THE SEVENTY-NINTH DAY

CARSON CITY (Tuesday), April 25, 2023

Senate called to order at 12:45 p.m.
President Anthony presiding.
Roll called.
All present.
Prayer by the Chaplain, President Rajan Zed.

Om
bhur bhuvah svah
tat savitur varenyam
bhargo devasya dhimahi
dhiyo you nah prachodayat.

We meditate on the transcendental glory of the deity supreme, who is inside the heart of the earth, inside the life of the sky and inside the soul of the Heaven. May he stimulate and illuminate our minds.

samani va akutih
samana hrdayani vah
samanam astu vo mano
yatha vah susahasti.

United your resolve, united your hearts, may your spirits be at one, that you may long together dwell in unity and concord.

niyatam kuru karma tvam karma jyayo hyakarmanah
sarirayatrapi ca te na prasiddhyedakarmanah.
yajnarthatkarmano'nyatra loko'yam karmabandhanah
tadartham karma kaunteya muktasangah samacara.

Fulfill all your duties; action is better than inaction. Even to maintain your body, you are obliged to act. Selfish action imprisons the world. Act selflessly, without any thought of personal profit.

ya te tanur vaci pratisthita ya srotre ya ca caksusi
ya ca manasi santata sivam tam kuru motkramih.

Be kind to us with your invisible form, which dwells in the voice, the eye, the ear and pervades the mind. Abandon us not.

Om shanti, shanti, shanti.

Peace, peace, peace be unto all.

OM.

Pledge of Allegiance to the Flag.

By previous order of the Senate, the reading of the Journal is dispensed with, and the President and Secretary are authorized to make the necessary corrections and additions.

MESSAGES FROM THE ASSEMBLY

ASSEMBLY CHAMBER, Carson City, April 24, 2023

To the Honorable the Senate:

I have the honor to inform your honorable body that the Assembly on this day passed, as amended, Assembly Bills Nos. 53, 73, 75, 91, 120, 132, 154, 162, 218, 219, 220, 242, 244, 298, 305, 333, 391, 410, 415, 426, 432; Assembly Joint Resolution No. 8.

CAROL AIELLO-SALA
Assistant Chief Clerk of the Assembly

WAIVERS AND EXEMPTIONS

NOTICE OF EXEMPTION

April 25, 2023

The Fiscal Analysis Division, pursuant to Joint Standing Rule No. 14.6, has determined the eligibility for exemption of: Senate Bills Nos. 226, 367.

WAYNE THORLEY
Fiscal Analysis Division

MOTIONS, RESOLUTIONS AND NOTICES

Senator Cannizzaro moved that for this legislative day, all necessary rules be suspended, and that the reprinting of all Senate bills and joint resolutions amended on the General File or the Resolution File be dispensed with, that the Secretary be authorized to insert all amendments adopted by the Senate, and that the bill or resolution be immediately placed on the appropriate reading file and considered next.

Remarks by Senator Cannizzaro.

This suspension eliminates having to wait for a reprint from the Legal Division before the Senate can vote on the passage of a bill or joint resolution.

Motion carried.

Senator Cannizzaro moved that the following person be accepted as an accredited press representative and be allowed the use of appropriate media facilities: KRNV NEWS: Justin Case.

Motion carried.

Senator Cannizzaro moved that Senate Bills Nos. 61, 296, 348, 423 and 433 be taken from the Secretary's Desk and placed at the top of the General File.

Motion carried.

Senator Cannizzaro moved that Senate Bills Nos. 35, 194, 243, 251 and 292 be taken from their positions on the General File and placed at the bottom of the General File.

Motion carried.

Senator Dondero Loop moved that Senate Bills Nos. 158, 226 and 367 be taken from their positions on the General File and re-referred to the Committee on Finance.

Motion carried.

INTRODUCTION, FIRST READING AND REFERENCE

Assembly Bill No. 53.

Senator Lange moved that the bill be referred to the Committee on Revenue and Economic Development.

Motion carried.

Assembly Bill No. 75.

Senator Lange moved that the bill be referred to the Committee on Judiciary.

Motion carried.

Assembly Bill No. 91.

Senator Lange moved that the bill be referred to the Committee on Natural Resources.

Motion carried.

Assembly Bill No. 132.

Senator Lange moved that the bill be referred to the Committee on Health and Human Services.

Motion carried.

Assembly Bill No. 162.

Senator Lange moved that the bill be referred to the Committee on Natural Resources.

Motion carried.

Assembly Bill No. 218.

Senator Lange moved that the bill be referred to the Committee on Commerce and Labor.

Motion carried.

Assembly Bill No. 219.

Senator Lange moved that the bill be referred to the Committee on Government Affairs.

Motion carried.

Assembly Bill No. 220.

Senator Lange moved that the bill be referred to the Committee on Natural Resources.

Motion carried.

Assembly Bill No. 242.

Senator Lange moved that the bill be referred to the Committee on Legislative Operations and Elections.

Motion carried.

Assembly Bill No. 244.

Senator Lange moved that the bill be referred to the Committee on Commerce and Labor.

Motion carried.

Assembly Bill No. 298.

Senator Lange moved that the bill be referred to the Committee on Commerce and Labor.

Motion carried.

Assembly Bill No. 305.

Senator Lange moved that the bill be referred to the Committee on Government Affairs.

Motion carried.

Assembly Bill No. 333.

Senator Lange moved that the bill be referred to the Committee on Government Affairs.

Motion carried.

Assembly Bill No. 391.

Senator Lange moved that the bill be referred to the Committee on Government Affairs.

Motion carried.

Assembly Bill No. 410.

Senator Lange moved that the bill be referred to the Committee on Commerce and Labor.

Motion carried.

Assembly Bill No. 415.

Senator Lange moved that the bill be referred to the Committee on Commerce and Labor.

Motion carried.

Assembly Bill No. 426.

Senator Lange moved that the bill be referred to the Committee on Growth and Infrastructure.

Motion carried.

Assembly Bill No. 432.

Senator Lange moved that the bill be referred to the Committee on Commerce and Labor.

Motion carried.

GENERAL FILE AND THIRD READING

Senate Bill No. 61.

Bill read third time.

The following amendment was proposed by Senator Scheible:

Amendment No. 516.

SUMMARY—Revises provisions relating to exploitation involving the deposits or proceeds of an account held by an older person or a vulnerable person in joint tenancy. (BDR 15-427)

AN ACT relating to crimes; providing that the holding of an account in joint tenancy does not, in and of itself, convey to the persons named on the account legal ownership of the account and the deposits and proceeds of the account in a manner that would preclude such a person from committing or being prosecuted for exploitation involving the control or conversion of any deposits or proceeds of the account; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law sets forth certain circumstances in which a deposit made in the names of two or more persons creates an account held in joint tenancy. Existing law provides, with certain exceptions, that the use by a depositor of the term "joint account," or a similar term, in designating the ownership of an account indicates the intent of the depositor that the account be held in joint tenancy. If an account is intended to be held in joint tenancy, existing law provides that the account or proceeds from the account are owned by the persons named on the account. (NRS 100.085)

In 1996, the Nevada Supreme Court held that the status of a defendant as a joint account holder under NRS 100.085 did not preclude her conviction for theft of money from the joint account because the jury could have concluded that the criminal intent and actions of the defendant arose before she placed the money into the joint account. (*Walch v. State*, 112 Nev. 25, 31-33 (1996)) In 2018, the Nevada Court of Appeals determined that NRS 100.085 establishes a presumption that a joint account holder has ownership of, and the authority to use, money in a joint account. The Court held that, under the reasoning of the Nevada Supreme Court, for a joint account holder to be convicted of theft based on the withdrawal or misuse of money from a joint account, the State is required to establish that the criminal intent of the joint account holder arose before the money was deposited into the joint account. (*Natko v. State*, 134 Nev. 841, 843-44 (Nev. Ct. App. 2018))

Existing law imposes criminal penalties on a person who exploits or who conspires to exploit an older person or vulnerable person. (NRS 200.5099, 200.50995) Existing law defines "exploitation" to mean, in general, any act taken by a person who has the trust and confidence of an older person or a vulnerable person or any use of the power of attorney or guardianship of an older person or a vulnerable person to obtain control of or to convert the person's money, assets or property with the intention of permanently depriving the person of the ownership, use, benefit or possession of his or her money, assets or property. (NRS 200.5092) ~~[Section]~~ Sections 1 and 5.5 of this bill ~~[provides]~~ provide that the mere fact that an account of an older person or a vulnerable person is held in joint tenancy does not, in and of itself, convey to the persons named on the account legal ownership of the account and the deposits and proceeds of the account in such a way that would preclude any of those persons from committing or being prosecuted for exploitation involving the control or conversion of any deposits or proceeds of the account, regardless of when the intent to commit exploitation arose.

Section 2-4 and 6 of this bill make conforming changes to indicate the proper placement of section 1 in the Nevada Revised Statutes.

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

Section 1. Chapter 200 of NRS is hereby amended by adding thereto a new section to read as follows:

The mere fact that an account of an older person or a vulnerable person is held in joint tenancy pursuant to NRS 100.085 does not, in and of itself, convey to all persons named on the account legal ownership of the account and the deposits and proceeds of the account in a manner that would preclude such a person from committing or being prosecuted for exploitation involving the control or conversion of any deposits or proceeds of the account if the facts and circumstances demonstrate that exploitation has occurred, regardless of whether the intent to commit exploitation arose before, during or after the creation of the account.

Sec. 2. NRS 200.5092 is hereby amended to read as follows:

200.5092 As used in NRS 200.5091 to 200.50995, inclusive, *and section 1 of this act,* unless the context otherwise requires:

1. "Abandonment" means:

(a) Desertion of an older person or a vulnerable person in an unsafe manner by a caretaker or other person with a legal duty of care; or

(b) Withdrawal of necessary assistance owed to an older person or a vulnerable person by a caretaker or other person with an obligation to provide services to the older person or vulnerable person.

2. "Abuse" means willful:

(a) Infliction of pain or injury on an older person or a vulnerable person;

(b) Deprivation of food, shelter, clothing or services which are necessary to maintain the physical or mental health of an older person or a vulnerable person;

(c) Infliction of psychological or emotional anguish, pain or distress on an older person or a vulnerable person through any act, including, without limitation:

(1) Threatening, controlling or socially isolating the older person or vulnerable person;

(2) Disregarding the needs of the older person or vulnerable person; or

(3) Harming, damaging or destroying any property of the older person or vulnerable person, including, without limitation, pets;

(d) Nonconsensual sexual contact with an older person or a vulnerable person, including, without limitation:

(1) An act that the older person or vulnerable person is unable to understand or to which the older person or vulnerable person is unable to communicate his or her objection; or

(2) Intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh or buttocks of the older person or vulnerable person; or

(e) Permitting any of the acts described in paragraphs (a) to (d), inclusive, to be committed against an older person or a vulnerable person.

3. "Exploitation" means any act taken by a person who has the trust and confidence of an older person or a vulnerable person or any use of the power of attorney or guardianship of an older person or a vulnerable person to:

(a) Obtain control, through deception, intimidation or undue influence, over the older person's or vulnerable person's money, assets or property with the intention of permanently depriving the older person or vulnerable person of the ownership, use, benefit or possession of his or her money, assets or property; or

(b) Convert money, assets or property of the older person or vulnerable person with the intention of permanently depriving the older person or vulnerable person of the ownership, use, benefit or possession of his or her money, assets or property.

➥ As used in this subsection, "undue influence" means the improper use of power or trust in a way that deprives a person of his or her free will and substitutes the objectives of another person. The term does not include the normal influence that one member of a family has over another.

4. "Isolation" means preventing an older person or a vulnerable person from having contact with another person by:

(a) Intentionally preventing the older person or vulnerable person from receiving visitors, mail or telephone calls, including, without limitation, communicating to a person who comes to visit the older person or vulnerable person or a person who telephones the older person or vulnerable person that the older person or vulnerable person is not present or does not want to meet with or talk to the visitor or caller knowing that the statement is false, contrary to the express wishes of the older person or vulnerable person and intended to prevent the older person or vulnerable person from having contact with the visitor;

(b) Physically restraining the older person or vulnerable person to prevent the older person or vulnerable person from meeting with a person who comes to visit the older person or vulnerable person; or

(c) Permitting any of the acts described in paragraphs (a) and (b) to be committed against an older person or a vulnerable person.

➥ The term does not include an act intended to protect the property or physical or mental welfare of the older person or vulnerable person or an act performed pursuant to the instructions of a physician of the older person or vulnerable person.

5. "Neglect" means the failure of a person or a manager of a facility who has assumed legal responsibility or a contractual obligation for caring for an older person or a vulnerable person or who has voluntarily assumed responsibility for his or her care to provide food, shelter, clothing or services which are necessary to maintain the physical or mental health of the older person or vulnerable person.

6. "Older person" means a person who is 60 years of age or older.

7. "Protective services" means services the purpose of which is to prevent and remedy the abuse, neglect, exploitation, isolation and abandonment of older persons or vulnerable persons. The services may include:

(a) The investigation, evaluation, counseling, arrangement and referral for other services and assistance; and

(b) Services provided to an older person or a vulnerable person who is unable to provide for his or her own needs.

8. "Vulnerable person" means a person 18 years of age or older who:

(a) Suffers from a condition of physical or mental incapacitation because of a developmental disability, organic brain damage or mental illness; or

(b) Has one or more physical or mental limitations that restrict the ability of the person to perform the normal activities of daily living.

Sec. 3. NRS 200.50925 is hereby amended to read as follows:

200.50925 For the purposes of NRS 200.5091 to 200.50995, inclusive, *and section 1 of this act*, a person:

1. Has "reasonable cause to believe" if, in light of all the surrounding facts and circumstances which are known or which reasonably should be known to the person at the time, a reasonable person would believe, under those facts and circumstances, that an act, transaction, event, situation or condition exists, is occurring or has occurred.

2. Acts "as soon as reasonably practicable" if, in light of all the surrounding facts and circumstances which are known or which reasonably should be known to the person at the time, a reasonable person would act within approximately the same period under those facts and circumstances.

Sec. 4. NRS 200.5099 is hereby amended to read as follows:

200.5099 1. Except as otherwise provided in subsection 6, any person who abuses an older person or a vulnerable person is guilty:

(a) For the first offense, of either of the following, as determined by the court:

(1) A category C felony and shall be punished as provided in NRS 193.130; or

(2) A gross misdemeanor and shall be punished by imprisonment in the county jail for not more than 364 days, or by a fine of not more than $2,000, or by both fine and imprisonment; or

(b) For the second and all subsequent offenses or if the person has been previously convicted of violating a law of any other jurisdiction that prohibits the same or similar conduct, of a category B felony and shall be punished by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 6 years,

➥ unless a more severe penalty is prescribed by law for the act or omission which brings about the abuse.

2. Except as otherwise provided in subsection 7, any person who has assumed responsibility, legally, voluntarily or pursuant to a contract, to care for an older person or a vulnerable person and who neglects the older person or vulnerable person, causing the older person or vulnerable person to suffer

physical pain or mental suffering, permits or allows the older person or vulnerable person to suffer unjustifiable physical pain or mental suffering or permits or allows the older person or vulnerable person to be placed in a situation where the older person or vulnerable person may suffer physical pain or mental suffering as the result of abuse or neglect is guilty:

(a) For the first offense, of either of the following, as determined by the court:

(1) A category C felony and shall be punished as provided in NRS 193.130; or

(2) A gross misdemeanor and shall be punished by imprisonment in the county jail for not more than 364 days, or by a fine of not more than $2,000, or by both fine and imprisonment; or

(b) For the second and all subsequent offenses, of a category B felony and shall be punished by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 6 years,

➥ unless a more severe penalty is prescribed by law for the act or omission which brings about the abuse or neglect.

3. Except as otherwise provided in subsection 4, any person who exploits an older person or a vulnerable person shall be punished:

(a) For the first offense, if the value of any money, assets and property obtained or used:

(1) Is less than $650, of either of the following, as determined by the court:

(I) A category C felony as provided in NRS 193.130; or

(II) A gross misdemeanor by imprisonment in the county jail for not more than 364 days, or by a fine of not more than $2,000, or by both fine and imprisonment;

(2) Is at least $650, but less than $5,000, for a category B felony by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 10 years, or by a fine of not more than $10,000, or by both fine and imprisonment; or

(3) Is $5,000 or more, for a category B felony by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 20 years, or by a fine of not more than $25,000, or by both fine and imprisonment; or

(b) For the second and all subsequent offenses, regardless of the value of any money, assets and property obtained or used, for a category B felony by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 20 years, or by a fine of not more than $25,000, or by both fine and imprisonment,

➥ unless a more severe penalty is prescribed by law for the act which brought about the exploitation. The monetary value of all of the money, assets and property of the older person or vulnerable person which have been obtained or used, or both, may be combined for the purpose of imposing punishment for an offense charged pursuant to this subsection.

4. If a person exploits an older person or a vulnerable person and the monetary value of any money, assets and property obtained cannot be determined, the person shall be punished:

(a) For the first offense, of either of the following, as determined by the court:

(1) A category C felony as provided in NRS 193.130; or

(2) A gross misdemeanor by imprisonment in the county jail for not more than 364 days, or by a fine of not more than $2,000, or by both fine and imprisonment; or

(b) For the second and all subsequent offenses, for a category B felony by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 20 years, or by a fine of not more than $25,000, or by both fine and imprisonment,

➥ unless a more severe penalty is prescribed by law for the act which brought about the exploitation.

5. Any person who isolates or abandons an older person or a vulnerable person is guilty:

(a) For the first offense, of either of the following, as determined by the court:

(1) A category C felony and shall be punished as provided in NRS 193.130; or

(2) A gross misdemeanor and shall be punished by imprisonment in the county jail for not more than 364 days, or by a fine of not more than $2,000, or by both fine and imprisonment; or

(b) For the second and all subsequent offenses, of a category B felony and shall be punished by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 10 years, and may be further punished by a fine of not more than $5,000,

➥ unless a more severe penalty is prescribed by law for the act or omission which brings about the isolation or abandonment.

6. A person who violates any provision of subsection 1, if substantial bodily or mental harm or death results to the older person or vulnerable person, is guilty of a category B felony and shall be punished by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 20 years, unless a more severe penalty is prescribed by law for the act or omission which brings about the abuse.

7. A person who violates any provision of subsection 2, if substantial bodily or mental harm or death results to the older person or vulnerable person, shall be punished for a category B felony by imprisonment in the state prison for a minimum term of not less than 2 years and a maximum term of not more than 20 years, unless a more severe penalty is prescribed by law for the act or omission which brings about the abuse or neglect.

8. In addition to any other penalty imposed against a person for a violation of any provision of NRS 200.5091 to 200.50995, inclusive, *and section 1 of this act* the court shall order the person to pay restitution.

9. As used in this section:

(a) "Allow" means to take no action to prevent or stop the abuse or neglect of an older person or a vulnerable person if the person knows or has reason to know that the older person or vulnerable person is being abused or neglected.

(b) "Permit" means permission that a reasonable person would not grant and which amounts to a neglect of responsibility attending the care and custody of an older person or a vulnerable person.

(c) "Substantial mental harm" means an injury to the intellectual or psychological capacity or the emotional condition of an older person or a vulnerable person as evidenced by an observable and substantial impairment of the ability of the older person or vulnerable person to function within his or her normal range of performance or behavior.

Sec. 5. (Deleted by amendment.)

Sec. 5.5. NRS 100.085 is hereby amended to read as follows:

100.085 1. When a deposit has been made in the name of the depositor and one or more other persons, and in a form intended to be paid or delivered to any one of them, or the survivor or survivors of them, the deposit is the property of the persons as joint tenants. If an account is intended to be held in joint tenancy, the account or proceeds from the account are owned by the persons named, and may be paid or delivered to any of them during the lifetime of all, or to the survivor or survivors of them after the death of less than all of the tenants, or the last of them to survive, and payment or delivery is a valid and sufficient release and discharge of the depository.

2. The making of a deposit in the form of a joint tenancy vests title to the deposit in the survivor or survivors.

3. When a deposit has been made in the name of the depositor and one or more other persons, and in a form to be paid or delivered to the survivor or survivors of them, but one or more of the other persons is not authorized to withdraw from the deposit during the life of the depositor or depositors, the person or persons so restricted have no present interest in the deposit, but upon the death of the last depositor entitled to withdraw, the deposit is presumed to belong to the survivor or survivors. Unless written notice of a claim against the deposit has been given by a survivor or a third person before payment or delivery, payment or delivery to a survivor is a valid and sufficient release and discharge of the depository.

4. For the purposes of this section, unless a depositor specifically provides otherwise, the use by the depositor of any of the following words or terms in designating the ownership of an account indicates the intent of the depositor that the account be held in joint tenancy:

(a) Joint;

(b) Joint account;

(c) Jointly held;

(d) Joint tenants;

(e) Joint tenancy; or

(f) Joint tenants with right of survivorship.

5. As set forth in section 1 of this act, the mere fact that an account of an older person or a vulnerable person is held in joint tenancy pursuant to this section does not, in and of itself, convey to all persons named on the account legal ownership of the account and the deposits and proceeds of the account in a manner that would preclude such a person from committing or being prosecuted for exploitation involving the control or conversion of any deposits or proceeds of the account if the facts and circumstances demonstrate that exploitation has occurred, regardless of whether the intent to commit exploitation arose before, during or after the creation of the account.

6. As used in this section:

(a) "Exploitation" has the meaning ascribed to it in NRS 200.5092.

(b) "Older person" has the meaning ascribed to it in NRS 200.5092.

(c) "Vulnerable person" has the meaning ascribed to in NRS 200.592.

Sec. 6. NRS 162C.330 is hereby amended to read as follows:

162C.330 1. The provisions of this chapter must not be construed to affect the requirement of any person to report the abuse, neglect, exploitation, isolation or abandonment of an older person or a vulnerable person as provided in NRS 200.5091 to 200.50995, inclusive ~~.~~ , *and section 1 of this act.*

2. As used in this section, the words and terms defined in NRS 200.5091 to 200.50995, inclusive, *and section 1 of this act* have the meanings ascribed to them in those sections.

Senator Scheible moved the adoption of the amendment.

Remarks by Senator Scheible.

Amendment No. 516 to Senate Bill No. 61 adds identical language from section 1 of the bill to a new section 5.5 to clarify the applicability of the bill's provisions to Chapter 100.085 of the Nevada Revised Statutes.

Amendment adopted.

Bill read third time.

Remarks by Senator Stone.

I know we have received an amendment on Senate Bill No. 61, but I have the original floor statement which I will read now. Senate Bill No. 61 provides the mere fact that an account of an older person or a vulnerable person is held jointly does not convey to the persons named on the account legal ownership of the account or any deposits or proceeds of the account in a way that would preclude such a person from committing or being prosecuted for exploitation of an older person or vulnerable person involving the control or conversion of funds from the account.

Roll call on Senate Bill No. 61:

YEAS—21.

NAYS—None.

Senate Bill No. 61 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

MOTIONS, RESOLUTIONS AND NOTICES

Senator Cannizzaro moved that Senate Bills Nos. 296, 348 and 423 be taken from their positions on the General File and placed on the General File following Senate Bill No. 303.

Motion carried.

Assembly Joint Resolution No. 8.

Senator Lange moved that the resolution be referred to the Committee on Legislative Operations and Elections.

Motion carried.

GENERAL FILE AND THIRD READING

Senate Bill No. 433.

Bill read third time.

Remarks by Senator Daly.

Senate Bill No. 433 requires the Labor Commissioner to adopt regulations establishing factors to be considered when determining whether prevailing wages are required to be paid on a public work. The bill also provides that the Labor Commissioner is not bound by any determination or finding of a public body relating to the applicability of the requirements for the payment of the prevailing wage. Lastly, any determination made by the Labor Commissioner regarding the applicability of those requirements is a final order for the purposes of judicial review.

Roll call on Senate Bill No. 433:

YEAS—13.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 433 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 6.

Bill read third time.

Remarks by Senator Hammond.

Senate Bill No. 6 revises provisions governing the release of personal information to reporters or editorial employees by the Department of Motor Vehicles for journalistic purposes. In addition, the bill prohibits the sale of information received from the Department except for certain insurance purposes and prohibits the Director [of the Department of Motor Vehicles] from releasing personal information to an individual or company for the purpose of selling the information except for certain insurance purposes.

Roll call on Senate Bill No. 6:

YEAS—21.

NAYS—None.

Senate Bill No. 6 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 20.

Bill read third time.

Remarks by Senator Flores.

Senate Bill No. 20 creates a process for filling a vacancy on a board of county commissioners: first, by an appointment made by the Governor from a list of two persons provided by the county; second, through a special election; or third, by a board of county commissioners pursuant to a process established by ordinance.

Roll call on Senate Bill No. 20:

YEAS—16.

NAYS—Buck, Krasner, Seevers Gansert, Stone, Titus—5.

Senate Bill No. 20 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 25.

Bill read third time.

Remarks by Senator Daly.

Senate Bill No. 25 requires the State Public Works Division to implement and maintain a long-term plan to address the future needs for suitable office spaces for the departments and agencies of the Executive Department of State Government.

Roll call on Senate Bill No. 25:

YEAS—21.

NAYS—None.

Senate Bill No. 25 having received a constitutional majority, Mr. President declared it passed.

Bill ordered transmitted to the Assembly.

Senate Bill No. 38.

Bill read third time.

Remarks by Senator Scheible.

Senate Bill No. 38 defines a "person in a position of authority" for the purposes of the bill to mean a person 18 years of age or older who is or was an employee or volunteer at a public or private school and who has had contact with a pupil while performing his or her duties. Such a person is guilty of a category C felony for knowingly contacting or communicating with, or attempting to contact or communicate with, a pupil under 18 years of age with the intent to convince the pupil to leave certain places where the pupil is located and engage in the commission of certain crimes or to cause or encourage the pupil to engage in certain unlawful acts or to facilitate the commission of such an act by the person in a position of authority.

The bill also makes it a category C felony for such a person to engage in similar conduct with any pupil with the intent to engage in the commission of certain crimes or cause or encourage the pupil to engage in sexual conduct, transmit certain sexual images, engage in certain unlawful acts or facilitate the person in a position of authority with committing certain unlawful acts.

The bill makes a person convicted of such offenses subject to certain other statutory provisions related to the commission of sexual offenses, such as sex offender registration and lifetime supervision. The bill also adds these violations to those for which certain education-related licenses may be suspended or revoked and provides that a person convicted of these violations forfeits all rights of employment after arrest.

Roll call on Senate Bill No. 38:

YEAS—21.

NAYS—None.

Senate Bill No. 38 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 40.

Bill read third time.

Remarks by Senator Harris.

Senate Bill No. 40 changes the name of the document issued by the Housing Division of the Department of Business and Industry from a "certificate of ownership" to a "certificate of title," allows certain documents to be issued in electronic form and revises requirements for certain transactions involving manufactured homes and buildings, mobile homes, factory-built housing or a commercial coach. The bill revises eligibility requirements for persons seeking assistance from the Account for Affordable Housing and revises provisions governing local ordinances concerning the placement of manufactured homes.

This bill is effective upon passage and approval for the purposes of adopting regulations and performing preparatory administrative tasks and repealing current law related to the issuance of a certificate of ownership and on July 1, 2023, for all other purposes.

Roll call on Senate Bill No. 40:

YEAS—21.

NAYS—None.

Senate Bill No. 40 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 57.

Bill read third time.

Remarks by Senator Lange.

Senate Bill No. 57 is an omnibus bill of the Division of Insurance of the Department of Business and Industry which makes numerous changes to provisions governing insurance, including revising circumstances under which the Commissioner of Insurance is authorized or required to hold a hearing on certain matters related to the business of insurance and requiring the Commissioner to issue a final order in a contested case within 45 days after the close of certain hearings; changing the terminology concerning the licensure of certain insurance professionals and standardizing the circumstances when an agent of an insurer is required to designate a natural person to represent the agency or to be responsible for the agency's compliance with the laws and regulations governing insurance; imposing certain requirements on an applicant for a license as a managing general agent, which may include, among other provisions, filing a surety bond in an amount determined by the Commissioner of Insurance; revising provisions concerning the duties and requirements of administrators of insurance, including clarifying that a person who administers a program of pharmacy benefits must be registered as an administrator; prohibiting certain insurers who issue a policy of health insurance who remove a prescription drug from a formulary from adding that prescription drug back into the formulary at a higher cost tier in the same plan year in which it was removed, except under certain circumstances; adopting a recommendation of the National Association of Insurance Commissioners to reduce from 1 percent to .15 percent the rate of interest used to determine the minimum nonforfeiture amounts allowed in annuity contracts; and excluding delinquency proceedings against an insurer from the Nevada Rules of Civil Procedure.

Roll call on Senate Bill No. 57:

YEAS—21.

NAYS—None.

Senate Bill No. 57 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 59.

Bill read third time.

Remarks by Senator Pazina.

Senate Bill No. 59 revises requirements relating to the operation and numbering of power-driven and sailing vessels and procedures and fees to obtain certificates of ownership for certain vessels. The bill also revises provisions related to certain crimes associated with operating a power-driven or sailing vessel under the influence of alcohol or a controlled substance while underway on the waters of this State. The game warden, sheriff or other peace officer is authorized to order the removal of vessels under certain conditions, and a court is authorized to prohibit a person from operating any vessel on interstate waters under certain circumstances until the person successfully completes a course in safe boating.

Roll call on Senate Bill No. 59:

YEAS—17.

NAYS—Buck, Krasner, Stone, Titus—4.

Senate Bill No. 59 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 60.

Bill read third time.

Remarks by Senators Ohrenschall and Seevers Gansert.

SENATOR OHRENSCHALL:

Senate Bill No. 60 makes various changes concerning elections, including authorizing a voter to request a replacement mail ballot and to designate a person to sign the replacement ballot on his or her behalf under certain circumstances; establishing a different timeline for filing a recount or an election contest that only applies to the election of presidential electors; providing a specific form of a declaration of candidacy for an independent candidate for partisan office; revising the date of service for members of election boards; revising provisions relating to when certain candidates may be declared elected at a primary election; prohibiting the tampering, interfering or attempting to interfere with any computer program used to conduct an election; requiring the Secretary of State to adopt regulations establishing a cyber-incident response plan for elections; prohibiting a person from being preregistered or registered to vote in more than one state at the same time; requiring a court to set a hearing no later than five days after the filing of an election contest; revising provisions relating to risk-limiting audits including the inspection of ballots and removing a requirement to conduct an audit prior to the certification of results; revising the deadline by which a withdrawal of candidacy must be presented by certain candidates; revising provisions relating to the limit on contributions to public officers in special elections, other than a special election to recall a public officer.

