
ASSEMBLY BILL NO. 383—ASSEMBLYMEN TORRES, PETERS, GORELOW, GONZÁLES; ANDERSON, BILBRAY-AXELROD, BROWN-MAY, CONSIDINE, D’SILVA, DURAN, JAUREGUI, C.H. MILLER, NEWBY, SUMMERS-ARMSTRONG, THOMAS AND WATTS

MARCH 22, 2023

JOINT SPONSORS: SENATOR D. HARRIS

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to health care. (BDR 40-116)

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

CONTAINS UNFUNDED MANDATE (§ 14 & NRS 287.010)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

AN ACT relating to health care; prohibiting a governmental entity from substantially burdening certain activity relating to contraception under certain circumstances; authorizing a person whose engagement in such activity has been so burdened to assert the violation as a claim or defense in a judicial proceeding; authorizing a court to award damages against a governmental entity that substantially burdens such activity in certain circumstances; expanding required insurance coverage of contraception; and providing other matters properly relating thereto.

Legislative Counsel’s Digest:

1 Existing law prescribes certain rights for a patient of a medical facility or a
2 facility for the dependent. (NRS 449A.100-449A.124) **Sections 2-7** of this bill
3 establish the Right to Contraception Act. **Sections 4 and 5** of this bill define certain
4 terms for purposes of the Act. **Section 6** of this bill applies the provisions of the Act
5 to all state and local laws and ordinances and the implementation of those laws and
6 ordinances, regardless of when those laws or ordinances were enacted. **Section 7** of



7 this bill generally prohibits a governmental entity from enacting or implementing
8 any limitation or requirement that singles out contraception and substantially
9 burdens: (1) the access of a person to contraceptives, contraception or information
10 related to contraception; or (2) the ability of a provider of health care to provide
11 contraceptives, contraception or information related to contraception within his or
12 her scope of practice, training and experience. **Section 7** creates an exception to
13 such prohibitions if the governmental entity demonstrates by clear and convincing
14 evidence that the burden, as applied to the person or provider of health care who is
15 subject to the burden: (1) furthers a compelling interest; and (2) is the least
16 restrictive means of furthering that interest. **Section 7** authorizes a person whose
17 ability to obtain or provide contraceptives, contraception or information related to
18 contraception is burdened to bring or defend an action in court and obtain
19 appropriate relief. **Section 7** requires a court to award costs and attorney's fees to a
20 person who prevails on such a claim.

21 Existing law requires public and private policies of insurance regulated under
22 Nevada law to include coverage for certain contraceptive drugs and devices,
23 including: (1) up to a 12-month supply of contraceptive drugs; (2) certain devices
24 for contraception; and (3) voluntary sterilization for women. (NRS 287.010,
25 287.04335, 422.27172, 689A.0418, 689B.0378, 689C.1676, 695A.1865,
26 695B.1919, 695C.1696, 695G.1715) **Sections 8 and 13-19** of this bill additionally
27 require such policies of insurance to cover: (1) voluntary sterilization for men; (2)
28 clinical services relating to covered contraceptive drugs, devices and services; and
29 (3) a portion of the cost of language translation services provided to facilitate the
30 provision of covered contraceptive drugs, devices and services. **Sections 8, 10 and**
31 **13-19** of this bill prohibit an insurer from requiring an insured to obtain prior
32 authorization before receiving a contraceptive drug. **Sections 8 and 13-19** also
33 require an insurer to: (1) cover certain contraceptive services when provided by a
34 pharmacist; and (2) reimburse a pharmacist for providing such services at a rate that
35 is not less than the rate provided to a physician, physician assistant or advanced
36 practice registered nurse. **Section 9** of this bill requires an insurer to demonstrate
37 the capacity to adequately deliver family planning services provided by pharmacists
38 to covered persons. **Sections 11 and 12** of this bill make conforming changes to
39 indicate the proper placement of **section 9** in the Nevada Revised Statutes.

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

1 **Section 1.** Chapter 449A of NRS is hereby amended by
2 adding thereto the provisions set forth as sections 2 to 7, inclusive,
3 of this act.

4 **Sec. 2.** *Sections 2 to 7, inclusive, of this act may be cited as*
5 *the Right to Contraception Act.*

6 **Sec. 3.** *As used in sections 2 to 7, inclusive, of this act, unless*
7 *the context otherwise requires, the words and terms defined in*
8 *sections 4 and 5 of this act have the meanings ascribed to them in*
9 *those sections.*

10 **Sec. 4.** *“Governmental entity” means the State of Nevada or*
11 *any of its agencies or political subdivisions.*

12 **Sec. 5.** *“Provider of health care” has the meaning ascribed*
13 *to it in NRS 629.031.*



1 **Sec. 6. 1.** *The provisions of sections 2 to 7, inclusive, of this*
2 *act apply to all state and local laws and ordinances and the*
3 *implementation of those laws and ordinances, whether statutory or*
4 *otherwise, and whether enacted before, on or after January 1,*
5 *2024.*

6 **2.** *State laws that are enacted on or after January 1, 2024, are*
7 *subject to the provisions of sections 2 to 7, inclusive, of this act*
8 *unless the law explicitly excludes such application by reference to*
9 *this section.*

10 **3.** *The provisions of sections 2 to 7, inclusive, of this act do*
11 *not:*

12 **(a)** *Authorize a governmental entity to burden:*

13 **(1)** *The access of any person to contraceptive services,*
14 *information related to contraception or any contraceptive drug or*
15 *device; or*

16 **(2)** *The ability of a provider of health care to provide*
17 *contraceptive services or information related to contraception or to*
18 *provide, administer, dispense or prescribe any contraceptive drug*
19 *or device within the scope of practice, training and experience of*
20 *the provider of health care.*

21 **(b)** *Authorize or sanction any sterilization procedure without*
22 *the voluntary and informed consent of the patient.*

23 **Sec. 7. 1.** *Except as otherwise provided in this section, a*
24 *governmental entity shall not enact or implement any limitation or*
25 *requirement that:*

26 **(a)** *Expressly, effectively, implicitly or, as implemented, singles*
27 *out contraceptives, contraception or information related to*
28 *contraception or any providers of health care or facilities that*
29 *provide contraceptives, contraception or information related to*
30 *contraception; and*

31 **(b)** *Substantially burdens:*

32 **(1)** *The access of a person to contraceptives, contraception*
33 *or information related to contraception; or*

34 **(2)** *The ability of a provider of health care to provide*
35 *contraceptives, contraception or information related to*
36 *contraception within the scope of practice, training and*
37 *experience of the provider of health care.*

