(Reprinted with amendments adopted on April 25, 2023)
SECOND REPRINT **S.B. 352**

SENATE BILL NO. 352–SENATORS SCHEIBLE, BUCK;
SEEVERS GANSERT 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; 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; 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 to the same extent as if the services were provided by another provider of health care; 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 6-13** additionally prescribe certain limitations on the imposition of a copayment or coinsurance for a drug for contraception. **Section 2** 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) notify covered persons of pharmacists and pharmacies who are available to provide family planning services to covered persons through the network of the insurer. **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 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 14.8** 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 14.2** of this bill makes a conforming change to update an internal reference changed by **section 14.8**.

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 15** 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 15** 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.

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:

(a) 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.

(b) Shall provide 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 and 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. 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 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. Such coverage must be provided to the same extent as if the services were provided by another provider of health care. 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. ***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 ~~[.~~

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

~~[(d)]~~ ***(e)*** "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 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. Such coverage must be provided to the same extent as if the services were provided by another provider of health care. 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. ***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 ~~[.~~

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

~~[(d)]~~ ***(e)*** "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. ***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. Such coverage must be provided to the same extent as if the services were provided by another provider of health care. 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. ***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 ~~[.~~

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

~~[(d)]~~ ***(e)*** "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. ***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 or a pharmacy operated by the society. Such coverage must be provided to the same extent as if the services***

were provided by another provider of health care. 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. ***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 ~~[.~~

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

~~[(d)]~~ ***(e)*** "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 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 or a pharmacy operated by the insurer. Such coverage must be provided to the same extent as if the services were provided by another provider of health care. 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. ***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 ~~[.~~

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

~~[(d)]~~ ***(e)*** "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. ***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 or a pharmacy operated by the health maintenance organization. Such coverage must be provided to the same extent as if the services were provided by another provider of health care. 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. ***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 ~~[.~~

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

~~[(d)]~~ ***(e)*** "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. ***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 or a pharmacy operated by the managed care organization. Such coverage must be provided to the same extent as if the services were provided by another provider of health care. 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. ***If the managed care organization charges a copayment or coinsurance for a drug for contraception, the managed care organization 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 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) ***"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 of health care" has the meaning ascribed to it in NRS 629.031.

~~[(d)]~~ ***(e)*** "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. ***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. 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. 14.2. 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. 14.8. 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. 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,]~~ ***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. 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 and sections 14.2 and 14.8 of this act become effective upon passage and approval.

2. Sections 1 to 14, inclusive, 15, 16 and 17 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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