SENATOR SEEVERS GANSERT:

I oppose Senate Bill No. 60. The amendment that we have does not reflect quite a few things that we did not hear in committee. Specifically, there is some language around if you register to vote after the deadline, then you could be instructed to register to vote electronically. So, if you were attempting to register after the deadline, you get sent to a computer to do that when, in fact, we should not be able to vote after the deadline to register. This is just one example.

SENATOR OHRENSCHALL:

I am happy to talk to my colleague from Washoe County, either now or offline, if she wants to direct me to whatever section of the bill she is referring to. I have gone over this bill with Legal, and I do believe it reflects what we heard in committee as to the proposed amendment.

Roll call on Senate Bill No. 60:

YEAS—13.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 60 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 63.

Bill read third time.

Remarks by Senator Dondero Loop.

Senate Bill No. 63 revises several policies and procedures of the Judicial Department, including, but not limited to, modernizing outdated provisions regarding the publication of contact information for judicial offices, revising where court may be held and authorizing remote hearings in certain circumstances, revising provisions governing record storage, expanding the purposes for which certain courts may do business on nonjudicial days, replacing the term "regulation" with "rule" where appropriate in relation to the adoption of rules by the Judicial Department, revising provisions relating to the compensation of court interpreters and translators, codifying the date on which the term of a justice appointed to fill a vacancy on the Nevada Supreme Court expires, clarifying that the provision of certain resources for the Supreme Court is the duty of the State, clarifying the obligations of a county in providing resources to a district court, providing that part-time judges may practice law in a firm or with a partner under certain conditions, removing obsolete language regarding the employment of certain staff by the Supreme Court and removing references to the specific number of justices on the Supreme Court and the judges initially appointed to the Court of Appeals.

Roll call on Senate Bill No. 63:

YEAS—20.

NAYS—Titus.

Senate Bill No. 63 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 66.

Bill read third time.

Remarks by Senator Hansen.

Senate Bill No. 66 establishes certain circumstances that will disqualify an individual for life from obtaining a commercial driver's license without the possibility of reinstatement if they have committed certain felony offenses including human trafficking, coercion or the transportation of a controlled substance. Employers are prohibited from allowing a person to operate a commercial motor vehicle under certain circumstances. The bill also revises provisions to comply with federal laws and to conform with federal definitions. Finally, the bill revises the circumstances in which the Department of Motor Vehicles will furnish information regarding a person's driving record to certain other jurisdictions.

Roll call on Senate Bill No. 66:

YEAS—21.

NAYS—None.

Senate Bill No. 66 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 78.

Bill read third time.

Remarks by Senator Doñate.

Senate Bill No. 78 revises provisions relating to residential rental property and landlord and tenant responsibilities. The bill establishes a new definition of "security deposit," revises how the deposit is to be handled upon the initiation and termination of tenancy, and the landlord must provide an itemized accounting of a security deposit.

Further, it also requires that a landlord may charge a rental application fee for every prospective tenant who intends to occupy. Finally, the bill exempts landlords of manufactured homes from the provisions of this bill and provides that a rental agreement entered into before this bill becomes effective is binding regardless of the provisions of this bill.

Part of the reason why I decided to bring this bill was part of my own encounters moving to Carson City. Fees need to be transparent both to the tenants and the landlords. We know that we have a lot of effort to go to make this system fair for everyone.

Roll call on Senate Bill No. 78:

YEAS—14.

NAYS—Buck, Goicoechea, Hansen, Krasner, Seevers Gansert, Stone, Titus—7.

Senate Bill No. 78 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 82.

Bill read third time.

Remarks by Senator Daly.

Senate Bill No. 82 makes various changes to the requirements for the utilization of apprentices on public works, including expanding the circumstances under which a person is treated as an apprentice, eliminating the threshold number of workers for the applicability of certain requirements to use apprentices, clarifying that the requirements for employing apprentices are applied on the basis of public works performed during a calendar year instead of on a per public work basis, requiring contractors or subcontractors to maintain and provide to the Labor Commissioner any supporting documentation that demonstrates a good faith effort to employ one or more apprentices for a certain percentage of the total hours performed on a public work, and requiring a contractor or subcontractor, beginning on or before February 15, 2025, and every year thereafter, to submit an annual report to the Labor Commissioner regarding the employment of apprentices.

Finally, the bill creates a penalty schedule for violations of certain provisions relating to the requirements for a contractor or subcontractor to employ one or more apprentices for a certain percentage of the total hours performed on a public work.

Roll call on Senate Bill No. 82:

YEAS—13.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 82 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 92.

Bill read third time.

Remarks by Senator Doñate.

Senate Bill No. 92 creates requirements for the licensing and regulation of sidewalk food vendors by the governing body of a county whose population is 100,000 or more, which is currently Clark and Washoe Counties. The bill also requires a local board of health to establish a process for a person to apply for a permit, license or other authorization from the local board of health to operate as a sidewalk vendor. Finally, the bill creates the nine-member Task Force on Safe Sidewalk Vending in the Office of the Secretary of State and authorizes the Secretary of State to establish an advisory board to support the services and activities of the task force.

This is a bill we believe can restore equity and help street food vendors with economic opportunity. We should not be criminalizing entrepreneurship, and I ask my colleagues to join me in support of this bill.

Roll call on Senate Bill No. 92:

YEAS—20.

NAYS—Stone.

Senate Bill No. 92 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 105.

Bill read third time.

Remarks by Senator Scheible.

Senate Bill No. 105 makes the Department of Corrections subject to the Nevada Administrative Procedure Act for the purposes of adopting regulations related to fiscal policy and correspondence and visitation with inmates.

Roll call on Senate Bill No. 105:

YEAS—21.

NAYS—None.

Senate Bill No. 105 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 114.

Bill read third time.

Remarks by Senator Flores.

Senate Bill No. 114 provides that a pupil who transfers to a charter school or school that uses a lottery system to enroll pupils is immediately eligible to participate and practice in any sanctioned sport or other interscholastic activity or event at the school. A pupil who transfers from one school to another school may, not more than once in his or her lifetime, elect to be immediately eligible. The bill also prohibits school districts, public schools and private schools from making regulations, rules, policies, procedures or requirements concerning the eligibility and participation of these pupils that are more restrictive than provisions prescribed by the Nevada Interscholastic Activities Association (NIAA).

Additionally, Senate Bill No. 114 prohibits the NIAA from penalizing, retaliating against or taking adverse action against any school or person for participating in a legislative process or advocating for or against any policy before a public body. The bill also allows a person or school to appeal a decision by the NIAA to the State Board of Education.

Roll call on Senate Bill No. 114:
YEAS—21
NAYS—None.

Senate Bill No. 114 having received a constitutional majority, Mr. President declared it passed, as amended.
Bill ordered transmitted to the Assembly.

Senate Bill No. 119.
Bill read third time.
Remarks by Senator Doñate.

Senate Bill No. 119 repeals the expiration date for certain third-party payers to cover services provided through telehealth due to the termination of the Declaration of Emergency for COVID-19. This bill will require third-party payers to continue covering telehealth services that align with Centers for Medicare and Medicaid Services standards, including patients eligible for originating sites in rural areas if the telehealth service is originating in a county with less than a 100,000 population, counseling or treatment related to a mental health condition or substance abuse disorder, and federally qualified health centers and rural health clinics.

Roll call on Senate Bill No. 119:
YEAS—21.
NAYS—None.

Senate Bill No. 119 having received a constitutional majority, Mr. President declared it passed, as amended.
Bill ordered transmitted to the Assembly.

Senate Bill No. 147.
Bill read third time.
Remarks by Senator Lange.

Senate Bill No. 147 requires an employee's unpaid wages to be paid immediately upon being placed on nonworking status by an employer. If an employer fails to pay the wages of an employee placed on nonworking status within 3 days, the wages continue to accrue at the same rate for each day up to 30 days or until paid in full, whichever is less.

The bill also provides that wages include amounts owed to an employee who is placed on nonworking status and whose employer fails to pay the employee by the statutory deadlines.

Roll call on Senate Bill No. 147:
YEAS—21.
NAYS—None.

Senate Bill No. 147 having received a constitutional majority, Mr. President declared it passed, as amended.
Bill ordered transmitted to the Assembly.

Senate Bill No. 148.
Bill read third time.
Remarks by Senators Lange and Buck.

SENATOR LANGE:

Senate Bill No. 148 prohibits a local school precinct from employing a person to carry out any responsibility that has not been transferred to the local school precinct from a large school district. Furthermore, a local school precinct must meet certain personnel ratios when hiring certain school

support staff to the extent that such staff is available and the precinct may use carried forward, year-end balances under certain circumstances to employ personnel necessary to meet such ratios.

Additionally, Senate Bill No. 148 requires the principal of a local school precinct to select certain employees in accordance with any applicable collective bargaining agreement. A superintendent making any decision regarding the assignment or reassignment of staff from a large school district to the local school precinct must first consult with the principal of the local school precinct and the school associate superintendent.

The provisions of this bill relating to the use of the carried forward, year-end balances are effective on January 1, 2024. The remaining provisions are effective on July 1, 2023.

SENATOR BUCK:

I oppose Senate Bill No. 148 because any time you force-place people in schools, it is not good for the school if they do not have buy-in. Also, the ratios are unattainable due to workforce shortages. And there are at least 1,000 support staff openings, so why cannot a few of these people get placed?

Roll call on Senate Bill No. 148:

YEAS—13.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 148 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 155.

Bill read third time.

Remarks by Senator Ohrenschall.

Senate Bill No. 155 authorizes homeless persons who commit certain enumerated misdemeanor offenses to be assigned to diversionary and specialty court programs. A court that assigns a homeless person to complete such a program of treatment may waive or reduce any fine associated with that misdemeanor, any administrative assessment or fee that would otherwise be imposed upon the homeless person for committing such an offense.

Roll call on Senate Bill No. 155:

YEAS—13.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 155 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 164.

Bill read third time.

Remarks by Senator Spearman.

Senate Bill No. 164 revises the requirements for the distribution of fees collected for special license plates indicating support for the Divine Nine so that all fees collected, in addition to all other governmental services taxes and applicable registration and license fees, are distributed to the Las Vegas Metropolitan Inter-Alumni Council of the United Negro College Fund.

And for those who are not aware, the Divine Nine represent a group of historically Black collegiate fraternities and sororities that were formed long before integration.

Roll call on Senate Bill No. 164:

YEAS—21.

NAYS—None.

Senate Bill No. 164 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 183.

Bill read third time.

Remarks by Senator Stone.

Senate Bill No. 183 sets forth the requirements for the installation and maintenance of secure drug take-back bins by collectors that are authorized under federal law to engage in drug take-back collection and the destruction of home-generated pharmaceutical waste. A collector that maintains a secure drug take-back bin and complies with the provisions of this bill is not subject to any discipline by the State Board of Pharmacy for any injury or harm that results from a collector maintaining a secure drug take-back bin on its premises unless the injury or harm directly results from the gross negligence or willful and wanton misconduct of the collector. In addition, the bill exempts a collector from compliance with any restriction established by the governing body of a county, city or other local government entity that would affect the collection and destruction of the contents of a secure take-back bin.

Roll call on Senate Bill No. 183:

YEAS—21.

NAYS—None.

Senate Bill No. 183 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 234.

Bill read third time.

The following amendment was proposed by Senator Scheible:

Amendment No. 512.

SUMMARY—Revises provisions governing communications with offenders. (BDR S-810)

AN ACT relating to offenders; providing for the establishment of a pilot program to provide ~~[communication services]~~ telephone calls free of charge between certain offenders and the ~~[children]~~ families of such offenders; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Section 1 of this bill requires the Department of Corrections to establish and administer a pilot program to provide ~~[communication services]~~ telephone calls free of charge between offenders in the custody of the Department who have been assigned to Florence McClure Women's Correctional Center and the ~~[children]~~ families of such offenders. Section 1 ~~[also: (1) authorizes the Director of the Department to apply for and accept any gift, donation, bequest, grant or other source of money to carry out the pilot program; and (2) requires any money received by the Director to be accounted for separately and used only to carry out the pilot program. If there is an insufficient amount of money from gifts, donations, bequests, grants or other sources of money received by the Director to carry out the pilot program, section 1: (1) requires the Director to authorize the State Controller to transfer money from the Offenders' Store~~

~~Fund to pay the cost of the pilot program; and (2) requires the State Controller to make the transfer.]~~ requires the pilot program to provide such an offender with a 15-minute telephone call each day to a member of the family of the offender free of charge. Finally, section 1 requires the Department to prepare and submit to the ~~[Director of the Legislative Counsel Bureau for transmittal to the 83rd Session of the Legislature]~~ Board of State Prison Commissioners a report concerning the participation of offenders in the pilot program.

Section 2 of this bill expires the provisions of section 1 on ~~[June 30,]~~ January 1, 2025.

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

Section 1. 1. The Department of Corrections shall establish and administer a pilot program to provide ~~[communication services]~~ telephone calls between offenders in the custody of the Department who have been assigned to Florence McClure Women's Correctional Center and the ~~[children]~~ families of such offenders. The program must:

(a) Be designed to facilitate and encourage a continuing relationship between the offenders and the ~~[children]~~ families of such offenders; and

(b) Provide ~~[communication services]~~ each offender with a 15-minute telephone call each day to a member of the family of the offender free of charge . ~~[between an offender and the child of the offender, regardless of whether the offender or child initiates or receives any communication provided through the service.]~~

2. ~~[The Director of the Department may apply for and accept any gift, donation, bequest, grant or other source of money to carry out the pilot program. Any money so received must be accounted for separately and may only be used by the Department to carry out the pilot program. If there is an insufficient amount of money from gifts, donations, bequests, grants or other sources of money to carry out the pilot program, the Director shall authorize the State Controller to transfer sufficient money from the Offenders' Store Fund to pay the cost of the pilot program, and the State Controller shall make the transfer if so authorized.~~

~~3.]~~ The Department may adopt regulations to administer the provisions of this section.

~~[4.]~~ 3. Nothing in this section shall be construed to authorize an offender to communicate with ~~[his or her child]~~ a person if the offender is otherwise prohibited by law or court order from communicating with the ~~[child.]~~ person.

~~[5.]~~ 4. On or before ~~[January]~~ July 1, ~~[2025,]~~ 2024, the Department shall submit to the ~~[Director]~~ Board of ~~[the Legislative Counsel Bureau for transmittal to the 83rd Session of the Legislature]~~ State Prison Commissioners a report with its findings ~~[and any recommendations. The report must include, without limitation:~~

~~(a) The number of children to whom communication services were provided as part of the pilot program, if known;~~

~~(b) A statistical comparison of the conduct of offenders who participated in the pilot program and offenders who did not participate in the pilot program, if practicable;~~

~~(c) A list of all grants applied for by the Director pursuant to subsection 2 and all such grants that were received; and~~

~~(d) Any recommendations:~~

~~(1) Relating to the pilot program; or~~

~~(2) For expanding opportunities for communication between offenders in the custody of the Department and the children of such offenders.~~

~~6. As used in this section:~~

~~(a) "Child" means a person who is less than 18 years of age.~~

~~(b) "Communication services" includes, without limitation, any service which enables real-time, two-way voice or audio-video communication, including, without limitation, Voice over Internet Protocol service.~~

~~(c) "Voice over Internet Protocol service" means any service that:~~

~~(1) Enables real-time, two-way voice communication originating from or terminating at the user's location in Internet Protocol or a successor protocol;~~

~~(2) Uses a broadband connection from the user's location; and~~

~~(3) Permits a user to receive a call that originates on the public switched telephone network and to terminate a call to the public switched telephone network.~~] concerning the participation of offenders in the pilot program.

Sec. 2. 1. This section becomes effective upon passage and approval.

2. Section 1 of this act becomes effective 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 on July 1, 2023, for all other purposes, and expires by limitation on ~~[June 30,]~~ January 1, 2025.

Senator Scheible moved the adoption of the amendment.

Remarks by Senator Scheible.

Amendment No. 512 to Senate Bill No. 234 deletes provisions requiring the establishment of a pilot program specifically for communications between Nevada Department of Corrections (NDOC) inmates and their children. Instead, it requires the pilot program to provide communication services between NDOC inmates and their families. Specifically, it is to apply to the Florence McClure Women's Correctional Center and provide telephone calls between the offenders and their family members free of charge. The amendment requires the pilot program to provide such calls for at least 15 minutes per day. It requires a report be submitted about the pilot program to the State Board of Prison Commissioners by July 1, 2024, and extends the sunset date for the pilot program to January 1, 2025.

Amendment adopted.

WAIVERS AND EXEMPTIONS

NOTICE OF EXEMPTION

April 25, 2023

The Fiscal Analysis Division, pursuant to Joint Standing Rule No. 14.6, has determined the eligibility for exemption of: Senate Bill No. 234.

WAYNE THORLEY

Fiscal Analysis Division

MOTIONS, RESOLUTIONS AND NOTICES

Senator Dondero Loop moved that Senate Bill No. 234 be taken from its position on the General File and re-referred to the Committee on Finance upon return from reprint.

Motion carried.

GENERAL FILE AND THIRD READING

Senate Bill No. 235.

Bill read third time.

Remarks by Senator Ohrenschall.

Senate Bill No. 235 authorizes a court to extend a pretrial release hearing at the request of either party or the court for good cause shown. It also allows an extension upon the stipulation of both parties, prescribes in what manner such a stipulation may be made, and prescribes when a continued trial must be rescheduled. A court is also authorized under Senate Bill No. 253 to impose new conditions of release if a person has failed to satisfy their prior conditions of release.

Roll call on Senate Bill No. 235:

YEAS—16.

NAYS—Buck, Goicoechea, Seevers Gansert, Stone, Titus—5.

Senate Bill No. 235 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 269.

Bill read third time.

Remarks by Senators Ohrenschall and Hansen.

SENATOR OHRENSCHALL:

Senate Bill No. 269 prohibits a person from restraining a dog outdoors during any time in which a heat advisory, excessive heat warning, windchill warning or winter storm warning has been issued for that area by the National Weather Service. The bill also eliminates certain exemptions from restraint limitations for dogs being used or trained to hunt and for dogs temporarily being cared for as part of a nonprofit rescue operation or formed for animal welfare purposes. Finally, the bill adds exemptions from restraint limitations for a dog being processed into a shelter or under the direct custody of a person engaged in a temporary task or activity with the dog for not more than one hour provided that a heat advisory, excessive heat warning, windchill warning or winter storm warning has not been issued for the area.

I urge everyone to support it. This will prevent animal cruelty, and it is reasonable.

SENATOR HANSEN:

I oppose Senate Bill No. 269. Currently, in NRS 574, there are three exemptions that will be removed by this bill. The first one involves people when they are out on hunting trips with an animal. The second one involves people that are camping with an animal. The last one I will read, "temporarily being cared for as part of a rescue operation or in any other manner in conjunction with a bona fide nonprofit organization formed for animal welfare purposes." These three exemptions are entirely reasonable and should remain in law. Unfortunately, with Senate Bill No. 269 they are being removed. I must, reluctantly, urge my colleagues to vote "no" on Senate Bill No. 269.

Roll call on Senate Bill No. 269:

YEAS—12.

NAYS—Buck, Flores, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—9.

Senate Bill No. 269 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 280.

Bill read third time.

Remarks by Senators Nguyen and Titus.

SENATOR NGUYEN:

Senate Bill No. 280 requires a hospital to provide for the insertion of long-acting reversible contraception (LARCs) immediately after childbirth if requested by a patient giving birth. The bill also prohibits a hospital from requiring a provider of health care who objects on religious grounds to the insertion of such contraception from having to participate in the service but requires such a provider to refer the patient to a provider who is willing to provide the service. An insurer is prohibited from refusing to cover LARCs immediately after childbirth. Additionally, the bill restricts the amount that a provider of health care or hospital is authorized to require a third-party insurer to pay for such contraception and associated testing.

SENATOR TITUS:

I support Senate Bill No. 280 with the caveat that I have been assured that the language will be changed in the Assembly because in rural areas, having the ability to insert an intrauterine device or implant progesterone may not exist. Hopefully, the language will be changed, and we will look at an injectable form of long-acting birth control that is reversible.

SENATOR NGUYEN:

That is the intent. It just did not come out in that respect. I agree with my Senate colleague, and I will continue to work to include a more comprehensive list of these LARCs.

Roll call on Senate Bill No. 280:

YEAS—21.

NAYS—None.

Senate Bill No. 280 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 293.

Bill read third time.

Remarks by Senator Doñate.

Senate Bill No. 293 requires a solar installation contractor who enters into an agreement for the lease or purchase of a residential distributed generation system to be licensed by the State Contractors Board and to comply with certain requirements relating to work offered and performed, advertisements and solicitations and for sales referrals and the generation of leads. The contractor must retain telephone recordings and comply with certain contractual requirements.

Roll call on Senate Bill No. 293:

YEAS—21.

NAYS—None.

Senate Bill No. 293 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 294.

Bill read third time.

Remarks by Senator Doñate.

Senate Bill No. 294 requires a licensed firearms dealer to provide with each firearm sold, or otherwise transferred, a locking device capable of securing the firearm and to post a notice on its premises that informs a buyer that the negligent storage of a firearm may result in imprisonment or a fine.

The bill also requires a plan used by a school district or governing body of a charter school for responding to a crisis, emergency or suicide to include the training of school police officers and certain other employees in active assailant movement techniques; provide support to pupils, faculty and staff who have experienced a crisis or emergency; ensure that a pupil's parent or legal guardian is notified of a crisis or emergency; and inform parents and legal guardians of state law related to the storage of firearms. School police officers are also required to receive training in active assailant movement techniques and active assailant training prior to beginning their service as a school police officer.

Finally, the bill requires the Department of Health and Human Services to develop and implement a safe firearm storage education campaign.

Roll call on Senate Bill No. 294:

YEAS—15.

NAYS—Buck, Goicoechea, Hansen, Krasner, Stone, Titus—6.

Senate Bill No. 294 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 298.

Bill read third time.

Remarks by Senator Doñate.

Senate Bill No. 298 revises various provisions related to the involuntary discharge of a resident of a residential facility for groups. Among other things, the bill prohibits the owner, agent or employee of a residential facility for groups or a provider of health care from acting as the representative of a resident in matters concerning the involuntary discharge of the resident unless the person is related to the resident and prohibits, with certain exceptions, the transfer or involuntary discharge of a resident from a residential facility for groups.

Roll call on Senate Bill No. 298:

YEAS—13.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 298 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 303.

Bill read third time.

Remarks by Senator Dondero Loop.

Senate Bill No. 303 revises provisions related to warranty work and recall services and repairs that are performed by automobile dealers under agreements with automobile manufacturers. Among other items, the bill establishes provisions concerning fair and reasonable compensation for labor and parts associated with services performed. The bill also prohibits a manufacturer from taking certain actions against an automobile dealer and requires the Director of the Department of Motor Vehicles to decide certain disputes.

Roll call on Senate Bill No. 303:
YEAS—21.
NAYS—None.

Senate Bill No. 303 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 296.

Bill read third time.

The following amendment was proposed by Senator Harris:

Amendment No. 532.

SUMMARY—Revises provisions related to traffic stops. (BDR 43-196)

AN ACT relating to traffic stops; prohibiting a peace officer from issuing a citation for certain violations relating to motor vehicles, unless the violation is discovered when the vehicle is halted or its driver is arrested for another alleged violation or offense; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law prohibits a peace officer from issuing a citation for certain violations relating to motor vehicles unless the violation is discovered: (1) when the vehicle is halted; or (2) the driver is arrested for another alleged violation or offense. (NRS 482.385, 483.2525, 484B.907, 484D.495, 484D.500) Sections 9.1-9.9 of this bill prohibit a peace officer from issuing a citation for certain violations relating to registration, license plates, permits for unregistered vehicles and equipment, unless the violation is discovered when the vehicle is halted or its driver is arrested for another alleged violation or offense.

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

Section 1. (Deleted by amendment.)

Sec. 2. (Deleted by amendment.)

Sec. 3. (Deleted by amendment.)

Sec. 4. (Deleted by amendment.)

Sec. 5. (Deleted by amendment.)

Sec. 6. (Deleted by amendment.)

Sec. 7. (Deleted by amendment.)

Sec. 8. (Deleted by amendment.)

Sec. 9. (Deleted by amendment.)

Sec. 9.1. NRS 482.205 is hereby amended to read as follows:

482.205 *1.* Except as otherwise provided in this chapter and NRS 706.188, every owner of a motor vehicle, trailer or semitrailer intended to be operated upon any highway in this State shall, before the motor vehicle, trailer or semitrailer can be operated, apply to the Department or a registered dealer for and obtain the registration thereof.

2. Except as otherwise provided in subsection 3, a citation may be issued for a violation of subsection 1 only if the violation is discovered when the vehicle is halted or its driver is arrested for another alleged violation or offense.

3. The provisions of subsection 2 do not apply if the registration of the motor vehicle, trailer or semitrailer has been expired for more than ~~[60]~~ 30 days.

Sec. 9.3. NRS 482.275 is hereby amended to read as follows:

482.275 1. The license plates for a motor vehicle other than a motorcycle, moped or motor vehicle being transported by a licensed vehicle transporter must be attached thereto, one in the rear and, except as otherwise provided in subsection 2, one in the front. The license plate issued for all other vehicles required to be registered must be attached to the rear of the vehicle. The license plates must be so displayed during the current calendar year or registration period.

2. If the motor vehicle was not manufactured to include a bracket, device or other contrivance to display and secure a front license plate, and if the manufacturer of the motor vehicle provided no other means or method by which a front license plate may be displayed upon and secured to the motor vehicle:

(a) One license plate must be attached to the motor vehicle in the rear; and

(b) The other license plate may, at the option of the owner of the vehicle, be attached to the motor vehicle in the front.

3. The provisions of subsection 2 do not relieve the Department of the duty to issue a set of two license plates as otherwise required pursuant to NRS 482.265 or other applicable law and do not entitle the owner of a motor vehicle to pay a reduced tax or fee in connection with the registration or transfer of the motor vehicle. If the owner of a motor vehicle, in accordance with the provisions of subsection 2, exercises the option to attach a license plate only to the rear of the motor vehicle, the owner shall:

(a) Retain the other license plate; and

(b) Insofar as it may be practicable, return or surrender both plates to the Department as a set when required by law to do so.

4. Every license plate must at all times be securely fastened to the vehicle to which it is assigned so as to prevent the plate from swinging and at a height not less than 12 inches from the ground, measuring from the bottom of such plate, in a place and position to be clearly visible, and must be maintained free from foreign materials and in a condition to be clearly legible.

5. Any license plate which is issued to a vehicle transporter or a dealer, rebuilder or manufacturer may be attached to a vehicle owned or controlled by that person by a secure means. No license plate may be displayed loosely in the window or by any other unsecured method in any motor vehicle.

6. ~~[Except as otherwise provided in subsection 7,]~~ If a license plate is attached to the rear of a vehicle in a clearly visible location, a citation may be issued for a violation of this section only if the violation is discovered while

the vehicle is halted or its driver is arrested for another alleged violation or offense.

7. ~~[The provisions of subsection 6 do not apply]~~ Nothing in this section shall be construed to prohibit a citation from being issued, regardless of whether the vehicle is halted or its driver is arrested for another alleged violation or offense, if no license plate is attached to the ~~[rear of the motor]~~ vehicle ~~[.]~~ in a clearly visible location.

Sec. 9.4. NRS 482.396 is hereby amended to read as follows:

482.396 1. A person who is not a dealer, manufacturer or rebuilder may apply to the Department for a permit to operate a vehicle which:

(a) Is not subject to the provisions of NRS 482.390, 482.395 and 706.801 to 706.861, inclusive; and

(b) Is not currently registered in this State, another state or a foreign country, or has been purchased by the applicant from a person who is not a dealer.

2. The Department shall adopt regulations imposing a fee for the issuance of the permit.

3. Each permit must:

(a) Bear the date of expiration in numerals of sufficient size to be plainly readable from a reasonable distance during daylight;

(b) Expire at 5 p.m. not more than 60 days after its date of issuance;

(c) Be affixed to the vehicle in the manner prescribed by the Department; and

(d) Be removed and destroyed upon its expiration or the issuance of a new permit or a certificate of registration for the vehicle, whichever occurs first.

4. The Department may authorize the issuance of more than one permit for the vehicle to be operated by the applicant.

5. A person who is not a dealer, manufacturer or rebuilder who purchased a vehicle described in subsection 1 may move the vehicle without being issued a permit pursuant to this section for 3 days after the date of purchase if the person carries in the vehicle:

(a) Proof of ownership or proof of purchase; and

(b) Proof of liability insurance.

6. ~~[Except as otherwise provided in subsection 7,]~~ If a permit is attached to the vehicle in a clearly visible location, a citation may be issued for a violation of this section only if the violation is discovered while the vehicle is halted or its driver is arrested for another alleged violation or offense.

7. The provisions of subsection 6 ~~[do]~~ must not ~~[apply]~~ be construed to prohibit a citation from being issued, regardless of whether the vehicle is halted or its driver is arrested for another alleged violation or offense, if ~~[no]~~ a permit is not affixed to the vehicle ~~[.]~~ in a clearly visible location.

Sec. 9.5. NRS 484D.115 is hereby amended to read as follows:

484D.115 1. Except as otherwise provided in chapters 484A to 484E, inclusive, of NRS and NRS 486.261, every motor vehicle, trailer, semitrailer and any vehicle which is being drawn at the end of a train of vehicles must be

equipped with at least two tail lamps mounted on the rear, which, when lighted as required by this chapter, emit a red light plainly visible from a distance of 500 feet to the rear, except that vehicles manufactured before July 1, 1969, must have at least one tail lamp if they were originally equipped with only one tail lamp.

2. Only the tail lamp on the rearmost vehicle of a train of vehicles need actually be seen from the distance specified.

3. On vehicles equipped with more than one tail lamp, the lamps must be mounted on the same level, as widely spaced laterally as practicable and at a height of not more than 72 inches nor less than 15 inches.

4. Every passenger car, bus and truck under 80 inches in overall width must be equipped with a lamp so constructed and placed as to illuminate with a white light the rear registration or license plate and render it clearly legible from a distance of 50 feet to the rear.