38 **2.** *A governmental entity may enact a requirement or*
39 *limitation described in subsection 1 if the governmental entity*
40 *demonstrates by clear and convincing evidence that the burden*
41 *imposed by the requirement or limitation on the activity described*
42 *in paragraph (b) of subsection 1, as applied to the person or*
43 *provider of health care who is subject to the burden:*

44 **(a)** *Further a compelling interest; and*

45 **(b)** *Is the least restrictive means of furthering that interest.*



1 **3. Notwithstanding any provision of NRS 41.0305 to 41.039,**
2 **inclusive, but subject to the limitation on damages set forth in**
3 **NRS 41.035 when applicable, a person or provider of health care**
4 **who has been substantially burdened in violation of this section**
5 **may assert that violation as a claim or defense in a judicial**
6 **proceeding and obtain appropriate relief. A court shall award**
7 **costs and attorney's fees to a person who prevails on such a claim**
8 **or defense pursuant to this section.**

9 **4. A court may find that a person is a vexatious litigant if the**
10 **person makes a claim within the scope of sections 2 to 7, inclusive,**
11 **of this act which is without merit, fraudulent or otherwise**
12 **intended to harass or annoy a person. If a court finds that a**
13 **person is a vexatious litigant pursuant to this subsection, the court**
14 **may deny standing to that person to bring further claims which**
15 **allege a violation of this section.**

16 **Sec. 8.** NRS 422.27172 is hereby amended to read as follows:

17 422.27172 1. The Director shall include in the State Plan for
18 Medicaid a requirement that the State pay the nonfederal share of
19 expenditures incurred for:

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

- 22 (1) Lawfully prescribed or ordered;
23 (2) Approved by the Food and Drug Administration; and
24 (3) Dispensed in accordance with NRS 639.28075;

25 (b) Any type of device for contraception which is lawfully
26 prescribed or ordered and which has been approved by the Food and
27 Drug Administration;

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

30 (d) Insertion or removal of a device for contraception;

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

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

35 (g) Voluntary sterilization ~~for women.~~; and

36 **(h) Any clinical services relating to the drugs, devices and**
37 **services described in paragraphs (a) to (g), inclusive. Such clinical**
38 **services, include, without limitation, services to monitor the use**
39 **and effectiveness of contraception.**

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

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

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



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

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

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

17 6. *The Plan must provide for the reimbursement of a*
18 *pharmacist for providing services described in subsection 1 that*
19 *are within the scope of practice of the pharmacist. The Plan must*
20 *not limit:*

21 (a) *Coverage for such services provided by a pharmacist to a*
22 *number of occasions less than the coverage for such services when*
23 *provided by another provider of health care.*

24 (b) *Reimbursement for such services provided by a pharmacist*
25 *to an amount less than the amount reimbursed for similar services*
26 *provided by a physician, physician assistant or advanced practice*
27 *registered nurse.*

28 7. *The Director shall include in the State Plan for Medicaid a*
29 *requirement that the State pay the nonfederal share of*
30 *expenditures incurred for:*

31 (a) *One-quarter of the costs of any language translation*
32 *services provided to facilitate the provision of any drug, device or*
33 *service described in subsection 1 to a recipient of Medicaid who is*
34 *eligible for the Children's Health Insurance Program; and*

35 (b) *One-half of the costs of any language translation services*
36 *provided to facilitate the provision of any drug, device or service*
37 *described in subsection 1 to a recipient of Medicaid who is not*
38 *eligible for the Children's Health Insurance Program.*

39 8. *The Plan must not require a recipient of Medicaid to*
40 *obtain prior authorization for the benefits described in paragraphs*
41 *(a) and (c) of subsection 1.*

42 9. As used in this section:

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

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



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

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

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

9 **Sec. 9.** Chapter 687B of NRS is hereby amended by adding
10 thereto a new section to read as follows:

11 *1. A health carrier which offers or issues a network plan
12 must demonstrate the capacity to adequately deliver family
13 planning services provided by pharmacists to covered persons in
14 accordance with the regulations adopted pursuant to subsection 2.*

15 *2. The Commissioner shall adopt regulations to carry out the
16 provisions of this section, including, without limitation,
17 regulations prescribing requirements for a health carrier to
18 demonstrate compliance with subsection 1. Those regulations
19 must not allow a health carrier to demonstrate the capacity to
20 adequately deliver family planning services to covered persons by
21 demonstrating that the health carrier has entered into a network
22 contract with one or more pharmacies for the sole purpose of
23 dispensing prescription drugs to covered persons.*

24 **Sec. 10.** NRS 687B.225 is hereby amended to read as follows:

25 687B.225 1. Except as otherwise provided in NRS
26 689A.0405, 689A.0412, 689A.0413, **689A.0418**, 689A.044,
27 689A.0445, 689B.031, 689B.0313, 689B.0315, 689B.0317,
28 689B.0374, **689B.0378**, 689C.1675, **689C.1676**, 695A.1856,
29 **695A.1865**, 695B.1912, 695B.1913, 695B.1914, **695B.1919**,
30 695B.1925, 695B.1942, **695C.1696**, 695C.1713, 695C.1735,
31 695C.1737, 695C.1745, 695C.1751, 695G.170, 695G.171,
32 695G.1714 , **695G.1715** and 695G.177, any contract for group,
33 blanket or individual health insurance or any contract by a nonprofit
34 hospital, medical or dental service corporation or organization for
35 dental care which provides for payment of a certain part of medical
36 or dental care may require the insured or member to obtain prior
37 authorization for that care from the insurer or organization. The
38 insurer or organization shall:

39 (a) File its procedure for obtaining approval of care pursuant to
40 this section for approval by the Commissioner; and

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

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



1 **Sec. 11.** NRS 687B.600 is hereby amended to read as follows:
2 687B.600 As used in NRS 687B.600 to 687B.850, inclusive,
3 *and section 9 of this act*, unless the context otherwise requires, the
4 words and terms defined in NRS 687B.602 to 687B.665, inclusive,
5 have the meanings ascribed to them in those sections.

6 **Sec. 12.** NRS 687B.670 is hereby amended to read as follows:
7 687B.670 If a health carrier offers or issues a network plan, the
8 health carrier shall, with regard to that network plan:

9 1. Comply with all applicable requirements set forth in NRS
10 687B.600 to 687B.850, inclusive ~~7~~, *and section 9 of this act*;

11 2. As applicable, ensure that each contract entered into for the
12 purposes of the network plan between a participating provider of
13 health care and the health carrier complies with the requirements set
14 forth in NRS 687B.600 to 687B.850, inclusive ~~7~~, *and section 9 of*
15 *this act*; and

16 3. As applicable, ensure that the network plan complies with
17 the requirements set forth in NRS 687B.600 to 687B.850, inclusive
18 ~~7~~, *and section 9 of this act*.

