 any benefit required by this section or the type of provider of health care to use for such treatment.

~~[12.]~~ ***13.*** 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 ~~[.]~~ ***; or***

(b) Require an insured to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1.

~~[13.]~~ ***14.*** 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.]~~ ***15.*** As used in this section:

(a) ***"In-network pharmacy" means a pharmacy that has entered into a contract with a carrier to provide services to insureds through a network plan offered or issued by the carrier.***

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

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

~~[(c)]~~ ***(d) "Provider network contract" means a contract between a carrier and a provider of health care or pharmacy specifying the rights and responsibilities of the carrier and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.***

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

~~[(d)]~~ ***(f)*** "Therapeutic equivalent" means a drug which:

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

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

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

Sec. 17. **NRS 695A.1865 is hereby amended to read as follows:**

695A.1865 1. Except as otherwise provided in subsection ~~[7,]~~ ***8,*** 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;]~~ ***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 ~~[10;]~~ ***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 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 shall provide coverage for any 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 is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the applicable provider network contract. Such coverage must be provided to the same extent as if the services were provided by another provider of health care, as applicable to the services being provided. 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.

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 coinsurance or require a longer waiting period or other condition for coverage for any benefit included in the benefit contract pursuant to subsection 1;

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

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

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

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

(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,]~~ ***this section,*** 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 to the prospective insured written notice of the coverage that the society refuses to provide pursuant to this subsection.

~~[8.]~~ ***9.*** A society 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 benefit contract 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 society may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception. ***If the society charges a copayment or coinsurance for a drug for contraception, the society may only require an insured to pay the copayment or coinsurance:***

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

~~[10.]~~ ***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.

~~[11.]~~ ***12.*** 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.]~~ ***13.*** 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 ~~[.]~~ ***; or***

(b) Require an insured to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1.

~~[13.]~~ ***14.*** 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.]~~ ***15.*** As used in this section:

(a) ***"In-network pharmacy" means a pharmacy that has entered into a contract with a society to provide services to insureds through a network plan offered or issued by the society.***

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

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

~~[(c)]~~ ***(d) "Provider network contract" means a contract between a society and a provider of health care or pharmacy specifying the rights and responsibilities of the society and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.***

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

~~[(d)]~~ ***(f)*** "Therapeutic equivalent" means a drug which:

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

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

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

Sec. 18. **NRS 695B.1919 is hereby amended to read as follows:**

695B.1919 1. Except as otherwise provided in subsection ~~[7.]~~ ***8,*** 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.]~~ ***12;*** 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.]~~ ***12;***

(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 contract for hospital or medical service;

(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 shall provide coverage for any 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 is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the applicable provider network contract. Such coverage must be provided to the same extent as if the services were provided by another provider of health care, as applicable to the services being provided. 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.

3. 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;

(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 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,]~~ ***this section,*** 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 insurer shall, before the issuance of a contract for hospital or medical service and before the renewal of such a contract, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

~~[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, copayment or coinsurance for any other drug or device that provides the same

method of contraception. ***If the insurer charges a copayment or coinsurance for a drug for contraception, the insurer may only require an insured to pay the copayment or coinsurance:***

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

~~[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;
(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.]~~ ***13.*** 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.]~~ ***14.*** 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***

(b) Require an insured to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1.

~~[14.]~~ ***15.*** 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.]~~ ***16.*** As used in this section:

(a) ***"In-network pharmacy" means a pharmacy that has entered into a contract with an insurer to provide services to insureds through a network plan offered or issued by the insurer.***

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

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

~~[(c)]~~ *(d) "Provider network contract" means a contract between an insurer and a provider of health care or pharmacy specifying the rights and responsibilities of the insurer and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.*

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

~~[(d)]~~ *(f)* "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. 19. **NRS 695C.1696 is hereby amended to read as follows:**

695C.1696 1. Except as otherwise provided in subsection ~~[7,]~~ *8,* 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;]~~ *12;* 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;]~~ *12;*

(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 shall provide coverage for any 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 is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the applicable provider network contract. Such coverage must be provided to the same extent as if the services were provided by another provider of health care, as applicable to the services being provided. 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.

3. 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.]~~ ***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 health maintenance organization.

~~[4.]~~ ***5.*** Except as otherwise provided in subsections ~~[9,]~~ 10***, 11*** and ~~[12,]~~ ***13,*** 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.]~~ ***6.*** Coverage pursuant to this section for the covered dependent of an enrollee must be the same as for the enrollee.