5. All such lamps must be wired to be lighted whenever the headlamps or auxiliary driving lamps are lighted.

6. *Except as otherwise provided in subsection 7, a citation may be issued for a violation of this section only if the violation is discovered while the vehicle is halted or its driver is arrested for another alleged violation or offense.*

7. The provisions of subsection 6 do not apply if more than one tail lamp mounted on the vehicle is broken.

8. Nothing in this section shall be construed to prohibit a peace officer from issuing an oral advisory or warning citation concerning a violation of this section, regardless of whether the violation is discovered while the vehicle is halted or its driver is arrested for another alleged violation or offense.

9. The provisions of this section do not apply to towable tools or equipment which is being towed during the hours of daylight.

Sec. 9.7. NRS 484D.120 is hereby amended to read as follows:

484D.120 1. Except as provided in subsection ~~[3,]~~ *6,* every motor vehicle, trailer, semitrailer and pole trailer must carry on the rear, either as a part of the tail lamps or separately, two or more red reflectors meeting the requirements of this section, except that vehicles of the types mentioned in NRS 484D.460 must be equipped with reflectors meeting the requirements of NRS 484D.150 and subsection 1 of NRS 484D.155.

2. Every such reflector must be mounted on the vehicle at a height not less than 15 inches nor more than 60 inches measured as set forth in NRS 484D.105, and must be of such size and characteristics and so mounted as to be visible at night from all distances within 600 feet to 100 feet from the vehicle when directly in front of lawful lower beams of headlamps, except that reflectors on vehicles manufactured or assembled before January 1, 1970, must be visible at night from all distances within 350 feet to 100 feet when directly in front of lawful upper beams of headlamps.

3. *Except as otherwise provided in subsection 4, a citation may be issued for a violation of this section only if the violation is discovered while the*

vehicle is halted or its driver is arrested for another alleged violation or offense.

4. The provisions of subsection 3 do not apply if more than one reflector mounted on the vehicle is broken.

5. Nothing in this section shall be construed to prohibit a peace officer from issuing an oral advisory or warning citation concerning a violation of this section, regardless of whether the violation is discovered while the vehicle is halted or its driver is arrested for another alleged violation or offense.

6. The provisions of this section do not apply to towable tools or equipment.

Sec. 9.9. NRS 484D.125 is hereby amended to read as follows:

484D.125 1. Except as provided in subsection ~~[5,]~~ *8,* every motor vehicle, trailer and semitrailer, and any vehicle which is being drawn at the end of a train of vehicles must be equipped with two or more stop lamps, except that any vehicle manufactured before July 1, 1969, must have at least one stop lamp if the vehicle was originally equipped with only one stop lamp.

2. Except as otherwise provided in chapters 484A to 484E, inclusive, of NRS, the stop lamp or lamps must:

(a) Be on the rear of the vehicle, and if there are two or more than two must be as widely spaced laterally as practicable;

(b) Display a red, amber or yellow light visible from a distance of not less than 300 feet to the rear in normal sunlight; and

(c) Be activated upon application of the brake.

3. On a combination of vehicles, stop lamps on the rearmost vehicle only are required.

4. A stop lamp may be incorporated with a tail lamp.

5. *Except as otherwise provided in subsection 6, a citation may be issued for a violation of this section only if the violation is discovered while the vehicle is halted or its driver is arrested for another alleged violation or offense.*

6. The provisions of subsection 6 do not apply if more than one stop lamp on the vehicle is broken.

7. Nothing in this section shall be construed to prohibit a peace officer from issuing an oral advisory or warning citation concerning a violation of this section, regardless of whether the violation is discovered while the vehicle is halted or its driver is arrested for another alleged violation or offense.

8. The provisions of this section do not apply to towable tools or equipment.

Sec. 10. The amendatory provisions of this act apply to a traffic stop which occurs on or after October 1, 2023.

Sec. 11. (Deleted by amendment.)

Senator Harris moved the adoption of the amendment.

Remarks by Senator Harris.

Amendment No. 532 to Senate Bill No. 296 deletes sections 1 through 9 in the bill and revises sections 9.1 to 9.9 to provide that a citation may be issued if a vehicle registration has been expired

for more than 30 days rather than more than 60 days. It also ensures that a license plate and permit must be visible.

Amendment adopted.

Bill read third time.

Remarks by Senators Harris and Stone.

SENATOR HARRIS:

Senate Bill No. 296 provides that certain traffic citations relating to registration, license plates, permits for unregistered vehicles and equipment may only be issued if the vehicle does not have an appropriate permanent license plate attached in a clearly visible location, is already halted, its driver is arrested for another violation or offense or the vehicle registration has been expired for 30 days or more.

Law enforcement, by some miracle, was able to come to neutral on this bill. Currently, in the State of Nevada, if you are not wearing your seatbelt, that is a secondary offense. If you are talking on your cell phone, that is a secondary offense. If we in this body truly believe that your license plate not being properly displayed and having the right amount of bolts is more related to safety than wearing your seatbelt or having your car registered more than 30 days late, then I think it makes sense to vote against this bill. Otherwise, this bill is in line with how we do things in Nevada. As long as we are safe on the roads and as long as we are not putting anyone in danger, we want our police officers focusing on reckless drivers, drivers under the influence and those people who we know are out there currently putting us all at risk. It simply does not make sense to ask our officers to enforce small tic-tac infractions and waste their time hassling everyday Nevadans when we know we do not gain any safety benefit from it.

SENATOR STONE:

I highly respect the author of Senate Bill No. 296, but we employ our police officers to enforce the laws of the State. This bill would dictate a different approach to enforcing the laws of the State. I worry about the precedent this law will create, dictating which laws we enforce and which ones we do not enforce. A better solution would be, if we do not want to enforce certain laws, to change the statute and avoid confusion on the streets.

Why do I support such stops? One, of course, is safety. If someone has a broken taillight that the driver may not be aware of, it could be a safety issue, especially up here when you have whiteouts—that I have never experienced being from Southern California—or fog down south. I fully support that no citation be issued for such a stop. Verifying that a driver has car insurance is very important. For expired tags, if they are not cited, what is the collection mechanism? This is a major revenue generator in our State and allowing a large population not to be held accountable for paying such fees could be problematic for our State.

Lastly, many dangerous criminals can be caught through some of these stops. I will give you an example. A convicted murderer from Texas who killed his child in 1974 was paroled in 1984 and moved to Riverside County, where I was from, and became an employee at Riverside County, where I was on the Riverside County Board of Supervisors. During this time, there was a serial killer in Riverside County called the Riverside County prostitute killer that murdered over 20 women. Through a routine traffic stop, evidence tying Mr. Suff to the murders was found. He was later arrested and convicted of these heinous murders.

The bottom line is, while I respect the author's desire to minimize officer-people interactions, this is a useful tool that should be maintained. For those reasons, I would respectfully ask for a "no" vote.

Roll call on Senate Bill No. 296:

YEAS—14.

NAYS—Buck, Goicoechea, Hammond, Krasner, Seevers Gansert, Stone, Titus—7.

Senate Bill No. 296 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 348.

Bill read third time.

The following amendment was proposed by Senator Doñate:

Amendment No. 513.

SUMMARY—Revises provisions relating to health facilities. (BDR 40-51)

AN ACT relating to health care; requiring written approval to close certain hospitals or convert ~~[a hospital]~~ such a hospital into a different type of health facility; requiring ~~[written approval to establish an independent center for emergency medical care in a certain location; requiring an independent center for emergency medical care to be licensed separately from certain other facilities;]~~ certain facilities that provide emergency medical services to provide certain notice to patients; establishing certain civil penalties; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires a person to obtain the written approval of the: (1) Director of the Department of Health and Human Services before making certain capital expenditures for construction of a new health facility under certain circumstances; or (2) the Chief Medical Officer before operating or undertaking any expenditure for the operation of a new medical helicopter within 150 miles from the base of an existing medical helicopter. (NRS 439A.100, 439A.104) Section 2 of this bill similarly requires a person to obtain the written approval of the Director before closing a hospital in a county whose population is 100,000 or more (currently Clark and Washoe Counties) or converting such a hospital into a different type of health facility. ~~[Section 3 of this bill additionally requires a person to obtain the written approval of the Director before establishing an independent center for emergency medical care located within 15 miles of another independent center for emergency medical care or a hospital.]~~ Sections 2 ~~[, 3]~~ and 7-9 of this bill provide that such approval is a condition to: (1) the issuance or renewal of a license for certain health facilities converted from a hospital ; ~~[or a newly established independent center for emergency medical care;]~~ and (2) certain amendments to such a license. Sections 5 and 10 of this bill authorize the Department and the Division of Public and Behavioral Health of the Department to impose certain civil penalties and take certain other disciplinary action against a person who ~~[: (1)]~~ closes a hospital in a county whose population is 100,000 or more or converts a hospital in such a county to a different type of health facility without written approval in violation of section 2 . ~~[; or (2) establishes an independent center for emergency medical care within 15 miles of another independent center for emergency medical care or a hospital without written approval in violation of section 3.]~~

Existing law requires: (1) a hospital to notify the Department of any merger, acquisition or similar transaction involving the hospital; and (2) a physician group practice or a person who owns all or substantially all of a physician group practice to notify the Department of certain similar transactions under certain circumstances. (NRS 439A.126) Section 4 of this bill authorizes the

Department to impose an administrative penalty against a hospital, physician group practice or person who owns all or substantially all of a physician group practice that fails to provide timely notice of the information required by existing law.

Existing law ~~[requires the operator of a medical facility, including an independent center for emergency medical care, or a facility for the dependent to obtain a license from the Division. (NRS 449.030) Section 6 of this bill requires an independent center for emergency medical care to be licensed separately from any other licensed facility.]~~ provides every patient of a medical facility, including an independent center for emergency medical care or hospital, with the right to receive certain information about the condition and care of the patient and the cost of such care. (NRS 449A.106) Section 10.5 of this bill requires an independent center for emergency medical care to post conspicuous notice that the independent center for emergency care is an emergency medical facility and will charge patients for an emergency room visit. If an off-campus location of a hospital provides emergency medical services, section 10.5 requires the off-campus location to provide each patient with: (1) certain notice concerning the rights of the patient upon registration; and (2) a more detailed notice concerning billing and payment after the patient is found not to have an emergency medical condition or after the emergency medical condition of the patient has been stabilized, as applicable.

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

Section 1. Chapter 439A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. *1. Except as otherwise provided in this section, no person may close a hospital in a county whose population is 100,000 or more or convert a hospital in such a county into a different type of health facility without first applying for and obtaining the written approval of the Director or the designee of the Director. The Division of Public and Behavioral Health of the Department shall not issue a new license or alter an existing license for conversion to a different type of health facility unless the Director or the designee of the Director has issued such an approval.*

2. The Director may adopt regulations which prescribe the process to apply for written approval pursuant to this section.

3. An applicant must provide any information requested by the Director or the designee of the Director for consideration of an application, which must include, without limitation, information related to:

(a) The location of the hospital;

(b) The ownership structure of the hospital;

(c) Whether the closure or conversion is likely to benefit any other health facility in the same geographic area as the hospital in which any person with an ownership interest in the hospital also has an ownership interest;

(d) An explanation of the need for the closure or conversion;

(e) Data regarding the population served by the hospital in the 24 months immediately preceding the application; and

(f) The manner in which and the locations where the population served by the hospital will be able to obtain the health services that were provided by the hospital during the 24 months following the closure or conversion of the hospital.

4. The Director or the designee of the Director shall not approve an application submitted pursuant to subsection 1 without considering the information required to be submitted pursuant to subsection 3.

5. The decision of the Director or the designee of the Director pursuant to this section is a final decision for the purposes of judicial review.

6. The provisions of this section do not apply to any person who ceases to operate hospitals in this State.

Sec. 3. ~~[*1. No person may establish an independent center for emergency medical care located within 15 miles of another independent center for emergency medical care or within 15 miles of a hospital without first applying for and obtaining the written approval of the Director or the designee of the Director. The Division of Public and Behavioral Health of the Department shall not issue a new license or alter an existing license for such an independent center for emergency medical care unless the Director or the designee of the Director has issued such an approval.*~~

~~*2. An applicant must provide any information requested by the Director or the designee of the Director for consideration of an application, including, without limitation, information related to:*~~

~~*(a) The financial stability and ownership structure of the proposed independent center for emergency medical care and any other health facility relevant to the application; and*~~

~~*(b) The potential effect of the proposed independent center for emergency medical care on the costs of health services.*~~

~~*3. The Director or the designee of the Director may approve an application submitted pursuant to subsection 1 only if the applicant demonstrates that:*~~

~~*(a) Based on the needs of the specific population to be served by the proposed independent center for emergency medical care and on the projected number of persons who need or will need the services offered by the proposed independent center for emergency medical care, there is a demonstrated need for the proposed independent center for emergency medical care;*~~

~~*(b) The existing independent centers for emergency medical care, existing urgent care facilities and existing hospitals in the geographic area to be served by the proposed independent center for emergency medical care are not willing to meet or are not capable of meeting the projected needs of the population to be served by the proposed independent center for emergency medical care;*~~

~~*(c) The applicant has the financial stability to provide emergency medical services to the population to be served by the proposed independent center for emergency medical care for a significant period of time;*~~

~~*(d) The proposed independent center for emergency medical care is likely to result in significantly reduced health care costs for the population to be served by the proposed independent center for emergency medical care and payors who cover that population;*~~

~~*(e) The proposed independent center for emergency medical care is unlikely to have an adverse effect on the quality of care provided to the population served by the proposed independent center for emergency medical care; and*~~

~~*(f) The approval of the application will not adversely affect an existing provider of emergency medical services.*~~

~~*4. In determining whether to approve an application submitted pursuant to subsection 1, the Director or the designee of the Director shall:*~~

~~*(a) Contact existing providers of emergency medical services and payors who cover the population to be served by the proposed independent center for emergency medical care;*~~

~~*(b) Ensure that such providers and payors have the opportunity to participate in any public hearing concerning the application; and*~~

~~*(c) Otherwise seek the input of such providers and payors.*~~

~~*5. The Department may by regulation require additional approval for a proposed change to a project which has previously been approved if the proposal would result in a change in the location of the project.*~~

~~*6. The decision of the Director or the designee of the Director pursuant to this section is a final decision for the purposes of judicial review.*~~

~~*7. As used in this section, "independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.]*~~ (Deleted by amendment.)

Sec. 4. NRS 439A.126 is hereby amended to read as follows:

439A.126 1. A hospital shall notify the Department of any merger, acquisition or joint venture with any entity, including, without limitation, a physician group practice, to which the hospital is a party or any contract for the management of the hospital not later than 60 days after the finalization of the transaction or execution of the contract for management, as applicable.

2. A physician group practice or a person who owns all or substantially all of a physician group practice shall notify the Department of a transaction described in subsection 3 to which the physician group practice or person, as applicable, is a party or any contract for the management of the physician group practice not later than 60 days after the finalization of the transaction or execution of the contract for management, as applicable, if:

(a) The physician group practices that are parties to the transaction or contract for management or that are owned by those parties represent at least 20 percent of the physicians who practice any specialty in a primary service area; and

(b) The physician group practice represents the largest number of physicians of any physician group practice that is a party to or owned by a party to the transaction or contract for management.

3. Notice must be provided pursuant to subsection 2 for any:

(a) Merger of, consolidation of or other affiliation between physician group practices, persons who own physician group practices or any combination thereof;

(b) The acquisition of all or substantially all of the properties and assets of a physician group practice;

(c) The acquisition of all or substantially all of the capital stock, membership interests or other equity interests of a physician group practice;

(d) The employment of all or substantially all of the physicians in a physician group practice; or

(e) The acquisition of an insolvent physician group practice.

4. Notice pursuant to subsection 1 or 2 must be provided in the form prescribed by the Department and must include, without limitation:

(a) The name of each party to the transaction or contract for management, as applicable;

(b) A description of the nature of the proposed relationship of the parties to the transaction or contract for management, as applicable;

(c) The names and any specialties of each physician who is a party or employed by or affiliated with a physician group practice that is a party to or is owned by a party to the transaction or contract for management, as applicable;

(d) The name and address of each business entity that will provide health services after the transaction or contract for management, as applicable;

(e) A description of the health services to be provided at each location of a business entity described in paragraph (d); and

(f) The primary service area to be served by each location of a business entity described in paragraph (d).

5. The Department shall:

(a) Post the information contained in the notices provided pursuant to subsections 1 and 2 on an Internet website maintained by the Department; and

(b) Annually prepare a report regarding market transactions and concentration in health care based on the information in the notices and post the report on an Internet website maintained by the Department.

6. *If a hospital, a physician group practice or a person who owns all or substantially all of a physician group practice fails to provide timely notice to the Department pursuant to subsection 1 or 2, as applicable, and the failure was not caused by excusable neglect, technical problems or other extenuating circumstances, the Department may impose against the hospital, physician group practice or person who owns all or substantially all of a physician group practice an administrative penalty of not more than $5,000 for each day of such failure.*

7. Any money collected as administrative penalties pursuant to this section must be accounted for separately and used by the Department to carry out the provisions of NRS 439A.111 to 439A.126, inclusive, or for any other purpose authorized by the Legislature.

8. As used in this section:

(a) "Physician group practice" means any business entity organized for the purpose of the practice of medicine or osteopathic medicine by more than one physician.

(b) "Primary service area" means an area comprising the smallest number of zip codes from which the hospital or physician group practice draws at least 75 percent of patients.

Sec. 5. NRS 439A.310 is hereby amended to read as follows:

439A.310 1. Except as otherwise provided in subsection 2, any person who violates any of the provisions of this chapter is liable to the State for a civil penalty of:

(a) Where the provision violated governs the licensing of a project which is required to be approved pursuant to NRS 439A.100 ~~[,]~~ *or section 2 ~~[or 3]~~ of this act*, not more than 10 percent of the proposed expenditure for the project.

(b) Where any other provision is violated, not more than $20,000 for each violation.

2. The Department shall not impose a penalty under this section if it applies for injunctive relief to prevent the same violation.

Sec. 6. ~~[NRS 449.030 is hereby amended to read as follows:~~

~~449.030 1. Except as otherwise provided in NRS 449.03013 and 449.03017, no person, state or local government or agency thereof may operate or maintain in this State any medical facility or facility for the dependent without first obtaining a license therefor as provided in NRS 449.029 to 449.2428, inclusive.~~

~~*2. Each independent center for emergency medical care must be licensed separately from any other independent center for emergency medical care, any other medical facility and any facility for the dependent.]~~ (Deleted by amendment.)

Sec. 7. NRS 449.080 is hereby amended to read as follows:

449.080 1. If, after investigation, the Division finds that the:

(a) Applicant is in full compliance with the provisions of NRS 449.029 to 449.2428, inclusive;

(b) Applicant is in substantial compliance with the standards and regulations adopted by the Board;

(c) Applicant, if he or she has undertaken a project for which approval is required pursuant to NRS 439A.100 ~~[,]~~ *or section 2 ~~[or 3]~~ of this act*, has obtained the approval of the Director of the Department of Health and Human Services; and

(d) Facility conforms to the applicable zoning regulations,

➥ the Division shall issue the license to the applicant.

2. Any investigation of an applicant for a license to provide community-based living arrangement services conducted pursuant to subsection 1 must include, without limitation, an inspection of any building operated by the applicant in which the applicant proposes to provide community-based living arrangement services.

3. A license applies only to the person to whom it is issued, is valid only for the premises described in the license and is not transferable.

Sec. 8. NRS 449.087 is hereby amended to read as follows:

449.087 1. A licensee must obtain the approval of the Division to amend his or her license to operate a facility before the addition of any of the following services:

(a) The intensive care of newborn babies.

(b) The treatment of burns.

(c) The transplant of organs.

(d) The performance of open-heart surgery.

(e) A center for the treatment of trauma.

2. The Division shall approve an application to amend a license to allow a facility to provide any of the services described in subsection 1 if:

(a) The applicant satisfies the requirements contained in NRS 449.080;

(b) The Division determines on the basis of the standards adopted by the Board pursuant to subsection 4 that there are an adequate number of cases in the community to be served to support amending the license to add the service; and

(c) The Division determines that the applicant satisfies any other standards adopted by the Board pursuant to subsection 4.

3. The Division may revoke its approval if the licensee fails to maintain substantial compliance with the standards adopted by the Board pursuant to subsection 4 for the provision of such services, or with any conditions included in the written approval of the Director issued pursuant to the provisions of NRS 439A.100 ~~[.]~~ *or section 2 ~~[or 3]~~ of this act.*

4. The Board shall:

(a) Adopt standards which have been adopted by appropriate national organizations to be used by the Division in determining whether there are an adequate number of cases in the community to be served to support amending the license of a licensee to add a service pursuant to this section; and

(b) Adopt such other standards as it deems necessary for determining whether to approve the provision of services pursuant to this section.

Sec. 9. NRS 449.089 is hereby amended to read as follows:

449.089 1. Each license issued pursuant to NRS 449.029 to 449.2428, inclusive, expires on December 31 following its issuance and is renewable for 1 year upon reapplication and payment of all fees required pursuant to subsection 4 and NRS 449.050, as applicable, unless the Division finds, after an investigation, that the facility has not:

(a) Satisfactorily complied with the provisions of NRS 449.029 to 449.2428, inclusive, or the standards and regulations adopted by the Board;

(b) Obtained the approval of the Director of the Department of Health and Human Services before undertaking a project, if such approval is required by NRS 439A.100 ~~[,]~~ *or section 2* ~~*[or 3]*~~ *of this act;* or

(c) Conformed to all applicable local zoning regulations.

2. Each reapplication for an agency to provide personal care services in the home, an agency to provide nursing in the home, a community health worker pool, a facility for intermediate care, a facility for skilled nursing, a provider of community-based living arrangement services, a hospital described in 42 U.S.C. § 1395ww(d)(1)(B)(iv), a psychiatric hospital that provides inpatient services to children, a psychiatric residential treatment facility, a residential facility for groups, a program of hospice care, a home for individual residential care, a facility for the care of adults during the day, a facility for hospice care, a nursing pool, the distinct part of a hospital which meets the requirements of a skilled nursing facility or nursing facility pursuant to 42 C.F.R. § 483.5, a hospital that provides swing-bed services as described in 42 C.F.R. § 482.58 or, if residential services are provided to children, a medical facility or facility for the treatment of alcohol or other substance use disorders must include, without limitation, a statement that the facility, hospital, agency, program, pool or home is in compliance with the provisions of NRS 449.115 to 449.125, inclusive, and 449.174.

3. Each reapplication for an agency to provide personal care services in the home, a community health worker pool, a facility for intermediate care, a facility for skilled nursing, a facility for the care of adults during the day, a residential facility for groups or a home for individual residential care must include, without limitation, a statement that the holder of the license to operate, and the administrator or other person in charge and employees of, the facility, agency, pool or home are in compliance with the provisions of NRS 449.093.

4. Each reapplication for a surgical center for ambulatory patients, facility for the treatment of irreversible renal disease, facility for hospice care, program of hospice care, hospital, facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home or rural clinic must be accompanied by the fee prescribed by the State Board of Health pursuant to NRS 457.240, in addition to the fees imposed pursuant to NRS 449.050.

Sec. 10. NRS 449.160 is hereby amended to read as follows:

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

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

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

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

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

(e) Failure of the applicant to obtain written approval from the Director of the Department of Health and Human Services as required by NRS 439A.100 *or section 2 ~~[or 3]~~ of this act* or as provided in any regulation adopted pursuant to NRS 449.001 to 449.430, inclusive, and 449.435 to 449.531, inclusive, and chapter 449A of NRS if such approval is required ~~[.]~~ *, including, without limitation, the closure or conversion of any hospital in a county whose population is 100,000 or more that is owned by the licensee without approval pursuant to section 2 of this act.*

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

(g) Violation of the provisions of NRS 458.112.

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

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

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

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

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

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

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

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

➥ The facility shall make the information available to the public pursuant to NRS 449.2486.

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

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

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

Sec. 10.5. Chapter 449A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An independent center for emergency medical care shall post conspicuously in each location where patients are admitted and registered a sign, in not less than 24 point boldface type, which states in English and Spanish:

NOTICE

This is an emergency medical facility that treats emergency medical conditions. You will be charged for a visit to an emergency room and not for a visit to an urgent care center.

2. An off-campus location shall provide to each patient of the emergency department of the off-campus location and any adult accompanying such a patient who is less than 18 years of age immediately upon registration a written statement in the following form:

PATIENT INFORMATION

This is an emergency medical facility that treats emergency medical conditions.

We will screen and treat you regardless of your ability to pay.

You have the right to ask questions regarding your treatment options and costs.

You have the right to receive prompt and reasonable responses to such questions and requests.

You have the right to reject treatment.

However, we encourage you to defer your questions until after we screen you for an emergency medical condition.

This is not a complete statement of patient information or rights. You will receive a more comprehensive statement after the completion of a medical screening examination that does not reveal an emergency medical condition or after your emergency medical condition has been stabilized.

3. After the completion of an appropriate medical screening examination of a patient of the emergency department of the off-campus location that does not reveal an emergency medical condition or after stabilizing the emergency medical condition of such a patient, an off-campus location shall provide the patient and, if the patient, is less than 18 years of age, any adult accompanying the patient, with written notice of:

(a) The policies of the off-campus location concerning the acceptance of patients enrolled in Medicaid and Medicare;

(b) The networks of third parties in which the off-campus location participates;

(c) The possibility that the patient may be billed separately by providers of health care at the off-campus location;

(d) The maximum price for emergency medical services that the off-campus location commonly provides; and

(e) Any additional fees that the off-campus location charges.

4. As used in this section:

(a) "Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.

(b) "Network" means a defined set of providers of health care who are under contract with a third party to provide health care services to persons covered by the third party.

(c) "Off-campus location" means a facility:

(1) With operations that are directly or indirectly owned or controlled by, in whole or in part, a hospital or which is affiliated with a hospital, regardless of whether it is operated by the same governing body as the hospital;

(2) That is located more than 250 yards from the main campus of the hospital;

(3) That provides services which are organizationally and functionally integrated with the hospital; and

(4) That is an outpatient facility providing emergency room services.

(d) "Third party" means any insurer, governmental entity or other organization providing health coverage or benefits in accordance with state or federal law.

Sec. 11. ~~[1. Notwithstanding the provisions of section 3 of this act, a person who has commenced a project before January 1, 2024, for the establishment of an independent center for emergency medical care is not required to obtain the written approval of the Director of the Department of Health and Human Services to continue that project.~~

~~2. Notwithstanding the amendatory provisions of section 6 of this act, an independent center for emergency medical care which is owned by the same owner as another medical facility or facility for the dependent and operating under the same license as that medical facility or facility for the dependent may continue to operate without a separate license until July 1, 2024. Such an independent center for emergency medical care is not required to obtain the written approval of the Director of the Department of Health and Human Services pursuant to section 3 of this act to obtain a separate license.~~

~~3. As used in this section:~~

~~(a) "Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.~~

~~(b) "Medical facility" has the meaning ascribed to it in NRS 449.0151.]~~ (Deleted by amendment.)

Sec. 12. 1. This section becomes effective upon passage and approval.

2. Sections 1 to 11, inclusive, of this act become effective:

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

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

Senator Doñate moved the adoption of the amendment.

Remarks by Senator Doñate.

Amendment No. 513 to Senate Bill No. 348 revises provisions relating to the closing and conversion of the hospital, deletes subsection 2 of section 6, and adds provisions relating to the required diagnosis, disclosures, rules and definitions regarding freestanding emergency departments.

Amendment adopted.
Bill read third time.
Remarks by Senators Doñate and Titus.

SENATOR DOÑATE:

Senate Bill No. 348 requires a person to obtain the written approval of the Director of Department of Health and Human Services before closing or converting a hospital into a different type of health facility. Senate Bill No. 348 also authorizes the Department to impose an administrative penalty against a hospital, physician group practice or owner of a physician group practice for failing to provide the required notice of certain information relating to mergers and acquisitions.

As I mentioned, we did have an amendment earlier that adds provisions relating to the required notices and disclosures of rules and rights for folks that receive services in emergency facilities. I urge my colleagues to vote in support of this bill.

SENATOR TITUS:

I oppose Senate Bill No. 348. Although well-intended, Senate Bill No. 348 will have the opposite effect of what the sponsor is trying to do. Senate Bill No. 348 will decrease and interfere with access to care. Specifically, it forces patients with acute emergencies to travel further for care. It will funnel patients to limited emergency rooms, increasing waiting times. In addition, it will break up continuity of care and lead to increased costs, the very issue the sponsor is trying to address.

Again and again, we hear about the lack of access to care and our limited medical resources. Honorable members of this body, we have heard day after day the inequities of our State. We have been told how racist we are, but the reality is this: those of us in health care have tried to solve the inequities and, in turn, have been targets. We are subject to excessive government regulations, ambulance-chasing lawyers and union-run health care insurers all demanding more of us without the willingness to compensate us. When a facility closes because they cannot afford to stay open but offers a local solution, they are attacked. Nevadans cannot afford Senate Bill No. 348, a bill that works against expanding access to care. I urge my colleagues to vote "no" on Senate Bill No. 348.

SENATOR DOÑATE:

I want to speak about the bill, why it was proposed, and the amendment so the rationale why this bill is important. I worked with many of my colleagues that represent the east side of Las Vegas. The news we heard most recently was a few months ago. Another hospital closed on the east side of Las Vegas. That is devastating. It is an occurrence that should not happen in this State, but it did.

Here is the result. As a health care administrator, when facilities close, patients must have the right to know where their care will now be delivered. That is the premise of the first sections of the bill. Also, in the amendment, we did remove sections 3 and 6 of the bill, which in its original intent was going to revise how we address emergency service departments. That is now removed from this bill and is not applicable anymore. The amendment does add a few provisions. If you are a patient and seeking care, you should have certain rights enabled to you as to what services you will get. A freestanding ER does not provide the same level of care to what you would receive in an acute hospital. It is different from an urgent care center. Patients deserve the knowledge and education on what they receive. To the comments that have been generated within this proposal, the bottom line is the State has an obligation to provide and facilitate the care that is delivered to patients throughout the State.

For me, growing up on the east side, it is unfair that my family has to travel a longer distance of time than residents that live on the west side or other parts of town. We all deserve a system that reflects each of us and the care delivery that we need. That is part of the bill's provisions in Senate Bill No. 348. I urge my colleagues to support this bill.

Roll call on Senate Bill No. 348:
YEAS—13.
NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 348 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 423.

Bill read third time.

The following amendment was proposed by Senator Harris:

Amendment No. 501.