19 **Sec. 13.** NRS 689A.0418 is hereby amended to read as
20 follows:

21 689A.0418 1. Except as otherwise provided in subsection ~~7~~,
22 8, an insurer that offers or issues a policy of health insurance shall
23 include in the policy coverage for:

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

- 26 (1) Lawfully prescribed or ordered;
27 (2) Approved by the Food and Drug Administration;
28 (3) Listed in subsection ~~10~~ 11; and
29 (4) Dispensed in accordance with NRS 639.28075;

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

- 31 (1) Lawfully prescribed or ordered;
32 (2) Approved by the Food and Drug Administration; and
33 (3) Listed in subsection ~~10~~ 11;

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

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

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

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

43 (g) Voluntary sterilization ~~for women~~;

44

(h) Any clinical service relating to the drugs, devices and

45 *services described in paragraphs (a) to (g), inclusive, including,*



1 *without limitation, services to monitor the use and effectiveness of*
2 *such drugs, devices and services; and*

3 *(i) One-quarter of the costs of any language translation*
4 *services provided to facilitate the provision of any item or service*
5 *described in paragraphs (a) to (h), inclusive.*

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

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

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

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

22 ~~[3.]~~ 4. If a covered therapeutic equivalent listed in subsection 1
23 is not available or a provider of health care deems a covered
24 therapeutic equivalent to be medically inappropriate, an alternate
25 therapeutic equivalent prescribed by a provider of health care must
26 be covered by the insurer.

27 ~~[4.]~~ 5. Except as otherwise provided in subsections ~~[8.]~~ 9, 10
28 and ~~[11.]~~ 12, an insurer that offers or issues a policy of health
29 insurance shall not:

30 (a) Require an insured to pay a higher deductible, any
31 copayment or coinsurance or require a longer waiting period or
32 other condition for coverage to obtain any benefit included in the
33 policy pursuant to subsection 1;

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

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

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

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



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

3 ~~{5.}~~ 6. Coverage pursuant to this section for the covered
4 dependent of an insured must be the same as for the insured.

5 ~~{6.}~~ 7. Except as otherwise provided in subsection ~~{7.}~~ 8, a
6 policy subject to the provisions of this chapter that is delivered,
7 issued for delivery or renewed on or after January 1, ~~{2022.}~~ 2024,
8 has the legal effect of including the coverage required by subsection
9 1, and any provision of the policy or the renewal which is in conflict
10 with this section is void.

11 ~~{7.}~~ 8. An insurer that offers or issues a policy of health
12 insurance and which is affiliated with a religious organization is not
13 required to provide the coverage required by subsection 1 if the
14 insurer objects on religious grounds. Such an insurer shall, before
15 the issuance of a policy of health insurance and before the renewal
16 of such a policy, provide to the prospective insured written notice of
17 the coverage that the insurer refuses to provide pursuant to this
18 subsection.

19 ~~{8.}~~ 9. An insurer may require an insured to pay a higher
20 deductible, copayment or coinsurance for a drug for contraception if
21 the insured refuses to accept a therapeutic equivalent of the drug.

22 ~~{9.}~~ 10. For each of the 18 methods of contraception listed in
23 subsection ~~{10.}~~ 11 that have been approved by the Food and Drug
24 Administration, a policy of health insurance must include at least
25 one drug or device for contraception within each method for which
26 no deductible, copayment or coinsurance may be charged to the
27 insured, but the insurer may charge a deductible, copayment or
28 coinsurance for any other drug or device that provides the same
29 method of contraception.

30 ~~{10.}~~ 11. The following 18 methods of contraception must be
31 covered pursuant to this section:

- 32 (a) Voluntary sterilization ; ~~{for women.}~~
- 33 (b) Surgical sterilization implants for women;
- 34 (c) Implantable rods;
- 35 (d) Copper-based intrauterine devices;
- 36 (e) Progesterone-based intrauterine devices;
- 37 (f) Injections;
- 38 (g) Combined estrogen- and progestin-based drugs;
- 39 (h) Progestin-based drugs;
- 40 (i) Extended- or continuous-regimen drugs;
- 41 (j) Estrogen- and progestin-based patches;
- 42 (k) Vaginal contraceptive rings;
- 43 (l) Diaphragms with spermicide;
- 44 (m) Sponges with spermicide;
- 45 (n) Cervical caps with spermicide;



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

7 ~~§11.1~~ **12.** Except as otherwise provided in this section and
8 federal law, an insurer may use medical management techniques,
9 including, without limitation, any available clinical evidence, to
10 determine the frequency of or treatment relating to any benefit
11 required by this section or the type of provider of health care to use
12 for such treatment.

13 ~~§12.1~~ **13.** An insurer shall not ~~use~~:

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

17 ~~—13.1~~ ; or

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

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

26 ~~§14.1~~ **15.** As used in this section:

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

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

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

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

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



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

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

6 **Sec. 14.** NRS 689B.0378 is hereby amended to read as
7 follows:

8 689B.0378 1. Except as otherwise provided in subsection ~~[7.]~~
9 **8**, an insurer that offers or issues a policy of group health insurance
10 shall include in the policy coverage for:

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

- 13 (1) Lawfully prescribed or ordered;
14 (2) Approved by the Food and Drug Administration;
15 (3) Listed in subsection ~~[11.]~~ **12**; and
16 (4) Dispensed in accordance with NRS 639.28075;

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

- 18 (1) Lawfully prescribed or ordered;
19 (2) Approved by the Food and Drug Administration; and
20 (3) Listed in subsection ~~[11.]~~ **12**;

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

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

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

29 (f) Management of side effects relating to contraception; ~~[and]~~

30 (g) Voluntary sterilization ~~[for women.]~~ ;

31 *(h) Any clinical service relating to the drugs, devices and*
32 *services described in paragraphs (a) to (g), inclusive, including,*
33 *without limitation, services to monitor the use and effectiveness of*
34 *such drugs, devices and services; and*

35 *(i) One-quarter of the costs of any language translation*
36 *services provided to facilitate the provision of any item or service*
37 *described in paragraphs (a) to (h), inclusive.*

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

43 *(a) Coverage for services listed in subsection 1 and provided by*
44 *such a pharmacist to a number of occasions less than the coverage*



1 *for such services when provided by another provider of health*
2 *care.*

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

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

10 ~~{3.}~~ 4. If a covered therapeutic equivalent listed in subsection 1
11 is not available or a provider of health care deems a covered
12 therapeutic equivalent to be medically inappropriate, an alternate
13 therapeutic equivalent prescribed by a provider of health care must
14 be covered by the insurer.