~~[6.]~~ ***7.*** Except as otherwise provided in subsection ~~[7,]~~ ***8,*** 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,]~~ ***this section,*** and any provision of the plan or the renewal which is in conflict with this section is void.

~~[7.]~~ ***8.*** 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.]~~ ***9.*** If a health maintenance organization 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.*** 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.]~~ ***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 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. ***If the health maintenance organization charges a copayment or coinsurance for a drug for contraception, the health maintenance organization may only require an enrollee to pay the copayment or coinsurance:***

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

~~[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;
(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.]~~ ***13.*** 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.]~~ ***14.*** 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 ~~[.]~~ ***; or***

(b) Require an enrollee to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1.

~~[14.]~~ ***15.*** 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.]~~ ***16.*** As used in this section:

(a) ***"In-network pharmacy" means a pharmacy that has entered into a contract with a health maintenance organization to provide services to enrollees through a network plan offered or issued by the health maintenance organization.***

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

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

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

~~[(c)]~~ ***(d) "Provider network contract" means a contract between a health maintenance organization and a provider of health care or pharmacy specifying the rights and responsibilities of the health maintenance organization and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.***

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

~~[(d)]~~ ***(f)*** "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. 20. **NRS 695G.1715 is hereby amended to read as follows:**

695G.1715 1. Except as otherwise provided in subsection ~~[7,]~~ ***8,*** 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;]~~ ***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 ~~[10;]~~ ***11;***

(c) Self-administered hormonal contraceptives dispenses 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 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 managed care organization shall provide coverage for any 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 is employed by or serves as an independent contractor of an in-network pharmacy and in accordance with the applicable provider network contract. Such coverage must be provided to the same extent as if the services were provided by another provider of health care, as applicable to the services being provided. 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.

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

~~[3.]~~ ***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 managed care organization.

~~[4.]~~ ***5.*** Except as otherwise provided in subsections ~~[8,]~~ 9***, 10*** and ~~[11,]~~ ***12,*** 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;

(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;

(c) 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.]~~ ***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 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,]~~ ***this section,*** and any provision of the plan or the renewal which is in conflict with this section is void.

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

~~[8.]~~ ***9.*** A managed care organization 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 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. ***If the managed care organization charges a copayment or coinsurance for a drug for contraception, the managed care organization may only require an enrollee to pay the copayment or coinsurance:***

(a) Once for the entire amount of the drug dispensed for the plan year; or

(b) Once for each 1-month supply of the drug dispensed.

~~[10.]~~ ***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.

~~[11.]~~ ***12.*** 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.]~~ ***13.*** 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 ~~[.]~~ ***; or***

(b) Require an insured to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1.

~~[13.]~~ ***14.*** 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.]~~ ***15.*** As used in this section:

(a) ***"In-network pharmacy" means a pharmacy that has entered into a contract with a managed care organization to provide services to insureds through a network plan offered or issued by the managed care organization.***

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

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

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

~~[(c)]~~ ***(d) "Provider network contract" means a contract between a managed care organization and a provider of health care or pharmacy specifying the rights and responsibilities of the managed care organization and the provider of health care or pharmacy, as applicable, for delivery of health care services pursuant to a network plan.***

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

~~[(d)]~~ ***(f)*** "Therapeutic equivalent" means a drug which:

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

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

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

Sec. 21. **1. The provisions of NRS 422.4053, as amended by section 2 of this act, do not apply to a contract between the Department of Health and Human Services and a pharmacy benefit manager or a health maintenance organization entered into pursuant to NRS 422.4053 before January 1, 2024, but do apply to any renewal or extension of such a contract.**

2. As used in this section:

(a) "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

(b) "Pharmacy benefit manager" has the meaning ascribed to it in NRS 683A.174.

Sec. 22. **The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.**

~~[Sec. 2.]~~ ***Sec. 23.*** 1. This section ~~[becomes]~~ **and sections 4 and 5 of this act become** effective upon passage and approval.

2. ~~[Section 1]~~ **Sections 1, 2, 3 and 6 to 22, inclusive,** of this act ~~[becomes]~~ **become** effective:

(a) Upon passage and approval for the purpose of performing any preparatory administrative tasks that are necessary to carry out the provisions of this act; and

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