SUMMARY—Revises provisions relating to motorcycles. (BDR 43-662)

AN ACT relating to motorcycles; ~~[increasing certain motorcycle safety fees; requiring an applicant for a motorcycle endorsement to a driver's license to pay an additional fee;]~~ revising provisions relating to penalties for driving without a motorcycle driver's license, motorcycle endorsement or permit to operate a motorcycle; establishing certain requirements for the renewal of a motorcycle endorsement to a driver's license; revising certain requirements for instructors for the Program for the Education of Motorcycle Riders; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

~~— [Existing law authorizes the Department of Motor Vehicles to impose for every motorcycle, a registration fee and an additional fee of $6 for motorcycle safety. (NRS 482.480) Section 1 of this bill increases the fee for motorcycle safety to $18.~~

~~— Existing law requires an applicant for a motorcycle endorsement to a driver's license to pay a fee of $5. (NRS 483.410) Section 2 of this bill requires such an applicant to pay an additional $45 fee for motorcycle safety which must be deposited in the State General Fund for credit to the Account for the Program for the Education of Motorcycle Riders.]~~

Existing law prohibits a resident of this State from driving a motorcycle upon a highway unless that person holds a valid motorcycle driver's license, a driver's license with a motorcycle endorsement or a permit to operate a motorcycle. (NRS 486.061) Existing law also provides that any person who violates this requirement is guilty of a misdemeanor. (NRS 486.381) Section 3 of this bill provides that a court must allow such a person to complete a course of motorcycle safety in lieu of imposing a fine for such a violation which must be completed within 9 months of the issuance of the final order.

Existing law provides that a motorcycle endorsement to a driver's license expires simultaneously with the expiration of the driver's license. (NRS 486.161) Existing regulations provide that a driver's license expires on the eighth anniversary of the birthday of the licensee, measured from the birthday of the licensee nearest the date of issuance or renewal. (NAC 483.043) Section 4 of this bill requires that an applicant for the renewal of a motorcycle endorsement, except for the first renewal of the motorcycle endorsement,

provide proof that the applicant has successfully completed a course of motorcycle safety in the immediately preceding ~~[8 years]~~ 12 months before the applicant may renew the motorcycle endorsement. Section 4 also provides that an applicant who submits such proof is not required to submit such proof again at any subsequent renewal that occurs within 7 years after such submission. Section 7 of this bill provides that this requirement does not take effect until January 1, 2032.

Existing law requires the Director of the Department of Motor Vehicles to establish ~~[: (1)]~~ the Program for the Education of Motorcycle Riders ~~[;]~~ and ~~[(2) a fee of not more than $150 for the Program. (NRS 486.372, 486.373) Existing law]~~ sets forth certain eligibility requirements for instructors of the Program. (NRS 486.372, 486.375) ~~[Section 5 of this bill removes the $150 Program fee.]~~ Section 6 of this bill removes the eligibility requirements that a Program instructor: (1) be a resident of this State or a member of the Armed Forces of the United States stationed at a military installation located in Nevada; and (2) has held a motorcycle driver's license or endorsement for at least 2 years.

~~[Section 6.5 of this bill authorizes the Director of the Department of Public Safety to transfer money from the Account for the Program for the Education of Motorcycle Riders to the Department for certain computer programming costs associated with sections 1 and 2.]~~

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

Section 1. ~~[NRS 482.480 is hereby amended to read as follows:~~

~~482.480 There must be paid to the Department for the registration or the transfer or reinstatement of the registration of motor vehicles, trailers and semitrailers, fees according to the following schedule:~~

~~1. Except as otherwise provided in this section, for each stock passenger car and each reconstructed or specially constructed passenger car registered to a person, regardless of weight or number of passenger capacity, a fee for registration of $33.~~

~~2. Except as otherwise provided in subsection 3:~~

~~(a) For each of the fifth and sixth such cars registered to a person, a fee for registration of $16.50.~~

~~(b) For each of the seventh and eighth such cars registered to a person, a fee for registration of $12.~~

~~(c) For each of the ninth or more such cars registered to a person, a fee for registration of $8.~~

~~3. The fees specified in subsection 2 do not apply:~~

~~(a) Unless the person registering the cars presents to the Department at the time of registration the registrations of all the cars registered to the person.~~

~~(b) To cars that are part of a fleet.~~

~~4. For every motorcycle, a fee for registration of $33 and for each motorcycle other than a trimobile, an additional fee of [$6] *$18* for motorcycle safety. The additional fee must be deposited in the State General Fund for~~

~~credit to the Account for the Program for the Education of Motorcycle Riders created by NRS 486.372.~~

~~— 5. For every moped, a one-time fee for registration of $33.~~

~~— 6. For each transfer of registration, a fee of $6 in addition to any other fees.~~

~~— 7. Except as otherwise provided in subsection 6 of NRS 485.317, to reinstate the registration of a motor vehicle that is suspended pursuant to that section:~~

~~— (a) A fee as specified in NRS 482.557 for a registered owner who failed to have insurance on the date specified by the Department, which fee is in addition to any fine or penalty imposed pursuant to NRS 482.557; or~~

~~— (b) A fee of $50 for a registered owner of a dormant vehicle who cancelled the insurance coverage for that vehicle or allowed the insurance coverage for that vehicle to expire without first cancelling the registration for the vehicle in accordance with subsection 3 of NRS 485.320,~~

~~→ both of which must be deposited in the Account for Verification of Insurance which is hereby created in the State Highway Fund. The money in the Account must be used to carry out the provisions of NRS 485.313 to 485.318, inclusive.~~

~~— 8. For every travel trailer, a fee for registration of $27.~~

~~— 9. For every permit for the operation of a golf cart, an annual fee of $10.~~

~~— 10. For every low-speed vehicle, as that term is defined in NRS 484B.637, a fee for registration of $33.~~

~~— 11. To reinstate the registration of a motor vehicle that is suspended pursuant to NRS 482.451 or 482.458, a fee of $33.~~

~~— 12. For each vehicle for which the registered owner has indicated his or her intention to opt in to making a contribution pursuant to paragraph (i) of subsection 3 of NRS 482.215 or subsection 4 of NRS 482.280, a contribution of $2. The contribution must be distributed to the appropriate county pursuant to NRS 482.1825.]~~ (Deleted by amendment.)

Sec. 2. ~~[NRS 483.410 is hereby amended to read as follows:~~

~~— 483.410 1. Except as otherwise provided in subsection 6 and NRS 483.330 and 483.417, for every driver's license, including a motorcycle driver's license, issued and service performed, the following fees must be charged:~~

~~An original or renewal license issued to a person 65 years of age or older..... $13.50~~

~~An original or renewal license issued to any person less than 65 years of age which expires on the eighth anniversary of the licensee's birthday ..... 37.00~~

~~An original or renewal license issued to any person less than 65 years of age which expires on or before the fourth anniversary of the licensee's birthday ..... 18.50~~

~~Administration of the examination required by NRS 483.330 for a noncommercial driver's license ..... 25.00~~

~~Each readministration to the same person of the examination required by NRS 483.330 for a noncommercial driver's license..... 10.00~~

~~Reinstatement of a license after suspension, revocation or cancellation, except a revocation for a violation of NRS 484C.110, 484C.120, 484C.130 or 484C.430, or pursuant to NRS 484C.210 and 484C.20 ..... 75.00~~

~~Reinstatement of a license after revocation for a violation of NRS 484C.110, 484C.120, 484C.130 or 484C.430, or pursuant to NRS 484C.210 and 484C.220 ..... 120.00~~

~~A new photograph, change of name, change of other information, except address, or any combination ..... 5.00~~

~~A duplicate license ..... 14.00~~

~~2. For every motorcycle endorsement to a driver's license, a fee of $5 *and an additional fee of $45 for motorcycle safety* must be charged. *The additional fee for motorcycle safety must be deposited in the State General Fund for credit to the Account for the Program for the Education of Motorcycle Riders created by NRS 486.372.*~~

~~3. If no other change is requested or required, the Department shall not charge a fee to convert the number of a license from the licensee's social security number, or a number that was formulated by using the licensee's social security number as a basis for the number, to a unique number that is not based on the licensee's social security number.~~

~~4. Except as otherwise provided in NRS 483.417, the increase in fees authorized by NRS 483.347 and the fees charged pursuant to NRS 483.415 must be paid in addition to the fees charged pursuant to subsections 1 and 2.~~

~~5. A penalty of $10 must be paid by each person renewing a license after it has expired for a period of 30 days or more as provided in NRS 483.386 unless the person is exempt pursuant to that section.~~

~~6. The Department may not charge a fee for the reinstatement of a driver's license that has been:~~

~~(a) Voluntarily surrendered for medical reasons; or~~

~~(b) Cancelled pursuant to NRS 483.310.~~

~~7. All fees and penalties are payable to the Administrator at the time a license or a renewal license is issued.~~

~~8. Except as otherwise provided in *subsection 2*, NRS 483.340, subsection 3 of NRS 483.3485, NRS 483.415 and 483.840, and subsection 3 of NRS 483.863, all money collected by the Department pursuant to this chapter must be deposited in the State Treasury for credit to the Motor Vehicle Fund.~~] (Deleted by amendment.)

Sec. 3. NRS 486.061 is hereby amended to read as follows:

486.061 *1.* Except for a nonresident who is at least 16 years of age and is authorized by the person's state of residency to drive a motorcycle, a person shall not drive:

~~[1.]~~ *(a)* A motorcycle, except a trimobile, upon a highway unless that person holds a valid motorcycle driver's license issued pursuant to NRS 486.011 to 486.381, inclusive, a driver's license issued pursuant to chapter 483 of NRS endorsed to authorize the holder to drive a motorcycle or a permit issued pursuant to subsection 4 or 5 of NRS 483.280.

~~[2.]~~ *(b)* A trimobile upon a highway unless that person holds a valid motorcycle driver's license issued pursuant to NRS 486.011 to 486.381, inclusive, or a driver's license issued pursuant to chapter 483 of NRS.

2. If, pursuant to NRS 486.381, a court of competent jurisdiction finds that a person has violated the requirement of paragraph (a) of subsection 1, the court shall permit the person to complete a course of motorcycle safety in lieu of assessing a fine for the violation. The course of motorcycle safety must be completed within 9 months of the date of the final order of the court and proof of successful completion of the course must be filed with the court.

Sec. 4. NRS 486.161 is hereby amended to read as follows:

486.161 1. Every motorcycle driver's license expires as prescribed by regulation.

2. The Department shall adopt regulations prescribing when a motorcycle driver's license expires.

3. Every *motorcycle driver's* license is renewable at any time before its expiration upon application, submission of the statement required pursuant to NRS 486.084 and payment of the required fee.

4. Every motorcycle endorsement to a driver's license issued on or after January 1, 1972, expires simultaneously with the expiration of the driver's license.

5. Except for the initial renewal of a motorcycle endorsement to a driver's license, an applicant for the renewal of a motorcycle endorsement after the first renewal must submit proof of the successful completion by the applicant of a course of motorcycle safety approved by the Department , in consultation with the Administrator of the Program, in the immediately preceding ~~[8 years.]~~ 12 months, except that an applicant who has submitted proof of the successful completion of a course of motorcycle safety is not required to submit such proof at any subsequent renewal that occurs within 7 years after such submission of proof.

~~[4.]~~ *6.* Except as otherwise provided in subsection 1 of NRS 483.384, each applicant for renewal must appear before an examiner for a driver's license and successfully pass a test of the applicant's eyesight.

Sec. 5. ~~[NRS 486.373 is hereby amended to read as follows:~~

~~486.373 [1.] A resident of this State who holds a driver's license, a motorcycle driver's license or a motorcycle endorsement to a driver's license or who is eligible to apply for such a license or endorsement, or a nonresident who is a member of the Armed Forces of the United States, a reserve component thereof or the National Guard and who is stationed at a military installation located in Nevada, may enroll in the Program.~~

~~[2. The Director shall establish a fee of not more than $150 for the Program.]~~ (Deleted by amendment.)

Sec. 6. NRS 486.375 is hereby amended to read as follows:

486.375 1. A person who:

(a) ~~[Is a resident of this State or is a member of the Armed Forces of the United States stationed at a military installation located in Nevada;~~

~~(b)]~~ Is at least 21 years old;

~~[(c)]~~ *(b)* Holds a motorcycle driver's license or a motorcycle endorsement to a driver's license issued by the Department;

~~[(d) Has held a motorcycle driver's license or endorsement for at least 2 years; and~~

~~(e)]~~ *and*

(c) Is certified as an instructor of motorcycle riders by a nationally recognized public or private organization which is approved by the Director,

➥ may apply to the Department for a license as an instructor for the Program.

2. The Department shall not license a person as an instructor if, within 2 years before the person submits an application for a license:

(a) The person has accumulated three or more demerit points pursuant to the uniform system of demerit points established pursuant to NRS 483.473, or has been convicted of, or found to have committed, traffic violations of comparable number and severity in another jurisdiction; or

(b) The person's driver's license was suspended or revoked in any jurisdiction.

3. The Director shall adopt standards and procedures for the licensing of instructors for the Program.

Sec. 6.5. ~~[The Director of the Department of Public Safety may, upon the request of the Director of the Department of Motor Vehicles, transfer not more than $96,499 from the Account for the Program for the Education of Motorcycle Riders created by NRS 486.372 to the Department of Motor Vehicles for the cost of computer programming required to implement the amendatory provisions of sections 1 and 2 of this act.]~~ (Deleted by amendment.)

Sec. 7. 1. This section becomes effective upon passage and approval.

2. Sections 1, 2, 5, 6 and 6.5 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.

3. Section 3 of this act becomes 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, 2025, for all other purposes.

4. Section 4 of this act becomes 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, 2032, for all other purposes.

Senator Harris moved the adoption of the amendment.

Remarks by Senator Harris.

Amendment No. 501 to Senate Bill No. 423 deletes proposed language relating to increasing certain motorcycle safety fees, fees for a motorcycle endorsement and the transfer of fees to the Account for the Program for the Education of Motorcycle Riders. It revises proof of completion of the course of motorcycle safety to the immediately preceding 12 months and provides that an applicant who submits such proof is not required to submit the proof again at any subsequent renewal that occurs within seven years.

Amendment adopted.

Bill read third time.

Remarks by Senators Harris and Hansen.

SENATOR HARRIS:

Senate Bill No. 423 revises provisions and renewal requirements related to motorcycle endorsement on the driver's license issued by the Department of Motor Vehicles (DMV). With the exception of the first renewal of a motorcycle endorsement, an applicant must submit proof of completion of a motorcycle safety course approved by the DMV in the immediately preceding 12 months. However, an applicant who submits such proof is not required to submit such proof again at any subsequent renewal that occurs within the following seven years. If a person is found to violate the motorcycle endorsement requirement, a court must allow the individual to complete a course in motorcycle safety in lieu of imposing a fine. The bill revises certain eligibility requirements for instructors of the program for the education of motorcycle riders and removes required program fees.

SENATOR HANSEN:

I oppose Senate Bill No. 423. We heard in testimony there are 160,000 people registered in Nevada who drive motorcycles. They are probably among the most libertarian group in the State. The idea that every eight years they will have to retake a test before they can get their license is tough. I am glad the amendment eliminated the part where they had to take a physical driver's test.

I own motorcycles, but I am not a licensed one for street use. The people that I do know that are motorcycle people will be upset they are going to be treated like they are 16 years old again and be forced to go through a process after they have been riding for so many years without that kind of oversight.

I urge my colleagues to vote "no," simply on a libertarian basis. There is no evidence there is a need in the State of Nevada to force 160,000 adults to go through another process to renew a motorcycle driver's license. I urge a "no" vote on Senate Bill No. 423.

Roll call on Senate Bill No. 423:

YEAS—13.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 423 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senator Cannizzaro moved that the Senate recess subject to the call of the Chair.

Motion carried.

Senate in recess at 2:21 p.m.

SENATE IN SESSION

At 6:09 p.m.
President Anthony presiding.
Quorum present.

MOTIONS, RESOLUTIONS AND NOTICES

Senator Cannizzaro moved that Senate Bill No. 35 be taken from its position on the General File and placed on the General File following Senate Bill No. 343.
Motion carried.

Senator Cannizzaro moved that Senate Bills Nos. 310, 321, 323 and 328 be taken from their positions on the General File and placed at the bottom of the General File.
Motion carried.

Senator Cannizzaro moved that Senate Bills Nos. 318, 326 and 379 be taken from their positions on the General File and placed on the Secretary's Desk.
Motion carried.

Senator Cannizzaro moved that Senate Bills Nos. 39, 133 and 352 be taken from the Secretary's Desk and placed at the bottom of the General File.
Motion carried.

INTRODUCTION, FIRST READING AND REFERENCE

Assembly Bill No. 73.
Senator Lange moved that the bill be referred to the Committee on Education.
Motion carried.

Assembly Bill No. 120.
Senator Lange moved that the bill be referred to the Committee on Commerce and Labor.
Motion carried.

Assembly Bill No. 154.
Senator Lange moved that the bill be referred to the Committee on Health and Human Services.
Motion carried.

GENERAL FILE AND THIRD READING

Senate Bill No. 314.
Bill read third time.
Remarks by Senators Lange and Hansen.

SENATOR LANGE:
Senate Bill No. 314 requires the Public Utilities Commission of Nevada to establish biennial targets for certain electric utilities in order to provide the greatest benefits to customers in relation

to the cost of procuring energy storage systems. The bill requires licensed individuals to install electrochemical energy storage systems in conformance with certain standards. Finally, the bill authorizes a provider of a training program for the installation of electrochemical energy storage to request the Joint Interim Standing Committee on Growth and Infrastructure to review the program and for the committee to include recommendations regarding the same in its final report.

Provisions related to biennial targets for the procurement of energy storage systems are effective on July 1, 2024. All other provisions are effective upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks and on October 1, 2023, for all other purposes. The definition of "facility for the storage of energy from renewable generation" expires by limitation on June 30, 2049.

SENATOR HANSEN:

I reluctantly oppose Senate Bill No. 314 simply because some of the amendments we requested apparently have not been approved. The way the wording of the bill is currently, if you are not a union contract, you will have a hard time getting this licensing. There was an attempt to make sure nonunion contractors would also have an ability to get this kind of licensing, and it was never amended in the bill. I urge everyone to vote "no" at this point.

Roll call on Senate Bill No. 314:

YEAS—13.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 314 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 333.

Bill read third time.

Remarks by Senators Neal and Seevers Gansert.

SENATOR NEAL:

Senate Bill No. 333 establishes provisions governing virtual currency and virtual currency business activities with or on behalf of a resident of this State. The bill requires a virtual currency business to register with the Commissioner of the Division of Financial Institutions before engaging in any activity in this State. The bill creates the Virtual Currency Recovery Account within the State General Fund as a fund to provide certain eligible persons in this State restitution from fraud, abuse and exploitation caused by a virtual currency business.

SENATOR SEEVERS GANSERT:

I support Senate Bill No. 333. Right now, we do not regulate cryptocurrency nor does the federal government. Much of what is in this bill is what we use to regulate banks and other types of saving associations.

Roll call on Senate Bill No. 333:

YEAS—17.

NAYS—Buck, Krasner, Stone, Titus—4.

Senate Bill No. 333 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 334.

Bill read third time.

Remarks by Senator Spearman.

Senate Bill No. 334 authorizes an energy storage system that is commercially available technology which is capable of retaining, storing and delivering energy using only "green hydrogen" to meet existing biennial storage targets.

Green hydrogen is produced through a certain process that is completely powered by renewable energy, not water.

Roll call on Senate Bill No. 334:

YEAS—21.

NAYS—None.

Senate Bill No. 334 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 335.

Bill read third time.

Remarks by Senators Ohrenschall and Stone.

SENATOR OHRENSCHALL:

Senate Bill No. 335 authorizes a justice court to create an eviction diversion program and provides guidelines for participation in the program. If the court assigns a tenant to such a program, the court must stay a pending action for summary eviction for up to 60 days after the tenant files an associated affidavit and must dismiss the pending action if the tenant pays the amount of rent in default or surrenders the premises before the stay expires.

The bill also authorizes a tenant to claim as an affirmative defense to certain eviction proceedings that the tenant has a pending application for rental assistance or that the landlord has refused to participate in the application process for or accept such rental assistance. The court must stay the proceedings for up to 60 days upon the assertion of such an affirmative defense unless the landlord receives an exemption from the court. The landlord may file a motion to rebut the tenant's affirmative defense, and if such a motion is filed, the court may hold a hearing or maintain the stay.

Under certain circumstances, the court must dismiss the eviction proceedings upon the granting of the application for rental assistance and receipt of the rental assistance by the landlord. However, these provisions do not apply if the rental assistance received by the landlord does not cure the default of the tenant. If the tenant proves certain claims, the court must deny the eviction.

The court may award damages if an eviction is denied for a landlord's refusal to participate in the application for or accept rental assistance. Further, a tenant or landlord may, in a separate cause of action, recover certain damages if the other party acted in bad faith.

SENATOR STONE:

I applaud the author for his genuine concern for people that are at risk of being evicted, and I share that concern. Landlords like myself were not allowed to evict during COVID as a result of the Executive Order by former Governor Steve Sisolak, nor would we have done so even if were legally allowed to. Let me state for the record that I have never evicted a tenant in the five years I have been a landlord in Nevada. We have never lost a tenant because we raised the rent. We do not see our tenants as numbers but rather as human beings that need help during challenging times. We have always worked with the CARES Housing Assistance Program. If they have an application for rental assistance, we always stay any type of effort to evict people.

Prior to COVID, Nevada had no problems with the process to pursue eviction if the tenant did not pay their rent or posed a public safety issue, and they had to be evicted. The process is not an abbreviated one. It has the appropriate noticing requirements and time for the tenant to mitigate their dire circumstances. First, a tenant is usually not a month behind but usually many months behind before they are served and given a seven-day notice that they can respond to. After that seven-day notice, it still takes weeks for a constable to come out and escort the delinquent tenant

out of the unit. Hence, there is already sufficient time for a tenant to cure the default if it is, in fact, curable.

This bill will cause greater delays and legal costs for a landlord that may need to evict a tenant. These unnecessary higher costs are ultimately passed on to the end user, the tenants, which is required by the language in most leases—including mine—with regards to the prevailing party to be awarded legal costs to enforce the provisions of the lease that they signed as a contract between a tenant and landlord. This will further hurt the people the author is trying to protect. The present system today works for the benefit of the tenant as well as the landlord. Everyone should be held accountable for their obligations under a lease, a legal contract between a landlord and a tenant. If the tenant follows the rules and pays the rent, there should be no issues. If not, there must be a streamlined legal avenue for landlords to have. For these reasons, I respectfully oppose Senate Bill No. 335.

SENATOR OHRENSCHALL:

I respect the comments made by my colleague from Senate District 20. I have to respectfully disagree. We have amended the bill quite a bit. The bill in this amended version provides 60 days. It is not a blanket stay on eviction. Someone has to provide an affirmative defense of their bona fide attempt to seek rental assistance. The court can get information about whether that is still active and whether it is still going. There are damages that can be awarded against the tenant if the affirmative defense was sought in bad faith.

In our part of the State down in Clark County, we have a homeless situation like we have never seen, so many unhoused of our brothers and sisters. If in two months, a program like this can help people get the rental assistance they need, make the landlords whole and cure the deficiency, it benefits all of us in terms of trying to keep people housed and try to make landlords whole. I urge your support.

Roll call on Senate Bill No. 335:

YEAS—12.

NAYS—Buck, Daly, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—9.

Senate Bill No. 335 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 336.

Bill read third time.

Remarks by Senator Stone.

Senate Bill No. 336 provides that statutes governing the practice of dentists, nurses, osteopathic physicians and assistants, podiatrists and optometrists do not apply to any person permitted to practice any other health care profession who does so within the scope of their authority. These exemptions apply to any conduct by a health care professional before, on or after the bill's effective date which has not been adjudicated by a regulatory body governing the practice of dentists, nurses, osteopathic physicians and assistants, podiatrists or optometrists. In addition, the bill requires such regulatory bodies to terminate any investigation or disciplinary proceedings for conduct that is outside the scope of the regulatory body.

In addition, the bill requires the State Board of Nursing to issue a certificate of registration to practice as a certified registered anesthetist to a qualified applicant and adopt regulations governing the practice of such nurses. Further, the bill authorizes a certified registered nurse anesthetist to order, prescribe, possess and administer controlled substances, poisons, dangerous drugs and devices to treat certain patients under the care of a licensed physician when working in a critical access hospital.

Roll call on Senate Bill No. 336:

YEAS—21.

NAYS—None.

Senate Bill No. 336 having received a two-thirds majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 343.

Bill read third time.

Remarks by Senators Cannizzaro, Stone and Seevers Gansert.

SENATOR CANNIZZARO:

I support Senate Bill No. 343. I will talk about this bill and refer to another bill that is coming up on our agenda, Senate Bill No. 35, because the two bills are companion bills of sorts. Senate Bill No. 343 establishes the crime of low-level fentanyl trafficking, which provides that anyone who knowingly or intentionally sells, manufacturers, delivers or brings into this State or is knowingly and intentionally in possession of illicit fentanyl, derivatives of fentanyl or mixtures containing fentanyl or their derivatives is guilty of such trafficking if the quantity involved is 4 grams or more but less than 14 grams. This bill also has provisions that keep our good Samaritan laws intact—which was an issue that was addressed when this bill was initially heard in the Judiciary Committee—which would provide that if somebody is experiencing an overdose or is with somebody who is experiencing an overdose and they call for medical attention, they cannot then be prosecuted. What we want to see is they are reaching out to save someone especially when fentanyl is concerned.

Senate Bill No. 35, which is a companion piece to Senate Bill No. 343, addresses some other aspects of fentanyl and how we are attempting to tackle what is a large crisis in our communities. I recognize there are legitimate concerns about how we will be addressing fentanyl use in our communities and ensure we are not overly criminalizing people who might be in mere possession of fentanyl. I would note that mere possession of any amount of fentanyl is currently a felony in the State of Nevada. What we are attempting to do with trafficking laws—which we do with our trafficking laws for all the other types of controlled substances that are regulated—is to say that when you are manufacturing, selling or bringing into this State or in possession of such a significant amount that that is not for personal use, and that crosses a threshold for someone who is actively working to distribute or profit from putting these substances into our communities.

Certainly, this bill will not eradicate all controlled substance use. But what we are seeing in our communities is an overwhelming increase in the number of individuals who are taking fentanyl or distributing it into our communities and who are having the effect of poisoning and killing many people, most of whom are young kids. Most people who experience a situation where they come into contact with fentanyl are lucky if they make it to an emergency room and do not find themselves in a situation where they are dead. That is the type of substance that fentanyl is, and that is why I support Senate Bill No. 343.

I know the thresholds are lower, but the reasoning for that is that it is a very small amount of fentanyl can cause such damage. While fentanyl possession is already a felony, what this is seeking to do is to allow an additional tool for those who are in possession of an extraordinary amount of fentanyl because they are not using it for personal use; they are using it to distribute into communities. And there has to be an answer that is not just that we cannot do anything for families who have loved ones who are dying from an epidemic in our communities. I urge my colleagues' support of Senate Bill No. 343.

I will speak to Senate Bill No. 35 but wanted to mention they are companion bills as they address a multitude of factors and are attempting to strike the right balance between making sure that we can utilize law enforcement to address what is an extremely dangerous market present in our communities while at the same time recognizing that there is also an accompanying opioid epidemic that is fueling this. How do you balance those two things? I think between preserving the good Samaritan pieces and increasing the ability for us to deal with fentanyl traffickers in our communities is striking part of that right balance along with Senate Bill No. 35.

I encourage my colleagues' support on Senate Bill No. 343.

SENATOR STONE:

I applaud our Majority Leader and our Attorney General to address this fentanyl crisis that we are having. The fentanyl crisis has touched probably most of us. I have lost a couple friends who had children who came from various socioeconomic groups and tried the opiate for the first time. There are no second chances with fentanyl. The intent of this bill is to get traffickers of fentanyl but may unnecessarily target people that are using fentanyl. We saw over 80,000 people die of fentanyl intoxication last year, and those numbers are probably going to be the same, if not more, in the coming year. I will be talking about Senate Bill No. 35 because they are basically both the same bills except for the level of crime, low-level, mid-level and high-level of trafficking.

My concern is that if you look at the bill language, it talks about illicitly manufactured fentanyl, any derivative of fentanyl or any mixture which contains fentanyl, and it is that amount, that weight, that includes not just fentanyl but maybe a filler, lactose or cellulose, that can push somebody into being a trafficker that is not a trafficker but is probably a user. Those who have mixtures of fentanyl are usually the end users. A user does not get pure fentanyl, and the reason why, as many of you have heard, is as little as two milligrams can kill you. You are looking at eight grains of salt. There is no way to sell eight grains of salt to somebody and say, "Go ahead and get high on this." So what these illicit traffickers do at a higher level is cut the fentanyl. It is like taking a pea, if you will, and imagine a pea being a ball of food coloring and you are incorporating that into five pounds of flour. To get that done efficiently is something called geometric dilution, which we use in compounding pharmacies. But these illicit distributors, purveyors of fentanyl, are not that scientific. You will get some people who will get samples of fentanyl in capsules or tablets who will say, "This stuff did not do very much for me at all." Then you get other people who get the capsule or the tablet, and they die. They die because they go into respiratory depression. By definition, fentanyl that is cut or diluted with an incipient like lactose or cellulose can be considered a mixture of fentanyl. Illicitly, you will see fentanyl coming in tablets or coming in capsules.

I will give you an example. An addict may have bought a 1 milligram fentanyl tablet, capsule or a bag of powder, which are mixtures of fentanyl. Tablets are like the size of a Tylenol tablet and weigh about 4 grams, which is equivalent to 4000 milligrams so if you have 1 milligram of fentanyl, then you have 3999 milligrams of lactose, cellulose or maybe even another drug, but you are going to be penalized as a trafficker because you are having 4 to 28 grams. If someone just had 3 tablets of this 1 milligram fentanyl, the total amount of fentanyl is 3 milligrams with a mixture weight of 12 grams, which is the basis for this crime. This bill refers to the total weight of the product collectively including fentanyl and the inactive ingredients, so the other drugs that are not related to fentanyl could also be included. This person would be found guilty by this bill of low-level trafficking by having 3 tablets, 12 grams that only has 3 milligrams of fentanyl, which is a category B felony.

I do not believe that is the motivation of the author. A category B felony is not less than 1 year in a maximum-term prison, not more than 6 years and a fine of not more than $50,000. I do not believe it is the author's intent to reignite the war on drugs with this bill, but it will have the unintended consequences of doing so. Users will be convicted of low-level trafficking as a result of their purchase and consumption of fentanyl mixtures to satisfy their powerful addiction.