15 ~~{4.}~~ 5. Except as otherwise provided in subsections ~~{9.}~~ 10, 11
16 and ~~{12.}~~ 13, an insurer that offers or issues a policy of group health
17 insurance shall not:

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

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

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

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

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

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

36 ~~{5.}~~ 6. Coverage pursuant to this section for the covered
37 dependent of an insured must be the same as for the insured.

38 ~~{6.}~~ 7. Except as otherwise provided in subsection ~~{7.}~~ 8, a
39 policy subject to the provisions of this chapter that is delivered,
40 issued for delivery or renewed on or after January 1, ~~{2022.}~~ 2024,
41 has the legal effect of including the coverage required by subsection
42 1, and any provision of the policy or the renewal which is in conflict
43 with this section is void.

44 ~~{7.}~~ 8. An insurer that offers or issues a policy of group health
45 insurance and which is affiliated with a religious organization is not



1 required to provide the coverage required by subsection 1 if the
2 insurer objects on religious grounds. Such an insurer shall, before
3 the issuance of a policy of group health insurance and before the
4 renewal of such a policy, provide to the group policyholder or
5 prospective insured, as applicable, written notice of the coverage
6 that the insurer refuses to provide pursuant to this subsection.

7 ~~[8.]~~ 9. If an insurer refuses, pursuant to subsection ~~[7.]~~ 8, to
8 provide the coverage required by subsection 1, an employer may
9 otherwise provide for the coverage for the employees of the
10 employer.

11 ~~[9.]~~ 10. An insurer may require an insured to pay a higher
12 deductible, copayment or coinsurance for a drug for contraception if
13 the insured refuses to accept a therapeutic equivalent of the drug.

14 ~~[10.]~~ 11. For each of the 18 methods of contraception listed in
15 subsection ~~[11.]~~ 12 that have been approved by the Food and Drug
16 Administration, a policy of group health insurance must include at
17 least one drug or device for contraception within each method for
18 which no deductible, copayment or coinsurance may be charged to
19 the insured, but the insurer may charge a deductible, copayment or
20 coinsurance for any other drug or device that provides the same
21 method of contraception.

22 ~~[11.]~~ 12. The following 18 methods of contraception must be
23 covered pursuant to this section:

- 24 (a) Voluntary sterilization ; ~~[for women:]~~
- 25 (b) Surgical sterilization implants for women;
- 26 (c) Implantable rods;
- 27 (d) Copper-based intrauterine devices;
- 28 (e) Progesterone-based intrauterine devices;
- 29 (f) Injections;
- 30 (g) Combined estrogen- and progestin-based drugs;
- 31 (h) Progestin-based drugs;
- 32 (i) Extended- or continuous-regimen drugs;
- 33 (j) Estrogen- and progestin-based patches;
- 34 (k) Vaginal contraceptive rings;
- 35 (l) Diaphragms with spermicide;
- 36 (m) Sponges with spermicide;
- 37 (n) Cervical caps with spermicide;
- 38 (o) Female condoms;
- 39 (p) Spermicide;
- 40 (q) Combined estrogen- and progestin-based drugs for
41 emergency contraception or progestin-based drugs for emergency
42 contraception; and
- 43 (r) Ulipristal acetate for emergency contraception.

44 ~~[12.]~~ 13. Except as otherwise provided in this section and
45 federal law, an insurer may use medical management techniques,



1 including, without limitation, any available clinical evidence, to
2 determine the frequency of or treatment relating to any benefit
3 required by this section or the type of provider of health care to use
4 for such treatment.

5 ~~13.1~~ 14. An insurer shall not ~~use~~ :

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

9 ~~14.1~~ ; or

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

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

18 ~~15.1~~ 16. As used in this section:

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

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

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

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

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

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

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

41 **Sec. 15.** NRS 689C.1676 is hereby amended to read as
42 follows:

43 689C.1676 1. Except as otherwise provided in subsection ~~7.1~~
44 8, a carrier that offers or issues a health benefit plan shall include in
45 the plan coverage for:



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

- 3 (1) Lawfully prescribed or ordered;
4 (2) Approved by the Food and Drug Administration;
5 (3) Listed in subsection ~~10;~~ **11**; and
6 (4) Dispensed in accordance with NRS 639.28075;

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

- 8 (1) Lawfully prescribed or ordered;
9 (2) Approved by the Food and Drug Administration; and
10 (3) Listed in subsection ~~10;~~ **11**;

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

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

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

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

20 (g) Voluntary sterilization ~~for women~~;

21 *(h) Any clinical service relating to the drugs, devices and*
22 *services described in paragraphs (a) to (g), inclusive, including,*
23 *without limitation, services to monitor the use and effectiveness of*
24 *such drugs, devices and services; and*

25 *(i) One-quarter of the costs of any language translation*
26 *services provided to facilitate the provision of any item or service*
27 *described in paragraphs (a) to (h), inclusive.*

28 *2. An insured is entitled to reimbursement for services listed*
29 *in subsection 1 which are within the authorized scope of practice*
30 *of a pharmacist when such services are provided by a pharmacist*
31 *who participates in the network plan of the carrier. The terms of*
32 *the health benefit plan must not limit:*

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

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

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

44 ~~3.~~ **4.** If a covered therapeutic equivalent listed in subsection 1
45 is not available or a provider of health care deems a covered



1 therapeutic equivalent to be medically inappropriate, an alternate
2 therapeutic equivalent prescribed by a provider of health care must
3 be covered by the carrier.

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

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

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

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

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

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

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

25 ~~[5.]~~ **6.** Coverage pursuant to this section for the covered
26 dependent of an insured must be the same as for the insured.

27 ~~[6.]~~ **7.** Except as otherwise provided in subsection ~~[7.]~~ **8**, a
28 health benefit plan subject to the provisions of this chapter that is
29 delivered, issued for delivery or renewed on or after January 1,
30 ~~[2022.]~~ **2024**, has the legal effect of including the coverage required
31 by subsection 1, and any provision of the plan or the renewal which
32 is in conflict with this section is void.

33 ~~[7.]~~ **8.** A carrier that offers or issues a health benefit plan and
34 which is affiliated with a religious organization is not required to
35 provide the coverage required by subsection 1 if the carrier objects
36 on religious grounds. Such a carrier shall, before the issuance of a
37 health benefit plan and before the renewal of such a plan, provide to
38 the prospective insured written notice of the coverage that the
39 carrier refuses to provide pursuant to this subsection.

