SENATE BILL NO. 352–SENATORS SCHEIBLE; AND STONE

MARCH 22, 2023

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to prescription drugs. (BDR 57-134)

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

CONTAINS UNFUNDED MANDATE (§ 7 & NRS 287.010)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

AN ACT relating to health care; 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; expanding required insurance coverage of contraception; revising requirements governing the dispensing of a drug used for contraception; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law imposes certain duties on a pharmacy benefit manager. (NRS 683A.178) **Section 1** 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 14** 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 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 3 and 6-13** of this bill

prohibit an insurer from requiring an insured to obtain prior authorization before receiving a contraceptive drug. **Sections 6-13** also require an insurer to: (1) cover certain contraceptive services when provided by a pharmacist; 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. **Section 2** of this bill requires an insurer to demonstrate the capacity to adequately deliver family planning services provided by pharmacists to covered persons. **Sections 4 and 5** of this bill make conforming changes to indicate the proper placement of **section 2** in the Nevada Revised Statutes.

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) **Section 15** of this bill instead requires a pharmacist to dispense 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 unless the patient is unable or unwilling to pay the applicable charge, copayment or coinsurance.

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

Section 1. 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. 2. Chapter 687B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health carrier which offers or issues a network plan must demonstrate the capacity to adequately deliver family

planning services provided by pharmacists to covered persons in accordance with the regulations adopted pursuant to subsection 2.

2. The Commissioner shall adopt regulations to carry out the provisions of this section, including, without limitation, regulations prescribing requirements for a health carrier to demonstrate compliance with subsection 1. Those regulations must not allow a health 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.

Sec. 3. 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. 4. NRS 687B.600 is hereby amended to read as follows:

687B.600 As used in NRS 687B.600 to 687B.850, inclusive, ***and section 2 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. 5. 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 2 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 2 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 2 of this act.***

Sec. 6. 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 insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who participates in the network plan of the insurer. The terms of the policy must not limit:***

(a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.

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

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, 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.

~~[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 ~~[.~~

~~13.]~~ ***; or***

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

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

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

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

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

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

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

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

Sec. 7. 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 insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who participates in the network plan of the insurer. The terms of the policy must not limit:***

(a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.

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

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, 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.

~~[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 ~~[.~~

~~14.]~~ ***; or***

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

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

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

under contract with the insurer. The term does not include an arrangement for the financing of premiums.

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

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

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

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

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

Sec. 8. 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. ***An insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who participates in the network plan of the carrier. The terms of the health benefit plan 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, 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.

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

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

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

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

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

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

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

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

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

Sec. 9. 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. ***An insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who participates in the network plan of the society. The terms of the benefit contract must not limit:***

(a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.

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

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

~~[3.]~~ ***4.*** If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the society.

~~[4.]~~ ***5.*** Except as otherwise provided in subsections ~~[8,]~~ 9 ***, 10*** and ~~[11,]~~ ***12,*** a society that offers or issues a benefit contract shall not:

(a) Require an insured to pay a higher deductible, any copayment or 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, 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.

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

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

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

(b) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole

or in part, through a defined set of providers under contract with the society. The term does not include an arrangement for the financing of premiums.

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

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

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

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

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

Sec. 10. 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 insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who participates in the network plan of the hospital or medical services corporation. The terms of the policy of health insurance 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, 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.

~~[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 ~~[.~~

~~14.]~~ ***; or***

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

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

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

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

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

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

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

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

Sec. 11. 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. ***An enrollee is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who participates in the network plan of the health maintenance organization. The terms of the evidence of coverage must not limit:***

(a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.

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

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, 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.

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

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

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

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

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

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

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

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

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

Sec. 12. 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. ***An insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who participates in the network plan of the managed care organization. The terms of the evidence of coverage must not limit:***

(a) Coverage for services listed in subsection 1 and provided by such a pharmacist to a number of occasions less than the coverage for such services when provided by another provider of health care.

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

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, 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.

~~[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 ~~[.~~

~~13.]~~ ***; or***

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

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) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or

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

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

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

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

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

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

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

Sec. 13. NRS 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.

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. 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) "Therapeutic equivalent" means a drug which:

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

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

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

Sec. 14. NRS 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.

Sec. 15. 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 the patient, dispense up to a 3-month supply of the drug or therapeutic equivalent.~~

~~(b) The second time dispensing the drug or therapeutic equivalent to the patient, dispense up to a 9-month supply of the drug or therapeutic equivalent, or any amount which covers the remainder of the plan year if the patient is covered by a health care plan, whichever is less.~~

~~(c) For a refill in a plan year following the initial dispensing of a drug or therapeutic equivalent pursuant to paragraphs (a) and (b), dispense up to~~] ***dispense*** 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. 16. 1. The provisions of NRS 422.4053, as amended by section 14 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. 17. 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. 18. 1. This section becomes effective upon passage and approval.

2. Sections 1 to 17, inclusive, of this act become effective:

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

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

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