If I may move on to Senate Bill No. 35, mid-level trafficking 14 to 28 grams is the equivalent of seven of those 1 milligram fentanyl tablets, which is a category B felony, and 28 grams is the equivalent of just 8 of these tablets. For that, they can get 20-plus years in prison for being a user trying to satisfy a habit, which I think many of us consider to be more of a health problem than a criminal problem. We had better build more prisons because if this bill is passed without any amendments, the old war on drugs will pale in comparison to the tens of thousands that could get life sentences for the crime of just being addicted to opiates and having a small amount of fentanyl mixtures that are purposely cut to not kill the addicted soul. The jail and prison rehabilitation program will be unaffordable to accommodate so many prisoners.

I would be honored to work with the authors to amend these bills that do little to go after the traffickers but instead criminalize opiate users that have health-care-related problems. I will support this bill today, but I hope the author will amend the bill, which if left unamended, will restart the war on drugs against vulnerable populations of Nevadans. I do not believe that to be the

intent of the author. I would be honored to work with the authors to try to make sure that that does not happen. I do urge a "yes" vote on these bills.

SENATOR SEEVERS GANSERT:

I think we can agree that the Majority Leader, the Senator from District 20 and I—and probably everyone in this room—violently agree that we need to do something about fentanyl. It is killing so many people.

To review in a different way, right now the State does not have any penalties unless you have 100 grams. That is a blanket for all Schedule I drugs. This bill proposes 4 grams, as does the other bill that is on our agenda. We had another bill that was at 4 milligrams. Four milligrams times 1000 is 4 grams. As little as 2 milligrams, 2 grains of salt, is lethal. The toxicity is enormous.

There are flaws in the bills we have before us—which I am still going to support because we have to do something and it is extremely complex—the bills do not consider the intent to sell. When I talked to Las Vegas Metro, the District Attorney's (DA) offices and law enforcement, the intent to sell is a critical piece. I believe that is what my colleague from Senate District 20 was talking about, not just having pills on you but the intent to sell.

Fentanyl is usually always mixed because straight fentanyl—again, 2 milligrams, which is 2 grains of salt—will kill you. It is always mixed. We have to be able to differentiate how much fentanyl is in a pill and how much the pills weigh if we want to prosecute them with category A, B and C felonies, or if we want to differentiate between those who are using the drugs versus selling the drugs. When I talked to the DA's office and other law enforcement, I was thinking about the kids that go to festivals and get handed some pills. They think, "I am just going to try this once," and then it is laced with fentanyl. We do not want to put them in prison for a long time, but we want to make sure it is not in their hands, which goes back to the intent to sell.

I am hopeful these bills at some point in time, or another bill that comes out of here, is amended to make sure we include intent to sell and also lower the amount of fentanyl. Again, we are at 100 grams. This is going to 4 grams. Lethal is 2 milligrams, 2 grains of salt. There have been discussions about how we cannot differentiate what is really in a pill. We can weigh them, but we do not really know how much is in there. So everybody is aware, as of March 24th, 2023, the State of Nevada and various municipalities have received $347 million from the different companies that have been sued through the national settlement agreement and also the State of Nevada. Of that, about $75 million has been spent on attorneys. The net is still over $300 million [*sic*]. I think we can afford equipment to figure out how to test and differentiate the weight versus what fentanyl is included in the drugs to make sure that we prosecute those who truly need to be prosecuted, and we do not capture those who are mistakenly using it or have an addiction problem. I think we all agree we need to do something. It is just how we do it. It is extremely complex, as I am sure everybody has figured out by now. I support this bill, and I hope we can amend some legislation before we end this session to make sure that we can get fentanyl off the streets.

Roll call on Senate Bill No. 343:

YEAS—15.

NAYS—Flores, Harris, Neal, Ohrenschall, Scheible, Spearman—6.

Senate Bill No. 343 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 35.

Bill read third time.

Remarks by Senators Cannizzaro and Stone.

SENATOR CANNIZZARO:

As I mentioned, Senate Bill No. 35 is a companion piece brought by the Attorney General's Office to Senate Bill No. 343. The two bills work together to address, again, multifacets of what we are seeing and what many people are acknowledging is, in fact, an epidemic and a crisis. Senate Bill No. 35 establishes the crimes of mid-level and high-level trafficking for illicitly manufactured

fentanyl and the derivatives thereof. I would note that trafficking, yes, can include possession because oftentimes what you will run into—as someone who worked in law enforcement for over a decade—is individuals with a large quantity, but what you do not find is an O sheet, a scale and an undercover officer who is engaging with that person looking to sell that particular substance, and there are no tools to address that issue. With 28 grams or more of fentanyl, someone who has that level of fentanyl is using it not for their own personal use, even if it is mixed with another substance. That is the purpose of trafficking laws, to be able to get at those individuals.

I would also note that when you do have intent to sell, I think sometimes we speak in this body like there is not any sort of tool or ability to acknowledge that trafficking includes the sales portion of that. Selling a controlled substance is already a category B felony in the State of Nevada, sale of a controlled substance. It can also have possession of a controlled substance with intent to sell. That is also a felony in the State of Nevada. What this is seeking to do is to get at a particular subsection of criminal activity that is putting these controlled substances into the community.

When we talk about illicitly manufactured fentanyl, what we are also talking about is the idea that fentanyl as we know it and how it is addressed in Nevada Revised Statutes is medical grade fentanyl, which you find in hospitals and other medical facilities that is used for pain management with doctors. That is not what we are seeing in the streets. What we are seeing, what we refer to as fentanyl, is a fentanyl derivative. It is something illicitly manufactured that you are not getting from a hospital, that is coming into our communities in a different fashion, which is why this is not a disciplinary measure for doctors, why this is something that is seeking to go further.

So I wanted to clarify a few pieces of that because we cannot look at these bills in a vacuum without looking at the rest of our Nevada Revised Statutes and how law enforcement can address some pieces of this but not a specific piece that we are encountering. That is the purpose for these bills and for other bills that include similar levels and similarly are trying to get at pieces of this.

What Senate Bill No. 35 also does is it does allow for the implementation of medication-assisted treatment programs in prisons and jails for offenders who have substance use disorders. We cannot talk about making sure that law enforcement has the right tools if we are not also willing to address the problems associated with why we are encountering those issues in our communities. Medication-assisted treatment is a huge piece of that. If we are going to talk about how we are trying to tackle these problems with individuals who have a substance use disorder, then there must be a place for having a conversation about treatment. That is one other piece that Senate Bill No. 35 seeks to address.

We would be remiss to look at one little piece of this and somehow argue that we are not trying to take a multifaceted approach or that somehow we can ignore the other statutes that exist because to do that makes it a little easier to criticize the policy that is in Senate Bill No. 35 and that we just talked about in Senate Bill No. 343 as they address that problem in a variety of ways. I urge my colleagues to support Senate Bill No. 35 as it is a companion piece of legislation to Senate Bill No. 343. I hope that I have clarified some of the pieces of the debate this evening.

SENATOR STONE:

I appreciate the Majority Leader's leadership on this especially with derivatives. If you have carfentanil, as an example, that is a commercially available drug usually used in veterinary medicine. It is ten times stronger than fentanyl and even more dangerous. If you look at these two bills, a very simple fix to some of the issues that I was describing before regarding the bulk weight is when you talk about illicit fentanyl, maybe putting "illicit pure fentanyl" or "illicit pure fentanyl derivative." That would ensure that the person that is in possession of the pure substances is, in fact, trying to traffic it.

Also, my wonderful colleague, our Minority Leader, talked about the funds that are available to be spent, opiate settlement funds. The machine that she was talking about was a gas chromatography machine, and they run about $120,000 each. We do not have any of those machines here in Nevada; we learned that during our sessions. We could, and we should, buy two of those machines—one for the Southern Crime Lab, one for the Northern Crime Lab—so that we can appropriately analyze these samples to make sure that somebody is not just a user versus a trafficker.

Again, I support these bills. I support the medical intervention on the prison side to try to help people wean themselves off of these highly addictive substances and, hopefully, get them on the

road to sobriety and leading a good life. These bills are great bills. There was no criticism meant other than I think there are unintended consequences that goes after people that we should not be going after. We need to go after the traffickers, and we need to get help for the people that are using and not raise the penalties on people that are innocently trying to satisfy an addiction for which they are horrifically addicted to opiate-type products. Again, I urge your "yes" vote on this.

Roll call on Senate Bill No. 35:

YEAS—15.

NAYS—Flores, Harris, Neal, Ohrenschall, Scheible, Spearman—6.

Senate Bill No. 35 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 344.

Bill read third time.

Remarks by Senators Neal and Buck.

SENATOR NEAL:

Senate Bill No. 344 prohibits principals, organizational teams and boards of trustees of large schools from impeding or discouraging public comment at certain meetings. The bill also requires large school districts to undergo an audit every six years regardless of the availability of money from the Legislature. Further, after being hired, a superintendent and a school associate superintendent must research and be evaluated on Nevada education laws and regulations as well as certain district policies and programs.

Additionally, Senate Bill No. 344 sets forth education requirements for a license for substitute teachers. The bill also allows certain employers to provide leave to an employee who is a parent or legal guardian of a child to attend meetings of the school or school district where the child in enrolled. An employee in the public service may similarly be granted such leave. Finally, Senate Bill No. 344 prohibits governing bodies of counties and cities from sponsoring, operating or expending money to support a charter school unless their program was in existence before July 1, 2023.

SENATOR BUCK:

Let me paint a picture for you. Downtown Las Vegas—many of the schools in that area are one- and two-star schools. To put that into perspective, that is 8 to 25 percent proficient in math or reading. The City of Las Vegas got together and said, "I am frustrated with the education system in our City." They helped create a foundation, and the State Public Charter School Authority authorized the opening of Strong Start Academy. Now, the demographics of this school is over 80 percent English Language Learners, 100 percent disenfranchised, free reduced lunch, and about 15 percent special education students. These are the very children this body continues to leave behind in failing schools.

Strong Start Academy is only one out of a few of the only bilingual schools for Latino students. I do not know about you, but I am frustrated with the lack of innovation and progress within Clark County School District (CCSD). I am frustrated that this body has done nothing to address those schools that are failing our students in the City of Las Vegas year after year for over a decade. You want to leave these children, these failing schools, these schools that are failing our kids and these children behind. And then you want to attack the very hope these kids have in this school that is making progress for them and is a beacon of hope in downtown Las Vegas, where many of the schools are failing our kids. I ask that this body vote "no" on this bill for many reasons but [inaudible].

SENATOR NEAL:

I support Senate Bill No. 344. We have done a lot for students of color. We passed Zoom. We passed Victory. This measure in this piece has a lot to do with legislation that came forward in 2015 which allowed a city to use their redevelopment dollars in order to create an early

kindergarten program, meaning pre-kindergarten. They asked for legislation to move forward to create pre-kindergarten programs because there was a gap within CCSD schools regarding pre-kindergarten programs. The legislative authority that was given to them said wraparound services in early childhood education. That current statute is still in play under NRS 279, which is the redevelopment law, and then the city decided they would then, or they are seeking now to expand and do K-3, K-5 and K-12.

Number one, it is not legally authorized. Number two, it is not in the best interest for cities to run schools. There is no data that supports the movement of cities starting to run schools. We already have a large school district. We already have charter schools. We have charter schools under the charter authority. We do not need cities to engage in the work of education. If they would like to continue the work in the gaps, such as early education and using their dollars to build into the schools to do wraparound services, no problem. Those are currently the needs established in law. Those are the needs being carved out in this bill. It is grandfathering in the existing activity that is happening with the City of Las Vegas. It is not removing it, but it is not allowing them to continue to grow into a space that, number one, they do not have the authority to grow into. Number two, they did not ask for that authority to expand.

I understand my colleague's passion for education, but I also have a passion for education. I have a passion to make sure the district runs effectively based on what it is supposed to do, which is serve kids, educate kids and provide the educational environment. That is their role. It is not the role of the city. The role of the city is to provide sewer services and other municipal services that they are set up to do within their charter. Education is something they wanted to engage in. If they want to engage in wraparound services and add additional dollars and human support into the existing schools being paid for by tax dollars, no problem, but currently in law, NRS 279 does not allow them to go beyond what they are doing, which is early-K wraparound services. I will close my remarks with that.

SENATOR BUCK:

This is authorized by the State Public Charter School Authority. Tax dollars go to the school. In the hearing, Las Vegas City said they do not run the school, they help give some funding to the foundation. I do not know that for sure, but I know that the State Public Charter School Authority authorized the school.

SENATOR NEAL:

This will be my final remark. I missed the opposition, but one thing that I do know is it is not transparent how the dollars work for these charter schools being run. It is not clear what the city dollars are, the Regional Development Authority (RDA) dollars that are going into the school versus the per-pupil expenditure. That question has been asked, and the way that it has been seen is that it is a blend. But it has never been clear on what pays for what. Whether the redevelopment dollars that are set apart for blight in that community—which in West Las Vegas they have severe blight. There have been historical problems of fighting for 30 years to remedy the blight that has been in those historical communities. Now those dollars are being expended for education when we already have dollars for education. My argument was and still is, from 2015 until now, that the RDA dollars should have been set aside to remedy the blight in housing, homelessness and other things that are going on in the city. Yet, they are using and diverting their dollars to run an early childcare program. I have grandfathered in that early childcare program in this bill, but I want to make it clear that the RDA dollars under NRS 279 should not cross over into NRS 388, 385. Those schools should remain in place. However, the city needs to spend their money on the existing blight that is going on in that area and in that district, which happens to be nested in Senate District 4. I think I have clear knowledge of my own district that, number one, I have served since 2011. Number two, the transparency around the money has never been indicated nor has it been clear on what city dollars cover what services and how.

Roll call on Senate Bill No. 344:

YEAS—13.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 344 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 346.

Bill read third time.

Remarks by Senators Spearman and Titus.

SENATOR SPEARMAN:

Senate Bill No. 346 authorizes certain transactions to be conducted through an electronic branch office of the Department of Motor Vehicles (DMV). The bill revises requirements related to certificates of registration and certificates of title of a vehicle and authorizes electronic signatures for these documents. The bill requires the DMV to design, prepare and issue special license plates for wholly electric powered vehicles and reduces the fees to issue and renew such license plates. Finally, the bill authorizes a licensed driver to operate an autocycle upon a highway.

This bill is effective upon passage and approval for the purposes of adopting regulations and performing preparatory administrative tasks and on January 1, 2024, for all other purposes. However, provisions relating to "autocycles" are effective upon the date the Director of the DMV notifies the Governor and the Director of the Legislative Counsel Bureau that the Department has sufficient resources available to carry out those provisions.

An "autocycle" means a three-wheeled motor vehicle that is designed with two front wheels and one rear wheel, has a steering wheel or handlebars, has safety belts for the driver and each passenger, uses foot pedals to control braking and acceleration, does not require the operator or passengers to straddle or sit astride and has been manufactured to meet the federal safety requirements for a motorcycle.

As a side note, I did check with Mr. Sean Sever to make sure what we are talking about here. They are trying to adjust what they are currently doing with respect to the fees. There is not an increase in fees; it is just bringing the legislation in line with the fees.

SENATOR TITUS:

Originally, I was going to be in opposition of this bill, but I do support this bill and encourage my colleagues to vote "yes." As the bill was written, it was a little tough to decipher. How the wording was originally, it looked like they were going to decrease and give a credit or a lower fee to a registration or a plate if it was an electric vehicle, when in reality they are just changing where the fees are. The plate will still have a charge. I do want to submit to this body that at some point, we do have to look at these electric vehicles and their use on our highways since they are not paying taxes on the fuel tax. Having said that, I am supporting this bill. Thank you to the sponsor.

Roll call on Senate Bill No. 346:

YEAS—21.

NAYS—None.

Senate Bill No. 346 having received a two-thirds majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 349.

Bill read third time.

Remarks by Senator Flores.

Senate Bill No. 349 requires a document preparation service to request an amended registration from the Secretary of State under certain circumstances, establishes advertising requirements and authorizes the suspension or revocation of a registration or civil penalties for certain violations. A document preparation service may use the term "Department of Motor Vehicles" or "DMV" in an advertisement if the term is immediately followed by language that clearly indicates the document preparation service is a third-party business and not affiliated with the Department. In addition,

the bill establishes notification and registration requirements and prohibits a person from misrepresenting themselves as a document preparation service or submitting an application for registration that contains substantial and material misstatements or omissions of fact.

Roll call on Senate Bill No. 349:
YEAS—21.
NAYS—None.

Senate Bill No. 349 having received a two-thirds majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 355.

Bill read third time.

Remarks by Senator Hammond.

Senate Bill No. 355 revises various provisions concerning financial institutions licensed in this State. The bill authorizes an employee of a financial institution under certain restrictions to engage in the business of lending in this State from a remote location separate from the principal place of business or branch office if authorized by the licensee in accordance with certain requirements. In addition, the bill requires a financial institution that owns or licenses computerized data that includes personal information to, after discovery or notification of a breach of security of the data, notify any resident of this State whose personal information was or is reasonably believed to have been acquired by an unauthorized person. The bill sets forth requirements for such notifications including notifying the Attorney General if the breach of security of the computerized system affects more than 500 residents of this State.

In addition, the bill extends existing provisions governing the requirements for a financial institution to report known or suspected exploitation of older or vulnerable persons to include procedures that a financial institution may follow to temporarily delay a requested disbursement from or a transaction involving an account of an older or vulnerable person.

Roll call on Senate Bill No. 355:
YEAS—20.
NAYS—Ohrenschall.

Senate Bill No. 355 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 359.

Bill read third time.

Remarks by Senator Ohrenschall.

Senate Bill No. 359 expands the definition of "community service" to include a community-based activity that facilitates civic engagement, facilitates or enhances connections between a child and his or her community, provides training in life or job skills or increases the employability of a child and is designed to achieve certain identifiable goals. The community service must be performed for and under the supervising authority of certain public entities or a private nonprofit corporation. The bill also revises provisions governing the suspension of a driver's license or a delay in the ability to apply for a driver's license. Finally, the bill removes the requirement that the court order the child to pay a fine for a first offense regarding truancy, instead authorizing the juvenile court to order the child to perform an additional 10 hours of community service for a combined total not to exceed 20 hours.

Roll call on Senate Bill No. 359:
YEAS—21.
NAYS—None.

Senate Bill No. 359 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 370.

Bill read third time.

Remarks by Senator Cannizzaro.

I support Senate Bill No. 370, which seeks to regulate health data privacy pieces. This bill prescribes protections for consumer health data maintained and used by certain entities that produce or provide products or services targeted to consumers in this State. The bill requires these regulated entities to develop and maintain privacy policies and obtain consent from consumers before collecting or sharing health data. The bill also requires entities to establish methods for consumers to request information about their data and to request for data deletion. The measure provides requirements governing a regulated entity's response to a consumer request, including the timeframe for responding and that an entity may respond free of charge in most circumstances. Further, the bill prohibits the sale of consumer health data without written authorization and restricts implementing geofencing around health care providers. Regulated entities are required to implement security measures and limit access to consumer health data.

In addition, this bill also seeks to establish provisions for the protection of what we might typically call biometric identifiers—those are things like facial, fingerprint or iris data—and establishes requirements for the collection, possession sharing and sale of that type of data. This puts parameters around persons who possess biometric identifiers and require them to develop, maintain and comply with written policies setting forth the retention and destruction of those biometric identifiers, and those must be made available to the public. The bill provides that violations of the provisions of this bill are considered deceptive trade practices and provides that provisions concerning consumer health data and biometric identifiers do not apply to data that is collected or disclosed under certain provisions of federal law or regulations or state law.

I would urge your support, my colleagues, for Senate Bill No. 370. This is an effort to help protect sensitive health data that is sometimes shared on apps and seeks to strike a balance between allowing individuals to use those applications to seek information about their own health while not being subject to releasing that out into the world or to be subject to other issues that may occur. I recognize this bill is still in the process of some negotiations, and I remain committed to continuing to work on this bill as it moves through the legislative process. It is establishing some good guidelines for consumer protection around sensitive health data. I urge your support of Senate Bill No. 370.

Roll call on Senate Bill No. 370:

YEAS—13.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 370 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 384.

Bill read third time.

Remarks by Senator Daly.

Senate Bill No. 384 revises provisions relating to the development of broadband services and infrastructure. The bill sets forth certain requirements related to the awarding of grants of federal money by state agencies based on certain factors and relative weights. The bill also requires applicants, broadband service providers and contractors in order to receive a certain weight in the application process to certify that they meet certain safety and training requirements, provide job opportunities with high-quality wages to residents of the State of Nevada. The job also requires payment of prevailing wages for the construction portion of the work.

Roll call on Senate Bill No. 384:

YEAS—13.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 384 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 391.

Bill read third time.

Remarks by Senators Harris, Titus, Krasner, Hansen and Scheible.

SENATOR HARRIS:

Senate Bill No. 391 prohibits a county, a city and an unincorporated town from sounding a siren, bell or alarm for any purpose other than alerting persons to an emergency, testing the siren, bell or alarm at reasonable time intervals of not more than once every six months or celebrating or recognizing a legal holiday.

The bill further authorizes the Attorney General to bring a civil action to collect a monetary penalty of up to $50,000 from a county, city or unincorporated town for each violation. Finally, the bill prohibits a county, city or unincorporated town from taking adverse employment action against an employee for reporting such a violation to the Attorney General or law enforcement.

I would like to note that I understand this bill is a little broad. It is broader than, ideally, I would like it to be. However, there is no way to constitutionally draft a law that targets one particular town or city nor do I think it is necessarily fair to do so.

I am, however, committed to figuring out some way, if it is out there, to allow certain towns who have noble intentions to continue their historic traditions. I have yet to figure out how to do that without giving other towns an avenue to continue to flout this body's intentions.

So I bring forward today a bill that I believe is, in fact, a bit heavy-handed, but here we are. We took a nice scalpel approach to this issue last session, and we landed ourselves back here again. It is my intention to solve this issue once and for all. That is what this bill is intended to do. I invite all folks who are smarter than me to bring their brains to figure out how to single out a town without singling out a town. I do not know if that is possible here in this body without violating the constitutional rights of each state and territory. But if we can find a way, I am down.

SENATOR TITUS:

I oppose Senate Bill No. 391. I appreciate my colleague's comments about what she indeed is trying to accomplish here. I will admit that during the turn of the century, the horn in the town south of here, in Minden, Gardnerville, did sound at 5:00. Its intent was to make sure everybody went home. Times have changed, however, and that is no longer the case. There are dozens of communities in rural Nevada that use the siren now not to send a curfew message but for Emergency Medical Services (EMS) purposes.

I want to read you what I received from the Mayor of Fallon, who has been the Mayor for decades. Mayor Ken Tedford said, "Our whistle does not and has never signified a curfew. Our whistle is not associated with any desire to drive any person away from our community. Rather, it is intended to keep drivers alert and that they are sharing the road with an emergency. It is indeed for public safety purposes."

Many of our communities sound that siren. I know the intent of the bill has changed so they could practice and send it out every six months. That is not enough. We do have to work on the bill, and I appreciate the offer there so that, number one, these sirens are not seen as a curfew but what they are intended to do, which is an EMS alarm, a sound to set the clock by, but no intent of sending anybody home.

SENATOR KRASNER:

I stand in support of Senate Bill No. 391. I am grateful to the author of this bill for bringing it back. For those of you who do not know, a similar bill was brought in the 81st Session, Assembly Bill 88. It specifically stated language about a siren or alarm previously sounding to require

persons of a particular race, ethnicity, national origin or color to leave the county, city or town. I think those are excellent words to make it crystal clear in the bill, and I am happy to work with you on it.

I sat through this bill hearing, and there were two rooms full of people. One room was so full that they had to open an overflow room, which was also full. Native American Indians, persons of color, they testified one after another that the sirens are offensive to them, their parents, their grandparents and their great grandparents. It is a stinging reminder every single day of what they went through. They testified that if they were not home at dark because of the siren, they were beaten, the women were raped, and people would disappear. During the hearing, two full rooms of people testified in opposition. They talked about the psychological impact of hearing the siren every single day. I urge your support.

SENATOR HANSEN:

I have several small towns in my district who have some type of siren, bell or whistle that has absolutely nothing to do with any racial issue whatsoever. Because this bill is so broad, you are punishing several dozen small cities in the State of Nevada because of the misdeeds of one town from at least 75 to 100 years ago. It does not make a lot of sense.

In conversations with the bill's sponsor from District 11, obviously, she does want to try to solve the issue, but this idea that you are going to go and punish every other small town in Nevada because of something that occurred 75 to 100 years ago in Minden-Gardnerville makes no sense. While I am sympathetic to what may have happened in the past, at some point we have to go forward and learn to get along together. If we are going to constantly bring up past issues, we are never going to be able to come together and have some level of harmony in our communities if we are constantly bringing up these things.

One suggestion I may have, it would be interesting to have—now tribe involved is the Washoe Tribe—it would be interesting to have a vote among the Washoe Tribe itself as to whether they want the siren removed. If, in fact, they voted to get rid of it, then they would have a much stronger case in this building. That is because there are some aggressive activists that are trying to reopen an old wound and eliminate some racial harmony that has occurred in the last 50 years in those communities. I think it is a mistake.

I grew up in Nevada. I grew up with lots of Indian kids and went to school with them. Right now I represent a bunch of different Indian colonies and reservations. I think if you were to ask the Washoe Indian Tribe and—maybe I am totally wrong—at some point they would want to see these kinds of things healed up, too. I would urge this body to vote "no," not because we want to somehow harm people and hurt them from psychological things that may have occurred 75 years ago, but because we need to move forward and start creating some level of racial harmony in our communities and not punish communities that have nothing to do with this at all.

Hopefully, we can work out some kind of resolution. I would love to have an opportunity to hear from the entire tribe itself that was impacted by this. In the meantime, we should vote "no." We should not be punishing cities that have nothing to do with the behavior that occurred in the Minden-Gardnerville area that ended at least 75 years ago.

SENATOR SCHEIBLE:

I am proud to support this bill today. We tried to take the measured approach. We tried to pass a narrowly tailored bill that would only target cities that were truly and clearly bad actors still utilizing these sirens for purposes of antagonizing people of particular races. It did not work.

We are back today, and I stand with my colleague from Senate District 11 in trying to rectify this problem because the comparison is not fair. It is not fair to compare a Native American Indian or a Black person living in Nevada having to listen to that siren every day versus a white person or another person who was not similarly affected by the sirens having to endure the silence for 24 hours a day. Give me a break. That is not a punishment. Not being able to signal an extremely offensive racist signal every single day is not a punishment. That should be our norm. We should expect our towns, our cities, our municipalities not to antagonize particular members of their constituency.

The fact that we have to come in here and tell certain towns that that is the law, frankly, is sad to me. It is not fair for anybody to suggest that there are two sides to this issue that have equal weight, that are both just trying to accomplish the same thing and that one side is going to suffer

if this bill passes because one side, what, is not going to get to hear the siren, is not going to get to hear the bell every single day? That is not a punishment. That is the smallest possible step that we can take to protect, support and uplift a section of our community that has been systemically discriminated against and for whom hearing the siren is incredibly offensive and for whom the siren signals everything that is wrong with the history of our country and our State.

If what we want to do is to move forward, talk about the things that we agree on, talk about racial unity and talk about resolving our differences, then we should do it by, number one, removing the barriers and signals that say to certain members of our State, "You do not belong here." Everybody belongs here in Nevada. I urge you all to vote in support of this bill.

SENATOR HARRIS:

I do not anticipate this is going to change anyone's mind on this vote, and I did not intend to share this today, but I want folks to understand that although the ordinance was dropped in 1970, this is not history. I received an email on April 8th of this year, 2023, that says, in part, "too bad they abandoned the sirens to make people like you leave town. I hope Nevadans will soon realize that your kind should never be in charge of anything in this country."

This history is not history. It is incumbent upon us to put these types of things in the history books. You can pass an ordinance to say that something means something else, but I guarantee you today that there are, unfortunately, Nevadans who wish that siren still applied to people like me. That means we need to act. That means that maybe we have to give up our 9:00 curfew call because history is not in the past. This is today.

So where do we go from here, folks? This is the choice that we have. As much as we would all like to think this siren no longer has this meaning, I have got a couple more emails to read you.

Roll call on Senate Bill No. 391:

YEAS—17.

NAYS—Goicoechea, Hansen, Stone, Titus—4.

Senate Bill No. 391 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 393.

Bill read third time.

Remarks by Senator Seevers Gansert.

Senate Bill No. 393 requires dental care insurance providers to report annual losses and premiums collected at the end of each calendar year to the Commissioner of Insurance. Based on the reports, the Commissioner must calculate average loss-to-premium ratios and identify providers with excessive rates. The Commissioner must also publish an online list of dental care insurance providers and their aggregate average loss-to-premium ratios. The Commissioner may examine the accounts, records and transactions of insurers for compliance and, if the Commissioner determines that an insurer is charging excessive rates, the insurer must submit an adjusted rate filing. The Commissioner may order compensation plans for insured persons who were affected.

Provisions of this bill related to insurers making annual reports to the Commissioner and the Commissioner conducting examinations for compliance are effective on January 1, 2024. Other provisions of the bill are effective on January 1, 2026.

Roll call on Senate Bill No. 393:

YEAS—21.

NAYS—None.

Senate Bill No. 393 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 394.
Bill read third time.
Remarks by Senators Neal, Seevers Gansert, Hansen and Stone.

SENATOR NEAL:

Senate Bill No. 394 prohibits the Governor's Office of Economic Development (GOED) from approving any tax abatement that exceeds $500,000.

I want to bring up what the intent was of this committee bill. In effect, what this does is make GOED have to come to the Legislature for any abatement that would be over $500,000. For me, I think this measure was brought forward because we have lost sight of the balance of power in how we give away tax abatements in the State.

I have reached my limit watching GOED give huge tax abatements to Tesla, then Tesla 2, and the Legislature not having any say in how our money is abated and given away to a large corporation. We need to start making a statement about what we give to billionaires in the State of Nevada. It is interesting how we can give benefits to the rich, but we will not sit down and give that kind of abatement to the poor. We will not sit down and give a tax abatement to build supportive housing, which will take care of our homelessness problem, but we will give $200 million in abatements, $500 million in abatements to a billionaire so he can get wealthier and not have to pay taxes in the State of Nevada.