40 ~~[8.]~~ **9.** A carrier may require an insured to pay a higher
41 deductible, copayment or coinsurance for a drug for contraception if
42 the insured refuses to accept a therapeutic equivalent of the drug.

43 ~~[9.]~~ **10.** For each of the 18 methods of contraception listed in
44 subsection ~~[10.]~~ **11** that have been approved by the Food and Drug
45 Administration, a health benefit plan must include at least one drug



1 or device for contraception within each method for which no
2 deductible, copayment or coinsurance may be charged to the
3 insured, but the carrier may charge a deductible, copayment or
4 coinsurance for any other drug or device that provides the same
5 method of contraception.

6 ~~10.~~ **11.** The following 18 methods of contraception must be
7 covered pursuant to this section:

- 8 (a) Voluntary sterilization ; ~~for women;~~
- 9 (b) Surgical sterilization implants for women;
- 10 (c) Implantable rods;
- 11 (d) Copper-based intrauterine devices;
- 12 (e) Progesterone-based intrauterine devices;
- 13 (f) Injections;
- 14 (g) Combined estrogen- and progestin-based drugs;
- 15 (h) Progestin-based drugs;
- 16 (i) Extended- or continuous-regimen drugs;
- 17 (j) Estrogen- and progestin-based patches;
- 18 (k) Vaginal contraceptive rings;
- 19 (l) Diaphragms with spermicide;
- 20 (m) Sponges with spermicide;
- 21 (n) Cervical caps with spermicide;
- 22 (o) Female condoms;
- 23 (p) Spermicide;
- 24 (q) Combined estrogen- and progestin-based drugs for
25 emergency contraception or progestin-based drugs for emergency
26 contraception; and
- 27 (r) Ulipristal acetate for emergency contraception.

28 ~~11.~~ **12.** Except as otherwise provided in this section and
29 federal law, a carrier may use medical management techniques,
30 including, without limitation, any available clinical evidence, to
31 determine the frequency of or treatment relating to any benefit
32 required by this section or the type of provider of health care to use
33 for such treatment.

34 ~~12.~~ **13.** A carrier shall not ~~use~~ :

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

38 ~~13.~~ ; or

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

41 **14.** A carrier must provide an accessible, transparent and
42 expedited process which is not unduly burdensome by which an
43 insured, or the authorized representative of the insured, may request
44 an exception relating to any medical management technique used by



1 the carrier to obtain any benefit required by this section without a
2 higher deductible, copayment or coinsurance.

3 ~~14;~~ 15. As used in this section:

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

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

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

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

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

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

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

26 **Sec. 16.** NRS 695A.1865 is hereby amended to read as
27 follows:

28 695A.1865 1. Except as otherwise provided in subsection ~~7;~~
29 **8**, a society that offers or issues a benefit contract which provides
30 coverage for prescription drugs or devices shall include in the
31 contract coverage for:

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

34 (1) Lawfully prescribed or ordered;

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

36 (3) Listed in subsection ~~10;~~ **11**; and

37 (4) Dispensed in accordance with NRS 639.28075;

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

39 (1) Lawfully prescribed or ordered;

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

41 (3) Listed in subsection ~~10;~~ **11**;

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



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

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

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

8 (g) Voluntary sterilization ~~for women~~;

9 *(h) Any clinical service relating to the drugs, devices and
10 services described in paragraphs (a) to (g), inclusive, including,
11 without limitation, services to monitor the use and effectiveness of
12 such drugs, devices and services; and*

13 *(i) One-quarter of the costs of any language translation
14 services provided to facilitate the provision of any item or service
15 described in paragraphs (a) to (h), inclusive.*

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

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

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

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

32 ~~3.~~ 4. If a covered therapeutic equivalent listed in subsection 1
33 is not available or a provider of health care deems a covered
34 therapeutic equivalent to be medically inappropriate, an alternate
35 therapeutic equivalent prescribed by a provider of health care must
36 be covered by the society.

37 ~~4.~~ 5. Except as otherwise provided in subsections ~~8.~~ 9, 10
38 and ~~11.~~ 12, a society that offers or issues a benefit contract shall
39 not:

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



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

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

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

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

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

15 ~~5.1~~ 6. Coverage pursuant to this section for the covered
16 dependent of an insured must be the same as for the insured.

17 ~~6.1~~ 7. Except as otherwise provided in subsection ~~7.1~~ 8, a
18 benefit contract subject to the provisions of this chapter that is
19 delivered, issued for delivery or renewed on or after January 1,
20 ~~2022,~~ 2024, has the legal effect of including the coverage required
21 by subsection 1, and any provision of the contract or the renewal
22 which is in conflict with this section is void.

23 ~~7.1~~ 8. A society that offers or issues a benefit contract and
24 which is affiliated with a religious organization is not required to
25 provide the coverage required by subsection 1 if the society objects
26 on religious grounds. Such a society shall, before the issuance of a
27 benefit contract and before the renewal of such a contract, provide
28 to the prospective insured written notice of the coverage that the
29 society refuses to provide pursuant to this subsection.

30 ~~8.1~~ 9. A society may require an insured to pay a higher
31 deductible, copayment or coinsurance for a drug for contraception if
32 the insured refuses to accept a therapeutic equivalent of the drug.

33 ~~9.1~~ 10. For each of the 18 methods of contraception listed in
34 subsection ~~10.1~~ 11 that have been approved by the Food and Drug
35 Administration, a benefit contract must include at least one drug or
36 device for contraception within each method for which no
37 deductible, copayment or coinsurance may be charged to the
38 insured, but the society may charge a deductible, copayment or
39 coinsurance for any other drug or device that provides the same
40 method of contraception.

41 ~~10.1~~ 11. The following 18 methods of contraception must be
42 covered pursuant to this section:

43 (a) Voluntary sterilization ; ~~for women;~~

44 (b) Surgical sterilization implants for women;

45 (c) Implantable rods;



- 1 (d) Copper-based intrauterine devices;
- 2 (e) Progesterone-based intrauterine devices;
- 3 (f) Injections;
- 4 (g) Combined estrogen- and progestin-based drugs;
- 5 (h) Progesterin-based drugs;
- 6 (i) Extended- or continuous-regimen drugs;
- 7 (j) Estrogen- and progestin-based patches;
- 8 (k) Vaginal contraceptive rings;
- 9 (l) Diaphragms with spermicide;
- 10 (m) Sponges with spermicide;
- 11 (n) Cervical caps with spermicide;
- 12 (o) Female condoms;
- 13 (p) Spermicide;
- 14 (q) Combined estrogen- and progestin-based drugs for
- 15 emergency contraception or progestin-based drugs for emergency
- 16 contraception; and
- 17 (r) Ulipristal acetate for emergency contraception.

18 ~~11.1~~ 12. Except as otherwise provided in this section and
19 federal law, a society may use medical management techniques,
20 including, without limitation, any available clinical evidence, to
21 determine the frequency of or treatment relating to any benefit
22 required by this section or the type of provider of health care to use
23 for such treatment.

24 ~~12.1~~ 13. A society shall not ~~use~~ :

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

28 ~~—13.1~~ ; or

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

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

37 ~~14.1~~ 15. As used in this section:

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

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



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

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

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

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

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

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

15 **Sec. 17.** NRS 695B.1919 is hereby amended to read as
16 follows:

17 695B.1919 1. Except as otherwise provided in subsection ~~7~~,
18 8, an insurer that offers or issues a contract for hospital or medical
19 service shall include in the contract coverage for:

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

22 (1) Lawfully prescribed or ordered;

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

24 (3) Listed in subsection ~~11~~ 12; and

25 (4) Dispensed in accordance with NRS 639.28075;

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

27 (1) Lawfully prescribed or ordered;

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

29 (3) Listed in subsection ~~11~~ 12;

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

32 (d) Insertion of a device for contraception or removal of such a
33 device if the device was inserted while the insured was covered by
34 the same contract for hospital or medical service;

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

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

39 (g) Voluntary sterilization ~~for women~~;

40 (h) *Any clinical service relating to the drugs, devices and*
41 *services described in paragraphs (a) to (g), inclusive, including,*
42 *without limitation, services to monitor the use and effectiveness of*
43 *such drugs, devices and services; and*



1 *(i) One-quarter of the costs of any language translation*
2 *services provided to facilitate the provision of any item or service*
3 *described in paragraphs (a) to (h), inclusive.*

4 2. *An insured is entitled to reimbursement for services listed*
5 *in subsection 1 which are within the authorized scope of practice*
6 *of a pharmacist when such services are provided by a pharmacist*
7 *who participates in the network plan of the hospital or medical*
8 *services corporation. The terms of the policy must not limit:*

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

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

17 3. An insurer that offers or issues a contract for hospital or
18 medical services must ensure that the benefits required by
19 subsection 1 are made available to an insured through a provider of
20 health care who participates in the network plan of the insurer.

21 ~~[3.]~~ 4. If a covered therapeutic equivalent listed in subsection 1
22 is not available or a provider of health care deems a covered
23 therapeutic equivalent to be medically inappropriate, an alternate
24 therapeutic equivalent prescribed by a provider of health care must
25 be covered by the insurer.

26 ~~[4.]~~ 5. Except as otherwise provided in subsections ~~[9.]~~ 10, 11
27 and ~~[12.]~~ 13, an insurer that offers or issues a contract for hospital or
28 medical service shall not:

29 (a) Require an insured to pay a higher deductible, any
30 copayment or coinsurance or require a longer waiting period or
31 other condition to obtain any benefit included in the contract for
32 hospital or medical service pursuant to subsection 1;

33 (b) Refuse to issue a contract for hospital or medical service or
34 cancel a contract for hospital or medical service solely because the
35 person applying for or covered by the contract uses or may use any
36 such benefit;

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

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

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



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

3 ~~§ 6.~~ Coverage pursuant to this section for the covered
4 dependent of an insured must be the same as for the insured.

5 ~~§ 7.~~ Except as otherwise provided in subsection ~~§ 8,~~ a
6 contract for hospital or medical service subject to the provisions of
7 this chapter that is delivered, issued for delivery or renewed on or
8 after January 1, ~~2022,~~ 2024, has the legal effect of including the
9 coverage required by subsection 1, and any provision of the contract
10 or the renewal which is in conflict with this section is void.

11 ~~§ 8.~~ An insurer that offers or issues a contract for hospital or
12 medical service and which is affiliated with a religious organization
13 is not required to provide the coverage required by subsection 1 if
14 the insurer objects on religious grounds. Such an insurer shall,
15 before the issuance of a contract for hospital or medical service and
16 before the renewal of such a contract, provide to the prospective
17 insured written notice of the coverage that the insurer refuses to
18 provide pursuant to this subsection.

19 ~~§ 9.~~ If an insurer refuses, pursuant to subsection ~~§ 8,~~ to
20 provide the coverage required by subsection 1, an employer may
21 otherwise provide for the coverage for the employees of the
22 employer.

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

26 ~~§ 11.~~ For each of the 18 methods of contraception listed in
27 subsection ~~§ 12~~ that have been approved by the Food and Drug
28 Administration, a contract for hospital or medical service must
29 include at least one drug or device for contraception within each
30 method for which no deductible, copayment or coinsurance may be
31 charged to the insured, but the insurer may charge a deductible,
32 copayment or coinsurance for any other drug or device that provides
33 the same method of contraception.

34 ~~§ 12.~~ The following 18 methods of contraception must be
35 covered pursuant to this section:

- 36 (a) Voluntary sterilization ; ~~for women;~~
- 37 (b) Surgical sterilization implants for women;
- 38 (c) Implantable rods;
- 39 (d) Copper-based intrauterine devices;
- 40 (e) Progesterone-based intrauterine devices;
- 41 (f) Injections;
- 42 (g) Combined estrogen- and progestin-based drugs;
- 43 (h) Progestin-based drugs;
- 44 (i) Extended- or continuous-regimen drugs;
- 45 (j) Estrogen- and progestin-based patches;



- 1 (k) Vaginal contraceptive rings;
- 2 (l) Diaphragms with spermicide;
- 3 (m) Sponges with spermicide;
- 4 (n) Cervical caps with spermicide;
- 5 (o) Female condoms;
- 6 (p) Spermicide;
- 7 (q) Combined estrogen- and progestin-based drugs for
- 8 emergency contraception or progestin-based drugs for emergency
- 9 contraception; and
- 10 (r) Ulipristal acetate for emergency contraception.

11 ~~12.1~~ 13. Except as otherwise provided in this section and
12 federal law, an insurer that offers or issues a contract for hospital or
13 medical services may use medical management techniques,
14 including, without limitation, any available clinical evidence, to
15 determine the frequency of or treatment relating to any benefit
16 required by this section or the type of provider of health care to use
17 for such treatment.