Senate Bill No. 394 was my way of trying to get at the issue of bringing this issue back into the control of the Legislature so that we can decide what we would like to abate in taxes. I think it is appropriate that we start to have the conversation and dialogue around what is the balance of power between an agency and the Legislature when it comes to the revenue that we need to generate and the revenue that we are expected to give away.

SENATOR SEEVERS GANSERT:

I oppose Senate Bill No. 394. In 2011, we changed the economic development programs within the State of Nevada. It was moved to the Office of the Governor, and it was tremendously successful.

First, Apple came. They have a data center that is across the highway from the Tahoe-Reno Industrial Center. Then, we have Tesla, we have Switch, we have all sorts of companies that have helped to diversify Northern Nevada. When you look at the economy in Northern Nevada, it has substantially changed from what it was 12, 14 years ago. It has been a huge success.

When companies come here and they are interested in locating to another place—it could be just an office, it could be a plant, it could be the headquarters—they want a quick response. Part of the reason we have been so successful is because the Governor's Office and their advisory board, the Governor himself, GOED are able to respond to the companies and ensure they understand that when they come here, it is much easier to do business than a lot of other states. The abatements are part of it. Some of the abatements are automatic, and I think that is something we need to review. There are some triggers we absolutely need to review.

But the speed with which we can compete with other states is critically important to the success of diversification. It is important because we want to have a much stronger and sustainable economy. We know gaming still is the driver, and Las Vegas, Clark County, is the driver of our economy right now, but we have also seen that when things like COVID happen, it just falls off the cliff.

We lead when we have economic downturns, and we lag on the way back. Right now, we do have a robust economy. When you look at Northern Nevada, we are diversified. We need to continue to diversify the entire State, and we can do that, in part, to being responsive to businesses who want to come here and potentially abating taxes for a limited period.

I agree that we need to look at the abatements that we have, but the speed to the deal is important. The proof is in the success that we have had in Northern Nevada but also throughout the State.

SENATOR HANSEN:

I am a little confused. I thought the bill had a tax in it, and that is why I was against the bill. Having been involved in the 2011 Session, the creation of GOED, tax abatements for bringing

Tesla here, I was fine with that at the time because we were in an economically desperate time and we were trying to prime the economic pump, which it did.

I was opposed to the creation of our current GOED. The way it was set up, the amount of money that they can use, as I recall, was up to $10 million worth of abatements without any oversight by the Legislature. I am concerned 500,000 may be too low, but I absolutely agree with the Senator who just spoke from District 4. I think the whole idea of allowing a separate Executive Branch agency to make incredible deals with some of these people—who frankly do not need it to come here in the first place—is wrong.

The real problem with the whole abatement idea is somebody has to make up the difference. While we do bring in a big company, somebody has to pay the tax revenues in the meantime that these guys are getting abatements for. Yes, in the long run, it is probably a good thing. If that is true, then it would be reasonable for the Legislature to have some level of oversight.

The idea that we have to do these decisions immediately or else they are going to go to Texas or somewhere, in some cases, that may be true. But in times like now, especially, when we have a labor shortage in the State and an abundance of businesses trying to come to Nevada to escape from places like California, I do not know if we need to have these kinds of abatements.

I am going to change. I was going to be a "no" on this because I thought it was a tax increase. I am going to support this because I think this is something that we, as a legislative body, do need to once again review.

I agree with my colleague that those original ideas that we had and severe economic downturns like we were experiencing back in the 76th Session—it is a night-and-day difference compared to what we have financially right now. We have so much money, we are spending money like there is no tomorrow. At the time, we were cutting programs right and left, and we were desperate to bring any businesses into the State. Tesla proved to be a gamble, and we rolled the dice, allowed those abatements and brought in Elon Musk and the giant factory. Since that time, I have been nervous about this constant expansion of abatement programs for giant companies that, frankly, do not need the abatements. I am going to vote in favor of this bill.

SENATOR STONE:

I migrated here from a state that has done everything they possibly can to push businesses out of the state. Sherwin Williams Paints, Tesla, companies from Silicon Valley—these companies are going to go someplace, and I see Nevada kind of at its infancy with 3.2 million people versus 40 million in the state to the west of us, where we really are at the foundation of our economic base. I think you will all agree that we need to diversify our economic base so that we can sustain ourselves during downturns in the economy. I believe we should be giving the Governor the authority to use incentives that have a long-term benefit to Nevadans to provide new jobs, to provide new tax revenues and diversify our economic base so that we can survive another pandemic or a downturn in the economy. They say we are going to have a horrific recession sometime in 2023-2024. We want to be prepared for that.

We are competing with other states that operate a lot faster than we do. I will give Arizona as an example. I worked for the United States Department of Labor. I worked with Governor Ducey, and I saw how fast they work to make a deal to bring high tech to Arizona. I want those high-tech, high-dollar jobs coming here to Nevada.

You are absolutely right. These are billion-dollar companies, but they are savvy billion-dollar companies that are going to look for the best deal that they possibly can get. Because we are a no-income-tax state, we have another benefit that other states do not have. We have land, a lot of it is federally owned that hopefully will be released so we can further our expansion not only in the northern part of the State but also in the southern part of the State.

But if we do not diversify our economic base, we are going to be sustaining issues from downturns in the economy. Yes, these are incentives, but there has to be a return on investment. I will guarantee you that the Governor and the Executive Branch is looking to make sure that the beneficiaries of these deals are not the companies relocating here but the citizens of the State of Nevada. I urge a "no" vote on this.

SENATOR HANSEN:

While I agree with my colleague on what he just said about the incentive program, we need to remember that 70 percent of the employment in the State of Nevada are from small businesses.

When you give incentives to these giant companies that come here, the small businesses have to pick up the economic difference. They are the ones that pay additional taxes.

We need to remember that we need to look out for our small business community every bit as much as we do for these giant corporations that come here. Yes, it is nice to have those big ones, but we seem to forget that the small ones are the economic drivers in this State, and the small ones are not getting any special abatements. Only the big ones are getting the special abatements, and consequently, the tax burden falls disproportionately on the businesses that are already here and provide the bulk of employment for the citizens of the State of Nevada.

SENATOR NEAL:

I strongly believe in economic diversification. I have carried business legislation in this building since 2011, which has been focused on small business. I thoroughly believe that we need to continue to diversify the State.

But I also believe that when it comes to legislative power, the balance between the Executive and the Legislature, we still have the power financially to decide how to raise revenue and whether to spend it. I think the power to abate should come back to the Legislature.

I understand, and I respect my colleague that has come here from the state that is large and has potentially pushed their businesses out. I never want to be like California. At the end of the day, we need to have the conversation—whether or not it is through this vehicle—we need to have the conversation about what is the appropriate balance of power in the State of Nevada. We need to talk about how we diversify, bring in midsize to small businesses and allow them to grow within the State of Nevada.

What we are doing is helping billionaires basically sit and profit off the State of Nevada without having to give anything back. Their abatements go on for 10 and 20 years. The prior abatement we had before we changed it under a colleague that has now left to go to the Attorney General's Office was allowing them to not only come here but also expand their abatement through their subsidiary. The initial $10 million could grow into $20 million, $30 million and $40 million because we had a loophole in the law.

It is time to have a conversation about what are appropriate abatements for the State. What are the measures we need to move forward in our diversification? Who would we like to come into the State? When we think about the vision for our State, we need to think about, "What do we want to look like 50 years from now?" Would we like to have these huge corporations that are saying, "You know what, I also do not want to pay any more taxes. I do not want to pay the abatement that you gave me when it is released." Suddenly, we are 20 years down the road looking at the fact that we cannot pay for schools, for health care or for homelessness.

We are sitting in this session where everybody is saying, "Oh, we have this $2 billion." Yet, in 2021, we were cutting kids. In 2019, we did not have any money. In 2017, we did not have any money. In 2015, we did not have any money. In 2013, we did not have any money. In 2011, we did not have any money. We were embarking on diversification, but diversification does not mean giving away your tax base.

SENATOR STONE:

I do not get an opportunity to banter with my colleague from Senate District 14, so I want to take that opportunity to debate him. A lot of these jobs that are being courted to Nevada are manufacturing jobs. Tesla is a manufacturing job. They manufacture batteries and are going to manufacturer electrified trucks. We have chipmakers in Southern Nevada that have come here to manufacture chips. For those of you that study economics, you know there is a multiplier effect of about four to five times the number of jobs that are being created, which includes small businesses.

The beneficiary will be entrepreneurs who want to come to Nevada to open businesses to support those large manufacturing employers. The beneficiary also is the people getting these jobs that may not have a job here today. You have to look in the long term. In 2026, 2027 and 2028, when maybe some of these abatements may wind down, there will be revenue coming into the State that we can use for the programs that my colleague so passionately says we need. We do need them, absolutely, but we need to plant some financial seeds if we want to have a diversified economic base. I believe that providing the Governor with the incentives to court these businesses to come here is going to accomplish that. I urge a "no" vote.

SENATOR SEEVERS GANSERT:

I know we are beating a dead horse, but I like data. When GOED came into our revenue committee, they talked about the return on investment. I want to make it clear, the return on investment for what we debated, which is a partial abatement for Tesla, was five-to-one. They invested $3 billion the first time, and they are investing another $3.5 billion.

As was mentioned by one of my colleagues, when they come here, there are all sorts of other businesses that come here. With that, we have growth in Northern Nevada. We have all experienced that in our neighborhoods up here in Northern Nevada, which drives sales tax and property tax. The businesses drive modified business tax.

According to GOED, for the last abatement they did related to Tesla, which was a much lesser deal, the State would net more than $766 million in new tax revenue over the next 20 years. "That is a 115-to-1 return on investment" according to GOED Deputy Director Bob Pots.

It is not about just the building where the company resides and just those employees. It is about the growth of the entire economy and the diversification of the economy. The first return on investment was five-to-one, and now they are expecting huge gains on that. Again, it helps small businesses and large businesses. It is about the bigger picture, not just the building where that is located.

Roll call on Senate Bill No. 394:

YEAS—14.

NAYS—Buck, Goicoechea, Hammond, Krasner, Seevers Gansert, Stone, Titus—7.

Senate Bill No. 394 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 404.

Bill read third time.

Remarks by Senators Ohrenschall and Seevers Gansert.

SENATOR OHRENSCHALL:

Senate Bill No. 404 sets forth what constitutes "satisfactory identification" for purposes of a voter challenge based on an allegation of not having residency in that precinct. The bill further provides that the provisions of existing law relating to voter challenges do not authorize a person to challenge the ability of a registered voter to vote by mail ballot. Finally, the bill requires the counting of the returns for early voting to begin no later than the first day of early voting.

SENATOR SEEVERS GANSERT:

I oppose Senate Bill No. 404 for a couple of reasons. The proof of where you live is a low bar; it is like a utility bill or a bank statement. As was just mentioned, the date to start counting ballots is the first day of early voting. Right now, we do not count ballots until the election is closed. The first day of early voting is weeks before the close of ballots. We need to be careful with our elections.

SENATOR OHRENSCHALL:

While Senate Bill No. 404 does allow for something like a utility bill to be something that can counter a challenge to residency, if there is a challenge to identity, that still requires photo identification. The language in the bill regarding the counting in section 8: "On or after the first day of early voting, the county clerk may order the appropriate board to begin the count … but, in any case, the count of the returns for early voting must begin not later than 8 a.m. on election day." This would still all be private. No information would be released prior to election day. Again, discretion is given to the county clerk as to whether they want to start the count on the first day of early voting or after, but they must start on election day.

Roll call on Senate Bill No. 404:
YEAS—13.
NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 404 having received a constitutional majority, Mr. President declared it passed, as amended.
Bill ordered transmitted to the Assembly.

Senate Bill No. 406.
Bill read third time.
Remarks by Senators Ohrenschall and Seevers Gansert.

SENATOR OHRENSCHALL:
Senate Bill No. 406 makes it unlawful for a person to use, threaten or attempt to use any force, intimidation, coercion, violence, restraint or undue influence to interfere with the performance of the duties of an elections official. The bill also makes it unlawful to retaliate against an elections official for performing such duties and to disseminate certain information about an elections official without consent. All of these crimes would be punishable under this bill as a category E felony.

Lastly, the bill authorizes a person to distribute certain items to persons waiting in line at a polling place to vote or register to vote.

I would like to let the body know that during our hearings, we heard testimony about many clerks and registrars who had decided to leave and stop performing those duties due to threats and fear they had performing their duties. I urge the body to support this legislation.

SENATOR SEEVERS GANSERT:
I support Senate Bill No. 406. We listened to quite a bit of testimony. My colleague from Senate District 21 pointed out that we had a number of clerks quit because of the harassment, stalking and threats that were made to them, which we cannot tolerate. The number was 10 out of 17 clerks quit after the last election or quit before. I know in Washoe County, we had one that went on leave because of that. We need to send a strong message that we have fair and secure elections, and that we should not be harassing our election officials.

Roll call on Senate Bill No. 406:
YEAS—21.
NAYS—None.

Senate Bill No. 406 having received a constitutional majority, Mr. President declared it passed, as amended.
Bill ordered transmitted to the Assembly.

Senate Bill No. 407.
Bill read third time.
Remarks by Senator Ohrenschall.
Senate Bill No. 407 revises various provisions related to the property of a decedent, including, but not limited to, court jurisdiction over the estate of a deceased person, the vesting of a homestead of a deceased spouse, how a court is authorized to assign an estate with a value of $100,000 or less, when publication of the sale of real property may be waived, when the requirement to conduct an appraisal of certain property may be waived, the means by which certain notices must be given, the means by which a settlor of a trust may determine whether the settlor or trustee is incapacitated, clarifying the confidentiality of certain pleadings and filings, the fiduciary powers of a protector of a trust, when court jurisdiction over a trust is proper and clarifying what must be contained in a notice declaring that a revocable trust has become irrevocable.

I want to let the body know this bill is the product of 18 months of work through the state bar trust and estate section. It was vetted by the State Bar Board of Governors, and it has been thoroughly looked at. I would urge its support. I believe it benefits our constituents with the trust and estate issues that we will all face.

Roll call on Senate Bill No. 407:
YEAS—21.
NAYS—None.

Senate Bill No. 407 having received a constitutional majority, Mr. President declared it passed, as amended.
Bill ordered transmitted to the Assembly.

Senate Bill No. 415.
Bill read third time.
Remarks by Senator Scheible.

Senate Bill No. 415 revises provisions under which a juvenile court may place a child on probation and with certain exceptions limits juvenile probation to 18 months. A validated risk assessment and mental health screening must be used to guide terms of juvenile probation. A juvenile court may extend probation up to 36 months under certain conditions and for a longer period upon the agreement of interested parties. Notice of hearings regarding the extension of probation must be given to the child, the child's attorney, probation officer and parent or guardian. The court must allow the parties to present evidence and testimony and must consider reports from the probation officer and Department of Juvenile Justice Services as well as the individualized case plan for the child. The juvenile court retains jurisdiction to oversee the payment of fines or restitution.

Roll call on Senate Bill No. 415:
YEAS—21.
NAYS—None.

Senate Bill No. 415 having received a constitutional majority, Mr. President declared it passed, as amended.
Bill ordered transmitted to the Assembly.

Senate Bill No. 417.
Bill read third time.
Remarks by Senators Scheible and Stone.

SENATOR SCHEIBLE:

Senate Bill No. 417 prohibits a unit owner, tenant, guest or an invitee of a unit owner in a homeowner association from taking or encouraging another person to take retaliatory action against an executive board, a board member or an employee for certain conduct. It also makes it a misdemeanor for certain persons within a common-interest community to bully another person within the same common-interest community. The bill removes information relating to personnel from the list of records that a board must make available to the public and provides that a unit owner must pay the actual costs incurred by an association to provide records for review. Finally, the bill authorizes the Commission on Common-Interest Communities and Condominium Hotels to impose sanctions disqualifying a person from serving as a member of the executive board on any person who files a vexatious, misleading, retaliatory, frivolous, false or fraudulent affidavit with the Real Estate Division.

SENATOR STONE:

I applaud our chair for bringing this forward. I support Senate Bill No. 417. Probably one of the most thankless jobs is being a member of an HOA, the abuse that sometimes they take. My

concern of the bill has been the definition of "retaliation" and making sure that one's constitutional first amendment rights are still protected. I have been working with some of the proponents of the bill that have promised some amendments that will come in the Assembly. They are going to address the social media aspects of making sure that if you make a threat to recall a board, that is not considered to be retaliatory. They have been very cooperative. I look forward to seeing those amendments in the Assembly. I am going to be voting for this today and urge the Senate to vote "yes" today.

Roll call on Senate Bill No. 417:

YEAS—20.

NAYS—Hammond.

Senate Bill No. 417 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 422.

Bill read third time.

Remarks by Senator Harris.

Senate Bill No. 422 establishes requirements governing the operation of a personal delivery device operated autonomously, semi-autonomously or remotely and is intended to transport cargo on pedestrian walkways and in designated areas including Nevada System of Higher Education campuses, offices and associated facilities. In addition, the bill authorizes a city or county to enact ordinances which regulate the time, place and manner of operation of mobile carrying devices, including the design of the device, and to require a business license or fee. Finally, a city council or governing body may enact ordinances which prohibit the transportation of alcohol and cannabis.

You may have seen these small little robots; we are calling them pizza bots, affectionately, around on University of Nevada, Las Vegas (UNLV) Day. These delivery devices are bringing food safely to a lot of our kids on campuses. We want to make sure we can have these robots deliver across the street or just across or adjacent to the campus where a lot of campus students are so they do not have to go through another delivery service and spend quite a bit more to get their food delivered to them. The counties are in support; UNLV is in support; Starship, who makes these cute little things; as well as Grubhub, who assists in these deliveries. It is a good bill. I urge your support.

Roll call on Senate Bill No. 422:

YEAS—21.

NAYS—None.

Senate Bill No. 422 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 427.

Bill read third time.

Remarks by Senators Flores, Hansen, Doñate and Buck.

SENATOR FLORES:

Senate Bill No. 427 requires an existing written safety program established by certain employers to include a program to mitigate heat illness on days that the temperature is expected to be 105 degrees Fahrenheit or greater regardless of whether employees work outdoors or in an indoor setting without climate control, a program to train employees who may be affected by issues related to heat illness, a program to mitigate exposure to poor air quality when the air reaches an Environmental Protection Agency Air Quality Index (AQI) value of 201 or greater and

a program to train employees who may be exposed to poor air quality on the hazards of working without personal protection equipment.

The bill requires programs and trainings to be provided in a language and format understandable to each employee. Finally, the bill exempts certain emergency services personnel from the requirements of this bill.

I urge your support. I will say that the bill has been amended significantly from its original drafting. We have had ongoing working groups composed mostly of folks who have had concerns or issues with the bill. We will continue to work with those folks who have issues.

I want to remind folks, this bill triggers when it is 105 degrees. We want to create a minimum standard that when it is 105 degrees in working conditions, you provide water. As I look around this room, every single one of you has water; it is not 105 degrees. That is because most employers—in fact, every single employer that I spoke to—provide water. We are saying that when it is 105 degrees, you should provide water.

If you are curious what that translates to, in Las Vegas in 2022, it was 105 degrees outdoors 38 times. In Reno, once. The other thing the bill says is that when the AQI is at 201 or greater, you will have some type of protective gear provided to your employees. If you want to know what that translates to, in Clark County, it was three times in 2022. In Washoe, it was twice in 2022.

These are minimum standards. I do not know a single employer in the State of Nevada that would send somebody to work in hot working conditions and not provide water. I do not know a single employer in the State of Nevada that would make some folks go work in poor air quality and not provide some masking. These are bare minimum standards that we are asking for.

I know lobbyists have come around, and there are concerns. I appreciate that. I am telling you we have been working with them and will continue working with them.

What we will not allow, however, is for someone to walk into my office—we are trying to work in good faith—wave their finger and threaten that we either take their negotiation or otherwise they are going to have some power over this body and circumvent the good-faith process we have. I say this to you because I needed to put it on the record, and I needed it to be abundantly clear. To everybody else working in good faith, my door is open, and I will continue to work with them.

SENATOR HANSEN:

I do appreciate the sponsor, and he has worked aggressively. I have been a contractor in Nevada for 37 years now; I would say the majority of that has been outdoors. All the things in this bill, frankly, we have been doing for 37 years, at least, that I know of. Like he pointed out, there are no employers that would not give people water in the first place.

Secondly, in the construction industry, my guys do not ask for water. They go and get whatever they need. The idea that there are all these people being denied water on hot days, I have a hard time believing that is the case. I think the problem with the bill, really, is it is getting down to the micromanagement level. As a construction worker, we had a safety meeting every week. We had a different topic 52 weeks out of the year. Heatstroke and things like that were always covered. In the north, a lot of times it is not heat but intense cold. Believe me, I worked outside on days that were miserable. That is a factor more so in the north than in the south.

I am certainly not against the idea of safety, but you do reach a point where it is micromanaging. It is duplication of efforts. All the things in this bill are already required to one degree or another by the Occupational Safety and Health Administration and by other federal standards. This bill is just adding on more layers of regulation for items that are already provided to workers and contractors in the State of Nevada now. Simply on the basis of redundancy, I would urge my colleagues to vote "no." This is already covered in law.

SENATOR DOÑATE:

I support this bill, and I want to thank my colleague from Senate District 2 for bringing this issue forward. I am not sure if I have ever had a chance to speak about this publicly, but many of my family members work outdoors. My first job was on the top of the Stratosphere on the rides working outdoors. To this day, my siblings—I have my two brothers—are both landscapers. Within the past year, during the summertime, my siblings have passed out. Many of my family members—my cousins, my uncles—are landscapers as well, and they have been hospitalized due to heat-borne illness.

This is an issue that personally affects me and affects many of the workers that are in my community. We need to provide these frontline workers that work outdoors the services they need, the equipment and, in this particular case, access to water and training to recognize when you are experiencing certain symptoms. These are quality measures that can help protect workers in the front.

There is one portion of this bill that we must have a conversation about at some point, which is what happens when workers are not able to fulfill their responsibilities due to the outlying quality factors that impact their work. We have instances where because of the changing climate, it is becoming burdensome because of the heat outside or air quality measures due to wildfires. We have an obligation to protect workers that might not be able to complete their work. This bill gets us a step further to protecting the workers that serve our State. I encourage my colleagues to vote in support of this bill.

SENATOR BUCK:

The Occupational Safety and Health Administration has the authority to regulate heat illness through the general duty clause of existing law. Placing the requirements in statute is unnecessary. The bill is too broad and does not take into consideration the various industry differences. How do you monitor drivers for heat illnesses who are remote? The bill would still require shade at night. What does cool water mean? Common sense for a few bad actors should not be legislated. I caution my colleagues that we should not enact a law that makes it easy to utilize the ambiguity within it as a weapon against business.

SENATOR FLORES:

I want to clarify that I do appreciate the comments of my colleague. Good actors are, obviously, already doing this. Unfortunately, there are folks who are not working for good actors. I agree these businesses are in the minority, but we have a responsibility to ensure we create some minimal safeguards in the State to ensure that workers have some protections.

Yes, I somewhat agree with my colleague's previous statement that we do not want to create one rule that fits for all industries. That is why the bill is broadly written, so that each industry can write its own specific rules. That is the way the bill is written now. Each industry will create a plan that fits its specific business plan. It is intentional. We do not want to force everyone to follow a single rule when some folks are driving trucks, others may be at a ranch and others are in a remote area. The bill is broad so we allow for flexibility.

Roll call on Senate Bill No. 427:

YEAS—13.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 427 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senator Cannizzaro moved that the Senate recess subject to the call of the Chair.

Motion carried.

Senate in recess at 8:06 p.m.

SENATE IN SESSION

At 9:00 p.m.

President Anthony presiding.

Quorum present.

Senate Bill No. 429.

Bill read third time.

Remarks by Senators Flores and Seevers Gansert.

SENATOR FLORES:

Senate Bill No. 429 establishes that certain abatements of taxes for new and expanding businesses in Nevada can only be granted by the Governor's Office of Economic Development for businesses with 50 or more full-time employees if the applying business provides at least 12 weeks of family and medical leave (FMLA) at a rate of at least 55 percent of the regular wage of an employee who has been employed by the business for at least one year.

SENATOR SEEVERS GANSERT:

I support Senate Bill No. 429. We had the hearing in committee, and we heard testimony about how important it is to professional working women to have FMLA and also if you are caretakers for other members of your family. I am not sure if this was mentioned or not, but this is only for companies that receive abatement. It is not across the State. It is only companies that are abated. If they can provide FMLA, they also get a federal tax credit. There is a greater incentive for them to add these programs to their benefits.

Roll call on Senate Bill No. 429:

YEAS—17.

NAYS—Hansen, Krasner, Stone, Titus—4.

Senate Bill No. 429 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 434.

Bill read third time.

Remarks by Senator Neal.

Senate Bill No. 434 makes substitute teachers eligible for membership in the Public Employees' Retirement System. The bill also provides system members the option of a reduced service retirement allowance with a benefit paid to a beneficiary for six months after a retiree's death.

This measure further requires a court in granting a divorce to provide an explanation or ensure that an explanation has been provided to the parties relating to a qualified domestic relations order.

Finally, with respect to the disposition of pension or retirement benefits, it replaces the "time rule" with the "frozen benefit rule." Under the "frozen benefit rule," the community interest in certain retirement benefits is "frozen" at the salary base and years of service of the party participating in the retirement system on the date on which the decree of legal separation or divorce is entered.

Roll call on Senate Bill No. 434:

YEAS—19.

NAYS—Buck, Krasner—2.

Senate Bill No. 434 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 436.

Bill read third time.

Remarks by Senators Spearman and Stone.

SENATOR SPEARMAN:

Senate Bill No. 436 requires the Commissioner of Insurance to submit a report to the Joint Interim Standing Committee on Commerce and Labor containing certain information concerning the service contract industry in Nevada on or before December 31, 2023, and on or before December 31 of each year thereafter.

SENATOR STONE:

I want to applaud the author for bringing this forward. There has to be some accountability with these home warranty services especially in the south when heating, ventilation and air conditioning goes down, and people are without air conditioning for weeks, two weeks or three weeks at a time. I applaud the author, and I urge a "yes" vote on this.

Roll call on Senate Bill No. 436:

YEAS—21.

NAYS—None.

Senate Bill No. 436 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 437.

Bill read third time.

Remarks by Senator Buck.

Senate Bill No. 437 extends the authority of the Nevada State Board of Accountancy to grant certain practice privileges to a certified public accounting firm organized as a corporation, limited-liability company, partnership or sole proprietorship that holds a valid registration in good standing from another state. These entities do not have to obtain a certificate or permit from or register with the Board, but they must consent to certain conditions and maintain an office in Nevada unless organized as a sole proprietorship. The bill also exempts from the registration requirement certain entities whose sole business is preparing tax returns and related schedules.

In addition, the bill revises certain provisions governing the requirements for a person to qualify for a certificate of certified public accountant and authorizes, rather than requires, the Board to charge a fee for an associated examination.

Roll call on Senate Bill No. 437:

YEAS—21.

NAYS—None.

Senate Bill No. 437 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 39.

Bill read third time.

The following amendment was proposed by Senator Scheible:

Amendment No. 533.

SUMMARY—Provides that certain records received, obtained and compiled by the Board on Indigent Defense Services in the Department of Indigent Defense Services and the Department are confidential under certain circumstances. (BDR 14-215)

AN ACT relating to indigent services; providing that certain records received by the Board on Indigent Defense Services in the Department of Indigent Defense Services or the Department which are protected by the

attorney-client privilege are confidential; providing that certain records received by the Board or the Department relating to the conduct of an attorney are confidential under certain circumstances; providing that certain records which are voluntarily disclosed to the Department remain protected by the attorney-client privilege under certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law: (1) creates the Board on Indigent Defense Services and the Department of Indigent Defense Services; and (2) requires the Board and the Department to perform certain duties related to the oversight of indigent defense services in this State. (NRS 180.300, 180.320,180.400, 180.410)

Section 1 of this bill provides , with certain exceptions, that all records received by the Board, the Department or a designee of the Department that are protected by the attorney-client privilege are confidential. Section 1 also provides that all records obtained or compiled during or after an investigation arising from a complaint related to the conduct of an attorney are confidential, unless releasing such records is necessary for the performance of the oversight functions or duties of the Board or Department. Additionally, section 1 clarifies that the Board and Department may, at their discretion, communicate or cooperate with, or provide records to, any professional licensing board or any other governmental agency that is investigating a ~~[person, except to the extent that such records are protected by the attorney-client privilege,]~~ complaint against an attorney pertaining to the representation of an indigent client by the attorney.

Existing law establishes a privilege for confidential communication between a client and the client's attorney. (NRS 49.035-49.115) However, existing law also provides that the privilege is waived if a person who holds the privilege voluntarily discloses or consents to disclosure of any significant part of the matter, unless the disclosure is itself a privileged communication or made to an interpreter employed merely to facilitate communications. (NRS 49.385) Section 2 of this bill provides that the privilege is additionally not waived if a disclosure is made to the Department or its designee for the purpose of: (1) requesting prior approval of a claim for compensation for certain legal expenses; (2) submitting a claim for compensation of certain legal fees or expenses reasonably incurred by an attorney providing indigent defense services; or (3) submitting a complaint against an attorney providing indigent defense services.

Section 3 of this bill makes a conforming change to reflect that certain records are confidential pursuant to section 1.

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

Section 1. Chapter 180 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in this section and NRS 239.0115, all records received by the Board, the Department or a designee of the

Department that are protected by the attorney-client privilege are confidential. ~~[Such records may include, without limitation, any records relating to the case file of a client or a claim for compensation or expenses made by an attorney pursuant to NRS 7.125 or 7.135.]~~

2. Except as otherwise provided in this section and NRS 239.0115, all records obtained or compiled during or after an investigation arising from a complaint received by the Board or the Department that are related to the conduct of an attorney are confidential, unless releasing such records is determined to be necessary for the oversight functions or duties of the Board or Department.

3. The provisions of this section do not prohibit the Board or the Department, at its discretion, from communicating or cooperating with, or providing any records to, any professional licensing board or any other governmental agency that is investigating a ~~[person, except to the extent that such records are protected by the attorney-client privilege.]~~ complaint against an attorney pertaining to the representation of an indigent client by the attorney.

4. As used in this section, "records" means any records, files, books, documents, papers, information or data that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

Sec. 2. NRS 49.385 is hereby amended to read as follows:

49.385 1. A person upon whom these rules confer a privilege against disclosure of a confidential matter waives the privilege if the person or the person's predecessor while holder of the privilege voluntarily discloses or consents to disclosure of any significant part of the matter.