18 ~~13.1~~ 14. An insurer shall not ~~use~~ :

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

22 ~~14.1~~ ; or

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

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

31 ~~15.1~~ 16. As used in this section:

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

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

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

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



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

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

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

9 **Sec. 18.** NRS 695C.1696 is hereby amended to read as
10 follows:

11 695C.1696 1. Except as otherwise provided in subsection ~~7;~~
12 **9**, a health maintenance organization that offers or issues a health
13 care plan shall include in the plan coverage for:

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

16 (1) Lawfully prescribed or ordered;

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

18 (3) Listed in subsection ~~11;~~ **13**; and

19 (4) Dispensed in accordance with NRS 639.28075;

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

21 (1) Lawfully prescribed or ordered;

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

23 (3) Listed in subsection ~~11;~~ **13**;

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

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

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

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

33 (g) Voluntary sterilization ~~for women~~;

34 ***(h) Any clinical service relating to the drugs, devices and
35 services described in paragraphs (a) to (g), inclusive, including,
36 without limitation, services to monitor the use and effectiveness of
37 such drugs, devices and services; and***

38 ***(i) Except as otherwise provided in subsection 2, one-quarter
39 of the costs of any language translation services provided to
40 facilitate the provision of any item or service described in
41 paragraphs (a) to (h), inclusive.***

42 ***2. A health maintenance organization that provides health
43 care services through managed care to recipients of Medicaid
44 under the State Plan for Medicaid shall include in a health care
45 plan that covers such services coverage for:***



1 (a) *One-quarter of the costs of any language translation*
2 *services provided to facilitate the provision of any item or service*
3 *described in paragraphs (a) to (h), inclusive, of subsection 1 to a*
4 *recipient of Medicaid who is eligible for the Children's Health*
5 *Insurance Program; and*

6 (b) *One-half of the costs of any language translation services*
7 *provided to facilitate the provision of any item or service described*
8 *in paragraphs (a) to (h), inclusive, of subsection 1 to a recipient of*
9 *Medicaid who is not eligible for the Children's Health Insurance*
10 *Program.*

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

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

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

25 4. A health maintenance organization must ensure that the
26 benefits required by ~~subsection~~ *subsections 1 and 2* are made
27 available to an enrollee through a provider of health care who
28 participates in the network plan of the health maintenance
29 organization.

30 ~~3.~~ 5. If a covered therapeutic equivalent listed in subsection 1
31 is not available or a provider of health care deems a covered
32 therapeutic equivalent to be medically inappropriate, an alternate
33 therapeutic equivalent prescribed by a provider of health care must
34 be covered by the health maintenance organization.

35 ~~4.~~ 6. Except as otherwise provided in subsections ~~9, 10~~ *11,*
36 *12* and ~~12,~~ *14,* a health maintenance organization that offers or
37 issues a health care plan shall not:

38 (a) Require an enrollee to pay a higher deductible, any
39 copayment or coinsurance or require a longer waiting period or
40 other condition to obtain any benefit included in the health care plan
41 pursuant to subsection 1 ~~1~~ *or 2;*

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



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

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

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

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

12 ~~{5.}~~ 7. Coverage pursuant to this section for the covered
13 dependent of an enrollee must be the same as for the enrollee.

14 ~~{6.}~~ 8. Except as otherwise provided in subsection ~~{7.}~~ 9, a
15 health care plan subject to the provisions of this chapter that is
16 delivered, issued for delivery or renewed on or after January 1,
17 ~~{2022.}~~ 2024, has the legal effect of including the coverage required
18 by ~~{subsection}~~ *subsections* 1 ~~{.}~~ and 2, and any provision of the
19 plan or the renewal which is in conflict with this section is void.

20 ~~{7.}~~ 9. A health maintenance organization that offers or issues
21 a health care plan and which is affiliated with a religious
22 organization is not required to provide the coverage required by
23 subsection 1 *or* 2 if the health maintenance organization objects on
24 religious grounds. Such an organization shall, before the issuance of
25 a health care plan and before the renewal of such a plan, provide to
26 the prospective enrollee written notice of the coverage that the
27 health maintenance organization refuses to provide pursuant to this
28 subsection.

29 ~~{8.}~~ 10. If a health maintenance organization refuses, pursuant
30 to subsection ~~{7.}~~ 9, to provide the coverage required by subsection
31 1 ~~{.}~~ *or* 2, an employer may otherwise provide for the coverage for
32 the employees of the employer.

33 ~~{9.}~~ 11. A health maintenance organization may require an
34 enrollee to pay a higher deductible, copayment or coinsurance for a
35 drug for contraception if the enrollee refuses to accept a therapeutic
36 equivalent of the drug.

37 ~~{10.}~~ 12. For each of the 18 methods of contraception listed in
38 subsection ~~{11.}~~ 13 that have been approved by the Food and Drug
39 Administration, a health care plan must include at least one drug or
40 device for contraception within each method for which no
41 deductible, copayment or coinsurance may be charged to the
42 enrollee, but the health maintenance organization may charge a
43 deductible, copayment or coinsurance for any other drug or device
44 that provides the same method of contraception.



1 ~~11.1~~ 13. The following 18 methods of contraception must be
2 covered pursuant to this section:

- 3 (a) Voluntary sterilization ; ~~for women;~~
- 4 (b) Surgical sterilization implants for women;
- 5 (c) Implantable rods;
- 6 (d) Copper-based intrauterine devices;
- 7 (e) Progesterone-based intrauterine devices;
- 8 (f) Injections;
- 9 (g) Combined estrogen- and progestin-based drugs;
- 10 (h) Progestin-based drugs;
- 11 (i) Extended- or continuous-regimen drugs;
- 12 (j) Estrogen- and progestin-based patches;
- 13 (k) Vaginal contraceptive rings;
- 14 (l) Diaphragms with spermicide;
- 15 (m) Sponges with spermicide;
- 16 (n) Cervical caps with spermicide;
- 17 (o) Female condoms;
- 18 (p) Spermicide;
- 19 (q) Combined estrogen- and progestin-based drugs for
20 emergency contraception or progestin-based drugs for emergency
21 contraception; and
22 (r) Ulipristal acetate for emergency contraception.

23 ~~12.2~~ 14. Except as otherwise provided in this section and
24 federal law, a health maintenance organization may use medical
25 management techniques, including, without limitation, any available
26 clinical evidence, to determine the frequency of or treatment relating
27 to any benefit required by this section or the type of provider of
28 health care to use for such treatment.

29 ~~13.3~~ 15. A health maintenance organization shall not ~~use~~ :

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

33 ~~—14.1~~ ; or

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

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

43 ~~15.5~~ 17. As used in this section:

44 (a) “Medical management technique” means a practice which is
45 used to control the cost or utilization of health care services or



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

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

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

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

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

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

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

21 **Sec. 19.** NRS 695G.1715 is hereby amended to read as
22 follows:

23 695G.1715 1. Except as otherwise provided in subsection ~~[7,]~~
24 **9**, a managed care organization that offers or issues a health care
25 plan shall include in the plan coverage for:

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

28 (1) Lawfully prescribed or ordered;

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

30 (3) Listed in subsection ~~[10;]~~ **12**; and

31 (4) Dispensed in accordance with NRS 639.28075;

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

33 (1) Lawfully prescribed or ordered;

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

35 (3) Listed in subsection ~~[10;]~~ **12**;

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

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

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

44 (f) Management of side effects relating to contraception; ~~[and]~~

45 (g) Voluntary sterilization ~~[for women.];~~



1 (h) Any clinical service relating to the drugs, devices and
2 services described in paragraphs (a) to (g), inclusive, including,
3 without limitation, services to monitor the use and effectiveness of
4 such drugs, devices and services; and

5 (i) Except as otherwise provided in subsection 2, one-quarter
6 of the costs of any language translation services provided to
7 facilitate the provision of any item or service described in
8 paragraphs (a) to (h), inclusive.

9 2. A managed care organization that provides health care
10 services through managed care to recipients of Medicaid under
11 the State Plan for Medicaid shall include in a health care plan
12 that covers such services coverage for:

13 (a) One-quarter of the costs of any language translation
14 services provided to facilitate the provision of any item or service
15 described in paragraphs (a) to (h), inclusive, of subsection 1 to a
16 recipient of Medicaid who is eligible for the Children's Health
17 Insurance Program; and

18 (b) One-half of the costs of any language translation services
19 provided to facilitate the provision of any item or service described
20 in paragraphs (a) to (h), inclusive, of subsection 1 to a recipient of
21 Medicaid who is not eligible for the Children's Health Insurance
22 Program.

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

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

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

37 4. A managed care organization must ensure that the benefits
38 required by ~~[subsection]~~ subsections 1 and 2 are made available to
39 an insured through a provider of health care who participates in the
40 network plan of the managed care organization.

41 ~~[3.]~~ 5. If a covered therapeutic equivalent listed in subsection 1
42 is not available or a provider of health care deems a covered
43 therapeutic equivalent to be medically inappropriate, an alternate
44 therapeutic equivalent prescribed by a provider of health care must
45 be covered by the managed care organization.



1 ~~[4.]~~ **6.** Except as otherwise provided in subsections ~~[8-9]~~ **10,**
2 **11** and ~~[11.]~~ **13,** a managed care organization that offers or issues a
3 health care plan shall not:

4 (a) Require an insured to pay a higher deductible, any
5 copayment or coinsurance or require a longer waiting period or
6 other condition to obtain any benefit included in the health care plan
7 pursuant to subsection 1 ~~[1.]~~ **or 2;**

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

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

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

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

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

22 ~~[5.]~~ **7.** Coverage pursuant to this section for the covered
23 dependent of an insured must be the same as for the insured.

24 ~~[6.]~~ **8.** Except as otherwise provided in subsection ~~[7.]~~ **9,** a
25 health care plan subject to the provisions of this chapter that is
26 delivered, issued for delivery or renewed on or after January 1,
27 ~~[2022.]~~ **2024,** has the legal effect of including the coverage required
28 by ~~[subsection]~~ **subsections 1 [1.] and 2,** and any provision of the
29 plan or the renewal which is in conflict with this section is void.

30 ~~[7.]~~ **9.** A managed care organization that offers or issues a
31 health care plan and which is affiliated with a religious organization
32 is not required to provide the coverage required by subsection 1 **or 2**
33 if the managed care organization objects on religious grounds. Such
34 an organization shall, before the issuance of a health care plan and
35 before the renewal of such a plan, provide to the prospective insured
36 written notice of the coverage that the managed care organization
37 refuses to provide pursuant to this subsection.

38 ~~[8.]~~ **10.** A managed care organization may require an insured
39 to pay a higher deductible, copayment or coinsurance for a drug for
40 contraception if the insured refuses to accept a therapeutic
41 equivalent of the drug.

42 ~~[9.]~~ **11.** For each of the 18 methods of contraception listed in
43 subsection ~~[10.]~~ **12** that have been approved by the Food and Drug
44 Administration, a health care plan must include at least one drug or
45 device for contraception within each method for which no



1 deductible, copayment or coinsurance may be charged to the
2 insured, but the managed care organization may charge a deductible,
3 copayment or coinsurance for any other drug or device that provides
4 the same method of contraception.

5 ~~10.~~ **12.** The following 18 methods of contraception must be
6 covered pursuant to this section:

- 7 (a) Voluntary sterilization ; ~~for women;~~
- 8 (b) Surgical sterilization implants for women;
- 9 (c) Implantable rods;
- 10 (d) Copper-based intrauterine devices;
- 11 (e) Progesterone-based intrauterine devices;
- 12 (f) Injections;
- 13 (g) Combined estrogen- and progestin-based drugs;
- 14 (h) Progestin-based drugs;
- 15 (i) Extended- or continuous-regimen drugs;
- 16 (j) Estrogen- and progestin-based patches;
- 17 (k) Vaginal contraceptive rings;
- 18 (l) Diaphragms with spermicide;
- 19 (m) Sponges with spermicide;
- 20 (n) Cervical caps with spermicide;
- 21 (o) Female condoms;
- 22 (p) Spermicide;
- 23 (q) Combined estrogen- and progestin-based drugs for
24 emergency contraception or progestin-based drugs for emergency
25 contraception; and
26 (r) Ulipristal acetate for emergency contraception.

27 ~~11.~~ **13.** Except as otherwise provided in this section and
28 federal law, a managed care organization may use medical
29 management techniques, including, without limitation, any available
30 clinical evidence, to determine the frequency of or treatment relating
31 to any benefit required by this section or the type of provider of
32 health care to use for such treatment.

33 ~~12.~~ **14.** A managed care organization shall not ~~use~~ :

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

37 ~~13.~~ ; or

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

40 **15.** A managed care organization must provide an accessible,
41 transparent and expedited process which is not unduly burdensome
42 by which an insured, or the authorized representative of the insured,
43 may request an exception relating to any medical management
44 technique used by the managed care organization to obtain any



1 benefit required by this section without a higher deductible,
2 copayment or coinsurance.

3 ~~H4.]~~ 16. As used in this section:

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

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

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

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

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

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

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

27 **Sec. 20.** The provisions of NRS 354.599 do not apply to any
28 additional expenses of a local government that are related to the
29 provisions of this act.

30 **Sec. 21.** 1. This section becomes effective upon passage and
31 approval.

32 2. Sections 1 to 20, inclusive, of this act become effective:

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

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