2. This section does not apply if the disclosure is:

(a) Itself a privileged communication; ~~[or]~~

(b) Made to an interpreter employed merely to facilitate communications ~~[.]~~ *; or*

(c) Made to the Department of Indigent Defense Services or a designee of the Department for the purpose of:

(1) Requesting prior approval of a claim pursuant to paragraph (a) of subsection 1 of NRS 7.135;

(2) Submitting a claim for compensation or expenses pursuant to NRS 7.125 or 7.135; or

(3) Submitting a complaint against an attorney providing indigent defense services pursuant to NRS 180.320.

Sec. 3. NRS 239.010 is hereby amended to read as follows:

239.010 1. Except as otherwise provided in this section and NRS 1.4683, 1.4687, 1A.110, 3.2203, 41.0397, 41.071, 49.095, 49.293, 62D.420, 62D.440, 62E.516, 62E.620, 62H.025, 62H.030, 62H.170, 62H.220, 62H.320, 75A.100, 75A.150, 76.160, 78.152, 80.113, 81.850, 82.183, 86.246, 86.54615, 87.515, 87.5413, 87A.200, 87A.580, 87A.640, 88.3355, 88.5927, 88.6067, 88A.345, 88A.7345, 89.045, 89.251, 90.730, 91.160, 116.757,

116A.270, 116B.880, 118B.026, 119.260, 119.265, 119.267, 119.280, 119A.280, 119A.653, 119A.677, 119B.370, 119B.382, 120A.640, 120A.690, 125.130, 125B.140, 126.141, 126.161, 126.163, 126.730, 127.007, 127.057, 127.130, 127.140, 127.2817, 128.090, 130.312, 130.712, 136.050, 159.044, 159A.044, 172.075, 172.245, 176.015, 176.0625, 176.09129, 176.156, 176A.630, 178.39801, 178.4715, 178.5691, 179.495, 179A.070, 179A.165, 179D.160, 200.3771, 200.3772, 200.5095, 200.604, 202.3662, 205.4651, 209.392, 209.3923, 209.3925, 209.419, 209.429, 209.521, 211A.140, 213.010, 213.040, 213.095, 213.131, 217.105, 217.110, 217.464, 217.475, 218A.350, 218E.625, 218F.150, 218G.130, 218G.240, 218G.350, 224.240, 226.300, 228.270, 228.450, 228.495, 228.570, 231.069, 231.1473, 232.1369, 233.190, 237.300, 239.0105, 239.0113, 239.014, 239B.026, 239B.030, 239B.040, 239B.050, 239C.140, 239C.210, 239C.230, 239C.250, 239C.270, 239C.420, 240.007, 241.020, 241.030, 241.039, 242.105, 244.264, 244.335, 247.540, 247.550, 247.560, 250.087, 250.130, 250.140, 250.150, 268.095, 268.0978, 268.490, 268.910, 269.174, 271A.105, 281.195, 281.805, 281A.350, 281A.680, 281A.685, 281A.750, 281A.755, 281A.780, 284.4068, 284.4086, 286.110, 286.118, 287.0438, 289.025, 289.080, 289.387, 289.830, 293.4855, 293.5002, 293.503, 293.504, 293.558, 293.5757, 293.870, 293.906, 293.908, 293.910, 293B.135, 293D.510, 331.110, 332.061, 332.351, 333.333, 333.335, 338.070, 338.1379, 338.1593, 338.1725, 338.1727, 348.420, 349.597, 349.775, 353.205, 353A.049, 353A.085, 353A.100, 353C.240, 360.240, 360.247, 360.255, 360.755, 361.044, 361.2242, 361.610, 365.138, 366.160, 368A.180, 370.257, 370.327, 372A.080, 378.290, 378.300, 379.0075, 379.008, 379.1495, 385A.830, 385B.100, 387.626, 387.631, 388.1455, 388.259, 388.501, 388.503, 388.513, 388.750, 388A.247, 388A.249, 391.033, 391.035, 391.0365, 391.120, 391.925, 392.029, 392.147, 392.264, 392.271, 392.315, 392.317, 392.325, 392.327, 392.335, 392.850, 393.045, 394.167, 394.16975, 394.1698, 394.447, 394.460, 394.465, 396.1415, 396.1425, 396.143, 396.159, 396.3295, 396.405, 396.525, 396.535, 396.9685, 398A.115, 408.3885, 408.3886, 408.3888, 408.5484, 412.153, 414.280, 416.070, 422.2749, 422.305, 422A.342, 422A.350, 425.400, 427A.1236, 427A.872, 432.028, 432.205, 432B.175, 432B.280, 432B.290, 432B.4018, 432B.407, 432B.430, 432B.560, 432B.5902, 432C.140, 432C.150, 433.534, 433A.360, 439.4941, 439.4988, 439.840, 439.914, 439A.116, 439A.124, 439B.420, 439B.754, 439B.760, 439B.845, 440.170, 441A.195, 441A.220, 441A.230, 442.330, 442.395, 442.735, 442.774, 445A.665, 445B.570, 445B.7773, 447.345, 449.209, 449.245, 449.4315, 449A.112, 450.140, 450B.188, 450B.805, 453.164, 453.720, 458.055, 458.280, 459.050, 459.3866, 459.555, 459.7056, 459.846, 463.120, 463.15993, 463.240, 463.3403, 463.3407, 463.790, 467.1005, 480.535, 480.545, 480.935, 480.940, 481.063, 481.091, 481.093, 482.170, 482.368, 482.5536, 483.340, 483.363, 483.575, 483.659, 483.800, 484A.469, 484B.830, 484B.833, 484E.070, 485.316, 501.344, 503.452, 522.040, 534A.031, 561.285, 571.160, 584.655, 587.877, 598.0964, 598.098, 598A.110, 598A.420, 599B.090, 603.070, 603A.210, 604A.303,

604A.710, 612.265, 616B.012, 616B.015, 616B.315, 616B.350, 618.341, 618.425, 622.238, 622.310, 623.131, 623A.137, 624.110, 624.265, 624.327, 625.425, 625A.185, 628.418, 628B.230, 628B.760, 629.047, 629.069, 630.133, 630.2671, 630.2672, 630.2673, 630.30665, 630.336, 630A.327, 630A.555, 631.332, 631.368, 632.121, 632.125, 632.3415, 632.3423, 632.405, 633.283, 633.301, 633.4715, 633.4716, 633.4717, 633.524, 634.055, 634.1303, 634.214, 634A.169, 634A.185, 635.111, 635.158, 636.262, 636.342, 637.085, 637.145, 637B.192, 637B.288, 638.087, 638.089, 639.183, 639.2485, 639.570, 640.075, 640.152, 640A.185, 640A.220, 640B.405, 640B.730, 640C.580, 640C.600, 640C.620, 640C.745, 640C.760, 640D.135, 640D.190, 640E.225, 640E.340, 641.090, 641.221, 641.2215, 641.325, 641A.191, 641A.217, 641A.262, 641B.170, 641B.281, 641B.282, 641C.455, 641C.760, 641D.260, 641D.320, 642.524, 643.189, 644A.870, 645.180, 645.625, 645A.050, 645A.082, 645B.060, 645B.092, 645C.220, 645C.225, 645D.130, 645D.135, 645G.510, 645H.320, 645H.330, 647.0945, 647.0947, 648.033, 648.197, 649.065, 649.067, 652.126, 652.228, 653.900, 654.110, 656.105, 657A.510, 661.115, 665.130, 665.133, 669.275, 669.285, 669A.310, 671.170, 673.450, 673.480, 675.380, 676A.340, 676A.370, 677.243, 678A.470, 678C.710, 678C.800, 679B.122, 679B.124, 679B.152, 679B.159, 679B.190, 679B.285, 679B.690, 680A.270, 681A.440, 681B.260, 681B.410, 681B.540, 683A.0873, 685A.077, 686A.289, 686B.170, 686C.306, 687A.060, 687A.115, 687B.404, 687C.010, 688C.230, 688C.480, 688C.490, 689A.696, 692A.117, 692C.190, 692C.3507, 692C.3536, 692C.3538, 692C.354, 692C.420, 693A.480, 693A.615, 696B.550, 696C.120, 703.196, 704B.325, 706.1725, 706A.230, 710.159, 711.600, *and section 1 of this act*, sections 35, 38 and 41 of chapter 478, Statutes of Nevada 2011 and section 2 of chapter 391, Statutes of Nevada 2013 and unless otherwise declared by law to be confidential, all public books and public records of a governmental entity must be open at all times during office hours to inspection by any person, and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. Any such copies, abstracts or memoranda may be used to supply the general public with copies, abstracts or memoranda of the records or may be used in any other way to the advantage of the governmental entity or of the general public. This section does not supersede or in any manner affect the federal laws governing copyrights or enlarge, diminish or affect in any other manner the rights of a person in any written book or record which is copyrighted pursuant to federal law.

2. A governmental entity may not reject a book or record which is copyrighted solely because it is copyrighted.

3. A governmental entity that has legal custody or control of a public book or record shall not deny a request made pursuant to subsection 1 to inspect or copy or receive a copy of a public book or record on the basis that the requested public book or record contains information that is confidential if the governmental entity can redact, delete, conceal or separate, including, without

limitation, electronically, the confidential information from the information included in the public book or record that is not otherwise confidential.

4. If requested, a governmental entity shall provide a copy of a public record in an electronic format by means of an electronic medium. Nothing in this subsection requires a governmental entity to provide a copy of a public record in an electronic format or by means of an electronic medium if:

(a) The public record:

(1) Was not created or prepared in an electronic format; and

(2) Is not available in an electronic format; or

(b) Providing the public record in an electronic format or by means of an electronic medium would:

(1) Give access to proprietary software; or

(2) Require the production of information that is confidential and that cannot be redacted, deleted, concealed or separated from information that is not otherwise confidential.

5. An officer, employee or agent of a governmental entity who has legal custody or control of a public record:

(a) Shall not refuse to provide a copy of that public record in the medium that is requested because the officer, employee or agent has already prepared or would prefer to provide the copy in a different medium.

(b) Except as otherwise provided in NRS 239.030, shall, upon request, prepare the copy of the public record and shall not require the person who has requested the copy to prepare the copy himself or herself.

Sec. 4. This act becomes effective upon passage and approval.

Senator Scheible moved the adoption of the amendment.

Remarks by Senator Scheible.

Amendment No. 533 for Senate Bill No. 39 adds language clarifying that the bill's provisions apply to both the Board of Indigent Defense Services and the Department of Indigent Defense Services. It further clarifies that certain communications or record sharing between the Board and the Department and certain other entities is permitted in relation to an investigation of a complaint against an attorney pertaining to the attorney's representation of an indigent client.

Amendment adopted.

Bill read third time.

Remarks by Senators Nguyen and Seevers Gansert.

SENATOR NGUYEN:

Senate Bill No. 39 provides that, with certain exceptions, all records received by the Board of Indigent Defense Services and the Department of Indigent Defense Services that are protected by attorney-client privilege are confidential. Similarly, all records obtained and compiled on, during or after the investigation arising from the complaint related to the attorney or conduct are confidential except when releasing such records is necessary for the performance of oversight functions by the Board or the Department. The bill also sets forth circumstances under which the Department may share information with licensing boards or other entities that are investigating a complaint against an attorney pertaining to the representation of an indigent client.

SENATOR SEEVERS GANSERT:

I support Senate Bill No. 39. I appreciate the amendment which cleared up language so that records related to compensation or expenses made by attorneys is no longer sealed and any

complaint against an attorney which pertains to the representation of an indigent client will not be sealed. I appreciate the amendment.

Roll call on Senate Bill No. 39:

YEAS—21.

NAYS—None.

Senate Bill No. 39 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 133.

Bill read third time.

Remarks by Senators Daly, Seevers Gansert and Scheible.

SENATOR DALY:

Senate Bill No. 133 prohibits a person from creating or serving in a false slate of presidential electors or conspiring to commit such acts. A person who violates these provisions is guilty of a category B felony, may be subject to a fine and liable for the cost of investigation and prosecution. The bill authorizes a person who believes that such an offense has occurred to notify the Secretary of State, who then must investigate or refer the alleged violation to the Attorney General for investigation and prosecution. Finally, the bill prohibits a person convicted of such an offense from being elected or appointed to public office.

SENATOR SEEVERS GANSERT:

I oppose Senate Bill No. 133. It has very broad language and extends subpoena powers to the Secretary of State. It has a category B felony, which is a very high level for folks who may be pretending to do something. I think our elections have been safe and secure, and this bill is an overreach as far as the response, especially with the subpoena power. Right now, the Secretary of State does not have subpoena power, and if you need to investigate, they can investigate. The Attorney General has that type of authority, and that is where this belongs.

SENATOR SCHEIBLE:

I will also be voting "no" on this measure today, but I want to make a clear statement about the reason for my "no" vote today. I absolutely believe that we should hold people accountable who engage in this kind of fraudulent and, frankly, treasonous behavior. However, the Nevada Revised Statutes allows a judge's discretion to grant probation to people in all kinds of offenses including battery with a deadly weapon, shooting at people, stealing from them, abusing animals, all kinds. Almost every single offense has the option of probation from a judge, including those resulting in people's death. I do not think it is appropriate to signal that this is worse than those crimes by tying the judge's hands and saying that they cannot give a person convicted under the statute probation. That is why I will be a "no" today.

Roll call on Senate Bill No. 133:

YEAS—11.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Ohrenschall, Scheible, Seevers Gansert, Stone, Titus—10.

Senate Bill No. 133 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 194.

Bill read third time.

The following amendment was proposed by Senator Ohrenschall:

Amendment No. 530.

SUMMARY—Revises provisions relating to step therapy protocols. (BDR 57-885)

AN ACT relating to insurance; requiring certain insurers to use evidence-based guidelines when developing a step therapy protocol; requiring such insurers to create a process by which an attending practitioner and an insured are authorized to apply for an exemption from a step therapy protocol; requiring such insurers to grant such an exemption in certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law establishes a process by which a person may request an exemption from a step therapy protocol established by his or her insurer for a prescription drug used to treat late stage cancer or an associated symptom. If such a request is granted, existing law requires the insurer to cover the prescription drug. (NRS 689A.04041, 689B.0305, 689C.1684, 695A.259, 695B.19085, 695C.17333, 695G.1675) Sections 1, 3-8 and 11 of this bill require certain private-sector insurers to establish a process by which an insured and his or her attending practitioner may: (1) request an exemption from a step therapy protocol that applies to prescription drugs; and (2) appeal a decision concerning such a request. Sections 1, 3-8 and 11 require an insurer to: (1) grant such a request if the attending practitioner submits certain information providing adequate justification for the exemption; and (2) make the process to request an exemption and submit an appeal accessible on an Internet website maintained by the insurer. Sections 1, 3-8 and 11 additionally require certain private-sector insurers to use guidelines based on medical or scientific evidence, if available, when developing a step therapy protocol. Section 2 of this bill makes a conforming change to indicate the proper placement of section 1 in the Nevada Revised Statutes.

Section 10 of this bill authorizes the Commissioner of Insurance to suspend or revoke the certificate of a health maintenance organization that fails to comply with the requirements of section 8. The Commissioner is also authorized to take such action against other health insurers who fail to comply with the requirements of sections 1, 3-7 and 11. (NRS 680A.200)

Sections 9 and 12 of this bill provide that the provisions of sections 8 and 11 do not apply to Medicaid managed care organizations. Sections 9 and 12 of this bill additionally provide that the provisions of sections 8 and 11, respectively, do not apply to a health maintenance organization or managed care organization that provides services to members of the Public Employees' Benefits Program.

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

Section 1. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. When developing a step therapy protocol, an insurer shall use guidelines based on medical or scientific evidence, if such guidelines are

available.

2. An insurer that offers or issues a policy of health insurance which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the insurer concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the insurer; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the insurer shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. An insurer shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the insurer a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The insurer shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current policy of health insurance at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current policy of health insurance at the time the attending practitioner selected the drug.

4. If an insurer does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request

within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the insurer shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 689A.04041 apply.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

Sec. 2. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~[.]~~ *, and section 1 of this act.*

Sec. 3. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. When developing a step therapy protocol, an insurer shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. An insurer that offers or issues a policy of group health insurance which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the insurer concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the insurer; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances

exist, the insurer shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. An insurer shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the insurer a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The insurer shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current policy of group health insurance at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current policy of group health insurance at the time the attending practitioner selected the drug.

4. If an insurer does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the insurer shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to ~~[any]~~ :

(a) Any prescription drug to which the provisions of NRS 689B.0305 apply.

(b) Any policy of group health insurance purchased or provided pursuant to NRS 287.010.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

Sec. 4. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. When developing a step therapy protocol, a carrier shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A carrier that offers or issues a health benefit plan which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the carrier concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the carrier; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the carrier shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A carrier shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the carrier a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The carrier shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current health benefit plan at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current health benefit plan at the time the attending practitioner selected the drug.

4. If a carrier does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the carrier shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 689C.1684 apply.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

Sec. 5. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, *and section 4 of this act* to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 6. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. When developing a step therapy protocol, a society shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A society that offers or issues a benefit contract which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the society concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the society; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the society shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A society shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the society a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The society shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current benefit contract at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current benefit contract at the time the attending practitioner selected the drug.

4. If a society does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the society shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 695A.259 apply.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

Sec. 7. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. When developing a step therapy protocol, a hospital or medical services corporation shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A hospital or medical services corporation that offers or issues a policy of health insurance which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the hospital or medical services corporation concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the hospital or medical services corporation; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the hospital or medical services corporation shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A hospital or medical services corporation shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits to the hospital or medical services corporation a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The hospital or medical services corporation shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current policy of health insurance at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current policy of health insurance at the time the attending practitioner selected the drug.

4. If a hospital or medical services corporation does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the hospital or medical services corporation shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 695B.19085 apply.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

Sec. 8. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. When developing a step therapy protocol, a health maintenance organization shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A health maintenance organization that offers or issues a health care plan which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an enrollee and his or her attending practitioner may:

(1) Request an exemption for the enrollee from the step therapy protocol; and

(2) Appeal a decision made by the health maintenance organization concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the health maintenance organization; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the health maintenance organization shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A health maintenance organization shall grant a request to exempt an enrollee from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the enrollee submits to the health maintenance organization a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The health maintenance organization shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the enrollee;

(2) Is expected to be ineffective based on the known clinical characteristics of the enrollee and the known characteristics of the required prescription drug;

(3) Has been tried by the enrollee, regardless of whether the enrollee was covered by the current health care plan at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the enrollee, based on medical necessity; or

(b) The enrollee is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the enrollee was covered by his or her current health care plan at the time the attending practitioner selected the drug.

4. If a health maintenance organization does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the

health maintenance organization shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the enrollee.

6. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 695C.17333 apply.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

Sec. 9. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, *and section 8 of this act*, 695C.1733, 695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.1759, 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694 to 695C.1698, inclusive, 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333, 695C.17345, 695C.17347, 695C.1735, 695C.1737, 695C.1743, 695C.1745 and 695C.1757 apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

6. The provisions of section 8 of this act do not apply to a health maintenance organization that provides health care services to members of the Public Employees' Benefits Program. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 10. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if the Commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, *and section 8 of this act* or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The Commissioner certifies that the health maintenance organization:

(1) Does not meet the requirements of subsection 1 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees or creditors or to the general public;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 11. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. When developing a step therapy protocol, a managed care organization shall use guidelines based on medical or scientific evidence, if such guidelines are available.

2. A managed care organization that offers or issues a health care plan which includes coverage for a prescription drug for the treatment of any medical condition that is part of a step therapy protocol shall:

(a) Establish a clear, convenient and readily accessible process by which an insured and his or her attending practitioner may:

(1) Request an exemption for the insured from the step therapy protocol; and

(2) Appeal a decision made by the managed care organization concerning a request for an exemption from the step therapy protocol pursuant to subparagraph (1);

(b) Make the process described in paragraph (a) accessible through an Internet website maintained by the managed care organization; and

(c) Except as otherwise provided in this paragraph, respond to a request made or an appeal submitted pursuant to paragraph (a) not later than 2 business days after the request is made or the appeal is submitted, as applicable. If the attending practitioner indicates that exigent circumstances exist, the managed care organization shall respond to the request or appeal within 24 hours after the request is made or the appeal is submitted, as applicable.

3. A managed care organization shall grant a request to exempt an insured from a step therapy protocol made in accordance with the process established pursuant to subsection 2 if the attending practitioner for the insured submits

to the managed care organization a statement which provides an adequate justification for the exemption and any documentation necessary to support the statement. The managed care organization shall determine whether such justification exists if the statement and documentation demonstrate that:

(a) Each prescription drug that is required to be used earlier in the step therapy protocol:

(1) Is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

(2) Is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics of the required prescription drug;

(3) Has been tried by the insured, regardless of whether the insured was covered by the current health care plan at the time, and was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event relating to the prescription drug; or

(4) Is not in the best interest of the insured, based on medical necessity; or

(b) The insured is stable on a prescription drug selected by his or her attending practitioner for the medical condition under consideration, regardless of whether the insured was covered by his or her current health care plan at the time the attending practitioner selected the drug.

4. If a managed care organization does not respond to a request for an exemption from a step therapy protocol or an appeal concerning a decision relating to such a request within the time frame prescribed by paragraph (c) of subsection 2, the request shall be deemed to have been granted.

5. If a request for an exemption from a step therapy protocol is granted pursuant to subsection 3 or deemed granted pursuant to subsection 4, the managed care organization shall immediately authorize coverage for and dispensing of the drug chosen by the attending practitioner for the insured.

6. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by this section, and any provisions of the policy that conflict with the provisions of this section is void.

7. The provisions of this section do not apply to any prescription drug to which the provisions of NRS 695G.1675 apply.

8. As used in this section:

(a) "Attending practitioner" means the practitioner, as defined in NRS 639.0125, who has primary responsibility for the treatment of the medical condition of an insured for which a prescription drug is prescribed.

(b) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

Sec. 12. NRS 695G.090 is hereby amended to read as follows:

695G.090 1. Except as otherwise provided in subsection 3, the provisions of this chapter apply to each organization and insurer that operates as a managed care organization and may include, without limitation, an insurer

that issues a policy of health insurance, an insurer that issues a policy of individual or group health insurance, a carrier serving small employers, a fraternal benefit society, a hospital or medical service corporation and a health maintenance organization.

2. In addition to the provisions of this chapter, each managed care organization shall comply with:

(a) The provisions of chapter 686A of NRS, including all obligations and remedies set forth therein; and

(b) Any other applicable provision of this title.

3. The provisions of NRS 695G.127, 695G.164, 695G.1645, 695G.167 , *section 11 of this act* and 695G.200 to 695G.230, inclusive, do not apply to a managed care organization that provides health care services to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. ~~[This subsection does]~~

4. The provisions of section 11 of this act do not apply to a managed care organization that provides health care services to members of the Public Employees' Benefits Program.

5. Subsections 3 and 4 do not exempt a managed care organization from any provision of this chapter for services provided pursuant to any other contract.

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

2. Sections 1 to 12, inclusive, of this act become effective:

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

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

Senator Ohrenschall moved the adoption of the amendment.

Remarks by Senator Ohrenschall.

Amendment No. 530 to Senate Bill No. 194 explicitly excludes any policy of group health insurance purchased or provided for employees of a local government agency from the requirement in the bill to provide an exemption from a step therapy protocol.

Amendment adopted.

Bill read third time.

Remarks by Senator Ohrenschall.

Senate Bill No. 194 requires certain private health insurers to establish a process for a covered person or attending practitioner of that covered person to request an exemption from that insurance company's step therapy protocol as well as establish a process to appeal a decision made by the insurer concerning a request for an exemption to that step therapy protocol. The bill sets forth the circumstances under which the insurer would be required to grant the exemption and the timeframes within which a health insurer must respond to a step therapy exemption or appeal request before the request is deemed to have been granted. If the insurer grants the exemption or the exemptions deemed granted, the bill requires health insurers to immediately authorize coverage for the requested prescription drug chosen by the attending practitioner for the insured. A health insurance policy issued or renewed on or after January 1, 2024, has the legal effect of including the required coverage and any provisions of the policy that are in conflict are void.

Roll call on Senate Bill No. 194:
YEAS—21.
NAYS—None.

Senate Bill No. 194 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 243.

Bill read third time.

The following amendment was proposed by Senator Scheible:

Amendment No. 502.

SUMMARY—Revises provisions relating to catalytic converters. (BDR 15-37)

AN ACT relating to catalytic converters; prohibiting certain acts relating to used catalytic converters under certain circumstances; establishing requirements relating to transactions involving used catalytic converters; providing penalties; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Section 2 of this bill provides that a person commits the offense of theft of a catalytic converter if the person willfully takes or attempts to take possession of, carries away or exercises control over a catalytic converter with the intent to deprive the rightful owner of the catalytic converter. Section 2 also provides that a person commits the offense of possession of a catalytic converter if the person possesses two or more used catalytic converters unless the person is licensed or authorized to possess a used catalytic converter.

Section 3 of this bill prohibits a person from purchasing a used catalytic converter from any person other than: (1) a licensed automobile wrecker; (2) a licensed scrap metal processor; (3) a licensed motor vehicle manufacturer, distributor, dealer or rebuilder; (4) any other business that may reasonably generate, possess or sell used catalytic converters; or (5) a person who possesses certain documentation that proves the person is the lawful owner or possessor of the used catalytic converter.

Section 4 of this bill provides that a person who violates any provision of section 2 or 3 is guilty of: (1) a category E felony, if the violation involves one used catalytic converter; (2) a category D felony, if the violation involves 2 or more, but less than 10, used catalytic converters; and (3) a category ~~[B]~~ C felony, ~~[punishable by imprisonment in the state prison for a minimum term of not less than 1 year and a maximum term of not more than 6 years,]~~ if the violation involves 10 or more used catalytic converters.

Existing law provides certain restrictions on the sale and purchase of scrap metal in this State and includes a catalytic converter in the definition of the term "scrap metal." (NRS 647.017, 647.092-647.098) Section 12 of this bill excludes a used catalytic converter from the definition of scrap metal.

Section 8 of this bill prohibits a licensed scrap metal processor from purchasing or receiving a used catalytic converter from any person other than

certain licensed businesses or a person possessing certain documentation that proves the person is the lawful owner or possessor of the used catalytic converter.

Existing law requires scrap metal processors to maintain certain records of purchases of scrap metal. (NRS 647.092-647.098) Section 9 of this bill requires scrap metal processors to maintain certain additional information if the scrap metal processor purchases a used catalytic converter from certain licensed businesses or a person who has documentation that proves the person is the lawful owner or possessor of the used catalytic converter. Section 9 also requires a scrap metal processor to: (1) maintain certain records of all used catalytic converters the scrap metal processor sells to another scrap metal processor; (2) maintain certain records related to used catalytic converters for a period of 2 years; and (3) make certain records related to used catalytic converters available to law enforcement upon demand.

Existing law authorizes a local law enforcement agency to establish an electronic reporting system, or to utilize an existing electronic reporting system, to receive information relating to the purchase of scrap metal by a scrap metal processor that transacts business within the jurisdiction of the local law enforcement agency. If a law enforcement agency establishes or uses such a system, existing law requires each scrap metal processor that transacts business within the jurisdiction of the local law enforcement agency to submit to the local law enforcement agency certain information relating to each purchase of scrap metal from certain persons. (NRS 647.0945) Section 14 of this bill requires each scrap metal processor to submit electronically to the local law enforcement agency certain additional information if the scrap metal processor purchases a used catalytic converter.

Section 10 of this bill prohibits a scrap metal processor from providing payment for a used catalytic converter to a seller unless: (1) the payment is made by check or through an electronic transfer of money cleared through an automated clearinghouse; (2) the seller is a person described in section 8; and (3) the scrap metal processor obtains certain information, including, without limitation, a statement written by the seller indicating from whom the seller obtained the used catalytic converter. Section 10 provides for an exception to these requirements for a scrap metal processor who holds a certain written agreement with the seller before purchasing a used catalytic converter.

Section 15 of this bill provides that a person who violates any provision of sections 8-10 is guilty of a misdemeanor. Section 15 authorizes a court to also issue an injunction prohibiting the person from engaging in the business of a scrap metal processor. Section 15 also provides that a scrap metal processor who is a natural person and who knowingly violates section 8 or sells a used catalytic converter that the scrap metal processor knows or should know is stolen is guilty of a felony, punishable by a penalty that is similar to the penalties set forth in section 4.

Sections 6 and 7 of this bill define the terms "permanently marked" and "used catalytic converter," respectively, for the purpose of provisions

governing scrap metal processors. Section 11 of this bill makes a conforming change to indicate the proper placement of sections 6 and 7 in the Nevada Revised Statutes.

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

Section 1. Chapter 202 of NRS is hereby amended by adding thereto the provisions set forth as sections 2, 3 and 4 of this act.

Sec. 2. *1. A person commits the offense of theft of a catalytic converter if the person willfully takes or attempts to take possession of, carries away or exercises control over a used catalytic converter with the intent to deprive the rightful owner of the catalytic converter.*

2. A person commits the offense of possession of a catalytic converter if the person possesses two or more used catalytic converters unless the person is:

(a) An automobile wrecker licensed pursuant to NRS 487.070;

(b) A scrap metal processor licensed pursuant to NRS 647.092 who maintains a fixed place of business and has obtained the used catalytic converter in accordance with the provisions of NRS 647.094 and 647.098;

(c) A motor vehicle manufacturer, distributor, dealer or rebuilder licensed pursuant to NRS 482.325;

(d) Any other business that may reasonably generate, possess or sell used catalytic converters; or

(e) A person possessing documentation that proves the person is the lawful owner or possessor of the used catalytic converter, including, without limitation, a certificate of title or registration that identifies the person as the legal or registered owner of the vehicle from which the used catalytic converter was removed and which includes a vehicle identification number that matches the vehicle identification number permanently marked on the used catalytic converter.

3. As used in this section:

(a) "Permanently marked" has the meaning ascribed to it in section 6 of this act.

(b) "Used catalytic converter" has the meaning ascribed to it in section 7 of this act.

Sec. 3. *1. A person shall not purchase a used catalytic converter for any purpose, including, without limitation, to dismantle, recycle or smelt, unless the person purchases the used catalytic converter from:*

(a) An automobile wrecker licensed pursuant to NRS 487.070;

(b) A scrap metal processor licensed pursuant to NRS 647.092 who maintains a fixed place of business and has obtained the used catalytic converter in accordance with the provisions of NRS 647.094 and 647.098;

(c) A motor vehicle manufacturer, distributor, dealer or rebuilder licensed pursuant to NRS 482.325;

(d) Any other business that may reasonably generate, possess or sell used catalytic converters; or

(e) A person possessing documentation that proves the person is the lawful owner or possessor of the used catalytic converter, including, without limitation, a certificate of title or registration that identifies the person as the legal or registered owner of the vehicle from which the used catalytic converter was removed and which includes a vehicle identification number that matches the vehicle identification number permanently marked on the used catalytic converter.

2. As used in this section:

(a) "Permanently marked" has the meaning ascribed to it in section 6 of this act.

(b) "Used catalytic converter" has the meaning ascribed to it in section 7 of this act.

Sec. 4. *A person who violates any provision of section 2 or 3 of this act is guilty of:*

1. If the violation involves one used catalytic converter, a category E felony and shall be punished as provided in NRS 193.130.

2. If the violation involves 2 or more, but less than 10, used catalytic converters, a category D felony and shall be punished as provided in NRS 193.130.

3. If the violation involves 10 or more used catalytic converters, a category ~~[B]~~ C felony and shall be punished ~~[by imprisonment in the state prison for a minimum term of not less than 1 year and a maximum term of not more than 6 years.]~~ as provided in NRS 193.130.

Sec. 5. Chapter 647 of NRS is hereby amended by adding thereto the provisions set forth as sections 6 to 10, inclusive, of this act.

Sec. 6. *"Permanently marked" means prominently engraved, etched, welded, metal-stamped, acid-marked or otherwise permanently displayed using a similarly reliable method of imparting a lasting mark on the exterior case of a used catalytic converter.*

Sec. 7. *"Used catalytic converter" means a catalytic converter or any part thereof that has been previously installed on a vehicle and has been removed. The term does not include a reconditioned or refurbished catalytic converter being sold at retail.*

Sec. 8. *A person who is authorized to purchase or otherwise receive a used catalytic converter pursuant to subsection 1 of NRS 647.0172 shall not purchase or otherwise receive a used catalytic converter for any purpose, including, without limitation, to dismantle, recycle or smelt, unless the person purchases or receives the used catalytic converter from:*

1. An automobile wrecker licensed pursuant to NRS 487.070;

2. A scrap metal processor licensed pursuant to NRS 647.092 who maintains a fixed place of business and has obtained the used catalytic converter in accordance with the provisions of NRS 647.094 and 647.098;

3. A motor vehicle manufacturer, distributor, dealer or rebuilder licensed pursuant to NRS 482.325;

4. Any other business that may reasonably generate, possess or sell used catalytic converters; or

5. A person possessing documentation that proves the person is the lawful owner or possessor of the used catalytic converter, including, without limitation, a certificate of title or registration that identifies the person as the legal or registered owner of the vehicle from which the used catalytic converter was removed and which includes a vehicle identification number that matches the vehicle identification number permanently marked on the used catalytic converter.

Sec. 9. *1. Except as otherwise provided in subsections 2 and 3, every scrap metal processor shall maintain in his or her place of business a book or other permanent record in which must be made, at the time of each purchase of a used catalytic converter, a record of the purchase that contains:*

(a) The place and date of the purchase.

(b) The name of the seller and the seller's valid driver's license number or valid identification card number and the state of issue.

(c) A general description of the vehicle delivering the used catalytic converter, including, without limitation, the state of the registration of the vehicle.

(d) A description of the used catalytic converter purchased, including, without limitation, the item type, quantity and vehicle identification number of the used catalytic converter.

(e) A description of the vehicle from which the used catalytic converter was removed, including, without limitation:

(1) The year, make, model and vehicle identification number of the vehicle; and

(2) If applicable, a copy of the title of the vehicle which includes a vehicle identification number that matches the vehicle identification number permanently marked on the used catalytic converter.

(f) A statement written by the seller indicating:

(1) That the seller is the lawful owner or possessor of the used catalytic converter; or

(2) The name of the person from which the seller obtained the used catalytic converter, including, if applicable, the name of the business as shown on a signed transfer document.

(g) The price paid by the scrap metal processor for the used catalytic converter.

(h) If the seller is a business entity, other than a scrap metal processor:

(1) The seller's physical business address;

(2) The seller's business telephone number; and

(3) The seller's business license number or tax identification number of the business.

2. A scrap metal processor who purchases a used catalytic converter from a business entity that holds a written agreement with another business that sells used catalytic converters for recycling purposes is required to maintain

in his or her place of business a book or other permanent record in which must be made, at the time of each purchase, a record of the purchase that contains:

(a) The name of the seller or agent acting on behalf of the seller.

(b) The seller's physical business address and business telephone number.

(c) The seller's business license number or tax identification number.

(d) The date and place of the transaction.

(e) The number of used catalytic converters received in the course of the transaction.

(f) The amount of money that was paid for each used catalytic converter in the course of the transaction.

(g) A copy of the written agreement.

3. A scrap metal processor who sells a used catalytic converter to another scrap metal processor shall maintain in his or her place of business a book or other permanent record in which must be made, at the time of each sale, a record of the sale that contains:

(a) The name and address of each person to whom each used catalytic converter is sold.

(b) The number of used catalytic converters being sold.

(c) The amount of money that was received for each used catalytic converter sold in the transaction.

(d) The date and place of the transaction.

4. All records kept pursuant to subsections 1, 2 and 3 must be kept and maintained for not less than 2 years.

5. All used catalytic converters purchased by the scrap metal processor and the records made and maintained in accordance with subsections 1 to 4, inclusive, must be made available at all times to a local law enforcement agency upon demand.

Sec. 10. *1. Except as otherwise provided in subsection 2, a scrap metal processor shall not provide payment for a used catalytic converter unless:*

(a) The payment is made by check or through an electronic transfer of money cleared through an automated clearinghouse;

(b) The seller is a person described in section 8 of this act; and

(c) The scrap metal processor obtains:

(1) A clear photograph or video of the:

(I) Seller at the time of the sale;

(II) Used catalytic converter being sold; and

(III) If applicable, the vehicle identification number permanently marked on the used catalytic converter;

(2) A copy of the seller's valid driver's license containing the photograph and address of the seller, or a copy of a state or federal government-issued identification card containing the photograph and address of the seller; and

(3) A statement written by the seller indicating:

(I) That the seller is the lawful owner or possessor of the used catalytic converter; or

(II) The name of the person from whom the seller obtained the used catalytic converter, including, if applicable, the name of the business as shown on a signed transfer document.

2. The provisions of subsection 1 do not apply to a scrap metal processor who buys a used catalytic converter if the scrap metal processor and the seller have a written agreement for the transaction which includes:

(a) A log or other regularly updated record of all used catalytic converters received pursuant to the agreement; and

(b) A description of each catalytic converter with enough particularity so that each of the used catalytic converters in the scrap metal processor's inventory can reasonably be matched to its description in the agreement.

Sec. 11. NRS 647.010 is hereby amended to read as follows:

647.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 647.011 to 647.018, inclusive, *and sections 6 and 7 of this act* have the meanings ascribed to them in those sections.

Sec. 12. NRS 647.017 is hereby amended to read as follows:

647.017 1. "Scrap metal" means ~~[:~~

~~(a) Nonferrous]~~ *nonferrous* metals, scrap iron, stainless steel or other material or equipment which consists in whole or in part of metal and which is used in construction, agricultural operations, electrical power generation, transmission or distribution, cable, broadband or telecommunications transmission, railroad equipment, oil well rigs or any lights maintained by the State or a local government, including, without limitation, street lights, traffic-control devices, park lights or ballpark lights . ~~[; and~~

~~(b) Catalytic converters.]~~

2. The term does not include waste generated by a household, aluminum beverage containers, used construction scrap iron , ~~[or]~~ materials consisting of a metal product in its original manufactured form which contains not more than 20 percent by weight nonferrous metal ~~[.]~~ *or used catalytic converters.*

Sec. 13. NRS 647.0172 is hereby amended to read as follows:

647.0172 "Scrap metal processor" means any person who:

1. Engages in the business of purchasing, trading, bartering or otherwise receiving scrap metal ~~[,]~~ or *used catalytic converters; or*

2. Uses machinery and equipment for processing and manufacturing iron, steel or nonferrous scrap into prepared grades, and whose principal product is scrap iron, scrap steel or nonferrous metallic scrap, not including precious metals, for sale for remelting purposes.

Sec. 14. NRS 647.0945 is hereby amended to read as follows:

647.0945 1. A local law enforcement agency may establish an electronic reporting system or utilize an existing electronic reporting system to receive information relating to the purchase of scrap metal *or used catalytic converters* by a scrap metal processor that transacts business within the jurisdiction of the local law enforcement agency. An electronic reporting system established or utilized pursuant to this subsection must:

(a) Be electronically secure and accessible only to:

(1) A scrap metal processor for the purpose of submitting the information required by subsection 2;

(2) An officer of the local law enforcement agency; and

(3) If applicable, an authorized employee of any designated third party.

(b) Provide for the electronic submission of information by a scrap metal processor.

2. If a local law enforcement agency establishes an electronic reporting system or utilizes an existing electronic reporting system pursuant to subsection 1, each scrap metal processor that transacts business within the jurisdiction of the local law enforcement agency shall, before 12 p.m. of each business day, submit electronically to the local law enforcement agency or, if applicable, a designated third party the following information regarding ~~[each]~~*:*

(a) Each purchase of scrap metal conducted on the preceding day from a person who sold the scrap metal in his or her individual capacity:

~~[(a)]~~ *(1)* The name of the seller;

~~[(b)]~~ *(2)* The date of the purchase;

~~[(c)]~~ *(3)* The name of the person or employee who conducted the transaction on behalf of the scrap metal processor;

~~[(d)]~~ *(4)* The name, street, house number and date of birth listed on the identification provided pursuant to paragraph (c) of subsection 1 of NRS 647.094 and a physical description of the seller, including the seller's gender, height, eye color and hair color;

~~[(e)]~~ *(5)* The license number and general description of any vehicle that delivered the scrap metal;

~~[(f)]~~ *(6)* The description of the scrap metal recorded pursuant to paragraph (h) of subsection 1 of NRS 647.094; ~~[and~~

~~(g)]~~ *(7)* The amount, in weight, of scrap metal purchased ~~[.]~~ *; and*

(b) Each purchase of a used catalytic converter conducted on the preceding day from a person who sold the used catalytic converter in his or her individual capacity:

(1) A statement written by the seller indicating:

(I) That the seller is the lawful owner or possessor of the used catalytic converter; or

(II) The name of the person from whom the seller obtained the used catalytic converter, including, if applicable, the name of the business as shown on a signed transfer document;

(2) If applicable, a copy of the title of the vehicle from which the used catalytic converter was removed which includes a vehicle identification number that matches the vehicle identification number permanently marked on the used catalytic converter;

(3) The year, make, model and vehicle identification number of the vehicle from which the used catalytic converter was removed; and

(4) A description of the used catalytic converter purchased or sold, including, without limitation, the item type, quantity and vehicle identification number permanently marked on the used catalytic converter.

3. If a scrap metal processor is required to submit information to a local law enforcement agency or, if applicable, a designated third party pursuant to subsection 2, the scrap metal processor shall display prominently at the point of purchase a public notice, in a form approved by the local law enforcement agency, describing the information that the scrap metal processor is required to submit electronically to the local law enforcement agency or, if applicable, the designated third party.

4. Nothing in this section shall be deemed to limit or otherwise abrogate any duty of a scrap metal processor to maintain a book or other permanent record of information pursuant to NRS 647.094.

5. If a local law enforcement agency establishes an electronic reporting system or utilizes an existing electronic reporting system to receive information pursuant to this section, the local law enforcement agency shall, on or before January 15 of each odd-numbered year, submit to the Director of the Legislative Counsel Bureau for transmittal to the Legislature a report regarding the effect of the electronic reporting system on the incidence of crime which relates to the sale or purchase of scrap metal *or used catalytic converters* within the jurisdiction of the law enforcement agency.

6. ~~[The]~~ *Except as otherwise provided in paragraph (b) of subsection 2, the* provisions of this section do not apply to the purchase of scrap metal *or a used catalytic converter* from a business entity.

7. The Division of Industrial Relations of the Department of Business and Industry shall, in consultation with representatives from local law enforcement agencies in this state and representatives from the scrap metal industry, adopt regulations to ensure the confidentiality of information which is reported and maintained pursuant to this section, including, without limitation, regulations providing for:

(a) The confidentiality of consumer information;

(b) The confidentiality of proprietary information;

(c) Equity of input into contractual terms;

(d) Contractual terms relating to disclaimers, indemnification and the ownership of data by a designated third party;

(e) Oversight of a designated third party that handles, maintains or has access to such information, including, without limitation, the qualifications, equipment, procedures and background checks required of a designated third party;

(f) The manner in which reported information may be used, shared or disseminated; and

(g) The maintenance of reported information in relationship to other data maintained by a law enforcement agency.

8. As used in this section, "designated third party" means any person with whom a local law enforcement agency has entered into a contract for the

purpose of receiving and storing any information required to be submitted electronically by a scrap metal processor pursuant to subsection 2.

Sec. 15. NRS 647.143 is hereby amended to read as follows:

647.143 *1.* ~~[Unless]~~ *Except as otherwise provided in subsection 3 and unless* a greater penalty is provided pursuant to specific statute, a person who violates any provision of NRS 647.094, 647.096 or 647.098 *or section 8, 9 or 10 of this act* is guilty of a misdemeanor.

2. In addition to the provisions of subsections 1 and 3, the court may issue an injunction prohibiting a person from engaging in the business of a scrap metal processor:

(a) For the first or second offense, for a period of not less than 30 days.

(b) For a third or subsequent offense, for a period of 1 year.

3. Any scrap metal processor who is a natural person and who knowingly violates section 8 of this act or who sells any used catalytic converter that the scrap metal processor knows or should know is a stolen catalytic converter, is guilty of:

(a) If the violation involves one used catalytic converter, a category E felony and shall be punished as provided in NRS 193.130.

(b) If the violation involves 2 or more, but less than 10, used catalytic converters, a category D felony and shall be punished as provided in NRS 193.130.

(c) If the violation involves 10 or more used catalytic converters, a category ~~*[B]*~~ *C felony and shall be punished* ~~*[by imprisonment in the state prison for a minimum term of not less than 1 year and a maximum term of not more than 6 years.]*~~ *as provided in NRS 193.130.*

Senator Scheible moved the adoption of the amendment.

Remarks by Senator Scheible.

Amendment No. 502 to Senate Bill No. 243 revises the penalties for certain violations involving a theft or sale of ten or more catalytic converters from a category B felony to a category C felony.

Amendment adopted.

Bill read third time.

Remarks by Senator Nguyen.

Senate Bill No. 243 sets forth provisions defining the offenses of theft or possession of a catalytic converter and provides graduated felony penalties for these offenses depending on the number of catalytic converters involved. A scrap metal processor who knowingly purchases, receives or sells a used catalytic converter that is not properly obtained or documented is subject to similar penalties as are set forth in regard to theft or possession of a catalytic converter.

Roll call on Senate Bill No. 243:

YEAS—20.

NAYS—Harris.

Senate Bill No. 243 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 251.

Bill read third time.

Remarks by Senators Flores and Buck.

SENATOR FLORES:

Senate Bill No. 251 adds policies for the transfer and reassignment of school district employees who are not teachers to the mandatory scope of collective bargaining for a local government employer. The policies must include the transfer and reassignment of employees of a large school district which has more than 100,000 pupils enrolled in its public schools during or in response to a reduction in workforce or in a surplus situation. Additionally, the bill provides that a large school district remains responsible for negotiating the policies for the transfer and reassignment of school district employees, including policies that provide placement rights to employees affected by a surplus situation during or in response to a reduction in workforce.

SENATOR BUCK:

This is another rinse and repeat, force-placement bill where inevitably you place staff at a school and then you hold the principal accountable for the results of the school on the Nevada school performance framework. You place a person at a school and the community, the School Organizational Teams do not have a say over who is placed at the school nor does the principal.

I will use Clark County School District (CCSD) as an example. Currently, CCSD has 1,283 openings for teachers. Anyone can apply. Supposedly, there are five to seven teachers out there that cannot get a job even though they have been on multiple interviews. I ask you, what could potentially be wrong? I think the unions need to try and coach these people because obviously there is a problem if you cannot find a job out of 1,283 openings.

Put yourself in the principal's shoes. Would you rather pick who works in your school or have someone randomly or arbitrarily placed there to teach children? As a principal, you are responsible for the Nevada school performance ratings and the results of student achievement. Now, imagine having zero control over hiring the very people who impact student success in your school each and every day. Can you imagine running a business with no autonomy over staffing? I could not. As an empowerment principal, we were lucky enough to have autonomy over staffing, scheduling, curriculum, budget and time. It made all the difference in moving the needle on student achievement. The autonomy of staffing is important to moving the needle for student achievement.

On another note, the more regulations, mandates and restrictions that you all put on these traditional public schools, the worse it becomes and the better for public charter schools recruitment and retention. Autonomy is the greatest reason to move out of a big, overregulated, overmandated forced-placement district and into a charter school where you have more control over your results. This is also a decision that is currently in the hands of the Nevada Supreme Court. I ask that you vote "no" today.

SENATOR FLORES:

I want to remind folks that Senate Bill No. 251 has nothing to do with teachers. This bill does not address teachers. I want to make that clear.

Roll call on Senate Bill No. 251:

YEAS—13.

NAYS—Buck, Goicoechea, Hammond, Hansen, Krasner, Seevers Gansert, Stone, Titus—8.

Senate Bill No. 251 having received a constitutional majority, Mr. President declared it passed.

Bill ordered transmitted to the Assembly.

Senate Bill No. 292.

Bill read third time.

Remarks by Senator Pazina.

Senate Bill No. 292 provides that principals are employed at-will for the first three years of employment, and that after those three years, a principal may be placed back on at-will status and subject to immediate dismissal if in each of two consecutive school years, the school's rating is reduced and at least one-half of the teachers request a transfer. If these events occur in any school year, mentoring must be provided to the principal and a survey of school conditions must be conducted. Additionally, the bill outlines certain entitlements of a principal who is reassigned.

Roll call on Senate Bill No. 292:

YEAS—21.

NAYS—None.

Senate Bill No. 292 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 310.

Bill read third time.

Remarks by Senator Goicoechea.

Senate Bill No. 310 provides for the licensure and regulation of expanded functions for dental assistants by the Board of Dental Examiners of Nevada and establishes an endorsement for dental hygienists to practice restorative-endorsed dental hygiene. The bill requires an expanded function dental assistant and a dental hygienist with special endorsements to practice restorative dental hygiene under the authorization of a dentist or a public health dental hygienist licensed in this State and sets forth the specific services and procedures they can perform under certain circumstances. The Board is required to adopt regulations related to the practice and continuing education requirements for the two professions. The bill establishes certain fees relating to licensure of expanded function dental assistants which are equal to similar fees that apply to dental hygienists.

In addition, the bill authorizes qualified dental hygienists to prescribe and dispense specific noncontrolled preventative drugs and other items used for such treatment and requires continuing education for such prescriptions. The Board must adopt regulations to authorize dental therapists and dental hygienists to administer local anesthesia and laser radiation if authorized by the supervising dentist licensed in this State.

Finally, the Board is required to submit a report to the Legislature not later than January 1, 2025, that includes certain information regarding the licensure of expanded function dental assistants, the special endorsement to practice restorative dental hygiene and the prescription and dispensing of drugs by certain dental hygienists.

This bill is about dental techs. Clearly, the amendment that came forward, I missed the mark with. It is not what is intended. I am asking the body—it is a two-thirds bill because of the fees required—to support this bill. Let me get it across to the other House. Let me provide dental techs better services for our dentists in our State and our public. The bottom line is, I apologize. The amendment was not what I thought it was going to be coming forward. I ask you to support it so I can get it across and get it fixed. It is a good bill.

Roll call on Senate Bill No. 310:

YEAS—17.

NAYS—Buck, Krasner, Seevers Gansert, Titus—4.

Senate Bill No. 310 having received a two-thirds majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 321.

Bill read third time.

Remarks by Senator Krasner.

Senate Bill No. 321 provides justice for victims and survivors of sexual assault. Senate Bill No. 321 prohibits storing the DNA profile of a survivor of sexual assault unless authorized by federal law or sharing the biological evidence of a survivor unless required to do so pursuant to a court order as part of discovery or if it is necessary to identify or prosecute the perpetrator of the assault. It is further prohibited to use forensic evidence to prosecute the survivor for any crime or for any other purpose not directly related to solving the crime or apprehending the perpetrator.

The bill also requires to the extent money is available the Central Repository for Nevada Records of Criminal History, the State DNA Database and each forensic laboratory to conduct an audit of any biological specimen or DNA information it stores or maintains. The audit must analyze compliance with state law on preservation of such evidence and identify the number of DNA profiles that should have been collected in 2021 but were not.

Roll call on Senate Bill No. 321:

YEAS—21.

NAYS—None.

Senate Bill No. 321 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 323.

Bill read third time.

Remarks by Senator Seevers Gansert.

Senate Bill No. 323 requires the Peace Officer Standards and Training Commission to adopt regulations to establish standards for the reciprocity of a person from another state or the federal government with a certification or law enforcement training equivalent to serve as a category III peace officer in this State.

Roll call on Senate Bill No. 323:

YEAS—21.

NAYS—None.

Senate Bill No. 323 having received a constitutional majority, Mr. President declared it passed.

Bill ordered transmitted to the Assembly.

Senate Bill No. 328.

Bill read third time.

Remarks by Senator Titus.

Senate Bill No. 328 makes the Cannabis Compliance Board subject to the provisions of the Nevada Administrative Procedure Act for the purposes of adopting, amending or repealing regulations and the adjudication of contested cases. The bill repeals statutes that set forth specific procedures for the Board to adopt, amend or repeal regulations and revises the procedures for the Board to take disciplinary action to conform with the procedures for the adjudication of contested cases.

Conflict of interest declared by Senator Ohrenschall.

Remarks by Senator Ohrenschall.

I have a disclosure to make on Senate Bill No. 328. Because we are considering Senate Bill No. 328 which directly affects the Cannabis Compliance Board, I would like to advise you, Mr. President, and the chamber that my wife serves as an appointed member of the Nevada

Cannabis Compliance Board. Seeking the advice of our Legislative Counsel and based on that advice, I plan to abstain on this vote and any future votes on Senate Bill No. 328.

Roll call on Senate Bill No. 328:
YEAS—19.
NAYS—Krasner.
NOT VOTING—Ohrenschall.

Senate Bill No. 328 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senate Bill No. 352.

Bill read third time.

The following amendment was proposed by Senator Scheible:

Amendment No. 503.

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

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; 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 insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy. 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 insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy. 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. *An insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy. 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. *An insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy or a pharmacy operated by the society. The terms of the benefit contract must not limit:*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~[8.]~~ *9.* A society may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

~~[9.]~~ *10.* For each of the 18 methods of contraception listed in subsection ~~[10]~~ *11* that have been approved by the Food and Drug Administration, a benefit contract must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the insured, but the society may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception. *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 insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy or a pharmacy operated by the insurer. 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. *An enrollee is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy or a pharmacy operated by the health maintenance organization. The terms of the evidence of coverage must not limit:*

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

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

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

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

~~[4.]~~ *5.* Except as otherwise provided in subsections ~~[9,]~~ 10 *, 11* and ~~[12,]~~ *13,* a health maintenance organization that offers or issues a health care plan shall not:

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

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

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

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

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

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

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

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

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

~~[8.]~~ *9.* If a health maintenance organization refuses, pursuant to subsection ~~[7,]~~ *8,* to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.

~~[9.]~~ *10.* A health maintenance organization may require an enrollee to pay a higher deductible, copayment or coinsurance for a drug for contraception if the enrollee refuses to accept a therapeutic equivalent of the drug.

~~[10.]~~ *11.* For each of the 18 methods of contraception listed in subsection ~~[11]~~ *12* that have been approved by the Food and Drug Administration, a health care plan must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the enrollee, but the health maintenance organization may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception. *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. *An insured is entitled to reimbursement for services listed in subsection 1 which are within the authorized scope of practice of a pharmacist when such services are provided by a pharmacist who is employed by or serves as an independent contractor of an in-network pharmacy or a pharmacy operated by the managed care organization. The terms of the evidence of coverage must not limit:*

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

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

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

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

~~[4.]~~ *5.* Except as otherwise provided in subsections ~~[8,]~~ 9 , *10* and ~~[11,]~~ *12*, a managed care organization that offers or issues a health care plan shall not:

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

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

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

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

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

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

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

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

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

prospective insured written notice of the coverage that the managed care organization refuses to provide pursuant to this subsection.

~~[8.]~~ *9.* A managed care organization may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

~~[9.]~~ *10.* For each of the 18 methods of contraception listed in subsection ~~[10]~~ *11* that have been approved by the Food and Drug Administration, a health care plan must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the insured, but the managed care organization may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception. *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. The Plan must not limit:*

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

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

7. The Plan must not require a recipient of Medicaid to obtain prior authorization for the benefits described in paragraphs (a) and (c) of subsection 1.

8. As used in this section:

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

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

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

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

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

Sec. 14. NRS 422.4053 is hereby amended to read as follows:

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

2. The Department may enter into a contract with:

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

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

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

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

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

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

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

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

(a) Paragraph (a) of subsection 2 may require the pharmacy benefit manager to provide the entire amount of any rebates received for the purchase of

prescription drugs, including, without limitation, rebates for the purchase of prescription drugs by an entity other than the Department, to the Department.

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

Sec. 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 ~~[becomes]~~ and sections 14.2 and 14.8 of this act become effective upon passage and approval.

2. Sections 1 to ~~[17,]~~ 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.

Senator Scheible moved the adoption of the amendment.

Remarks by Senator Scheible.

Amendment No. 503 to Senate Bill No. 352 adds new provisions to authorize certain persons and entities who are authorized to dispense controlled substances and dangerous drugs to acquire controlled substances and dangerous drugs directly from an outsourcing facility.

Amendment adopted.

The following amendment was proposed by Senator Stone:

Amendment No. 529.

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

AN ACT relating to health care; clarifying that a pharmacy benefit manager is subject to certain provisions of law governing an insurer for which the pharmacy benefit manager manages prescription drug coverage; expanding required insurance coverage of contraception; revising requirements governing the dispensing of a drug used for contraception; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law imposes certain duties on a pharmacy benefit manager. (NRS 683A.178) Section 1 of this bill clarifies that a pharmacy benefit manager that manages prescription drug benefits for an insurer is required to comply with the same provisions of the Nevada Insurance Code as are applicable to the insurer.

Existing law authorizes the Department of Health and Human Services to enter into a contract with a pharmacy benefit manager or a health maintenance organization to manage, direct and coordinate all payments and rebates for prescription drugs and all other services and payments relating to the provision of prescription drugs under the State Plan for Medicaid and the Children's Health Insurance Program. (NRS 422.4053) Section 14 of this bill requires such a contract to require the pharmacy benefit manager or health maintenance organization to comply with certain provisions of law regarding the provision of prescription drugs under the State Plan for Medicaid and the Children's Health Insurance Program.

Existing law requires public and private policies of insurance regulated under Nevada law to include coverage for up to a 12-month supply of contraceptive drugs. (NRS 287.010, 287.04335, 422.27172, 689A.0418,

689B.0378, 689C.1676, 695A.1865, 695B.1919, 695C.1696, 695G.1715) Sections 3 and 6-13 of this bill prohibit an insurer from requiring an insured to obtain prior authorization before receiving a contraceptive drug. Sections 6-13 also require an insurer to: (1) cover certain contraceptive services when provided by a pharmacist ~~[,]~~ 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 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 ~~[insured is entitled to reimbursement]~~ 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* ~~*[insured is entitled to reimbursement]*~~ *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. ~~*[An insured is entitled to reimbursement]*~~ *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. ~~*[An insured is entitled to reimbursement]*~~ *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 ~~[insured is entitled to reimbursement]~~ 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. ~~*[An enrollee is entitled to reimbursement]*~~ *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. ~~*[An insured is entitled to reimbursement]*~~ *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. 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 becomes effective upon passage and approval.

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

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

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

Senator Stone moved the adoption of the amendment.

Remarks by Senator Stone.

Amendment No. 529 to Senate Bill No. 352 requires an insurer to cover certain contraceptive services when provided by a pharmacist to the same extent as if the first services were provided by another provider of healthcare.

Amendment adopted.

Bill read third time.

Remarks by Senator Stone.

Senate Bill No. 352 makes various changes relating to the dispensing of prescription drugs. Specifically, the bill clarifies that a pharmacy benefit manager (PBM) who manages prescription drug benefits for an insurer must comply with the same provisions of the Nevada Insurance Code as the insurer, provides that insurers may only charge an insured a copayment or coinsurance for a contraceptive drug once for the entire amount of the drug dispensed for the plan year or once for each one-month supply of the drug, requires health policy insurers to demonstrate their capacity to adequately deliver family planning services provided by pharmacists and to notify insureds of participating pharmacists and pharmacies in the relevant network plan, requires insurers to provide certain coverage for contraceptive services provided by pharmacists to the same extent as if the services were provided by another provider of health care and to reimburse a pharmacist for providing such services at a rate that is not less than the rate provided to certain health care providers who provide similar services, requires a pharmacist to dispense a certain number of months' supply of a contraceptive drug up to a 12-month supply or another amount that covers the remainder of the plan year under certain circumstances and authorizes certain persons and entities who are authorized to dispense controlled substances and dangerous drugs to acquire controlled substances and dangerous drugs directly from an outsourcing facility.

Finally, the bill requires a contract entered by the Department of Health and Human Services with a PBM or health maintenance organization (HMO) concerning prescription drugs to require the PBM or HMO to comply with the provisions of law regarding prescription drug provisions under the State Plan for Medicaid and the Children's Health Insurance Program. This requirement does not apply to a contract entered before January 1, 2024.

Roll call on Senate Bill No. 352:

YEAS—21.

NAYS—None.

Senate Bill No. 352 having received a constitutional majority, Mr. President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

Senator Cannizzaro moved that the Senate adjourn until Wednesday, April 26, 2023, at 11:00 a.m.

Motion carried.

Senate adjourned at 9:39 p.m.

Approved: STAVROS ANTHONY
President of the Senate

Attest: BRENDAN BUCY
Secretary of the Senate