

ASSEMBLY BILL NO. 249—ASSEMBLYMEN FRIERSON, BILBRAY-AXELROD, SPRINKLE, BENITEZ-THOMPSON, YEAGER; ELLIOT ANDERSON, ARAUJO, BROOKS, BUSTAMANTE ADAMS, CARLTON, CARRILLO, COHEN, DALY, DIAZ, FLORES, FUMO, JAUREGUI, JOINER, MCCURDY II, MILLER, MONROE-MORENO, NEAL, OHRENSCHALL, SPIEGEL, SWANK, THOMPSON AND WATKINS

MARCH 1, 2017

Referred to Committee on Health and Human Services

SUMMARY—Requires the State Plan for Medicaid and all health insurance plans to provide certain benefits relating to contraception. (BDR 38-858)

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

CONTAINS UNFUNDED MANDATE (§§ 3, 4)
(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; requiring the State Plan for Medicaid to provide certain benefits relating to contraception at no additional cost to the enrollee; requiring a pharmacist to dispense up to a 12-month supply of contraceptives in certain circumstances; requiring all health insurance plans to provide certain benefits relating to contraception at no additional cost to the insured; and providing other matters properly relating thereto.

Legislative Counsel’s Digest:

1 Existing law requires most health insurance plans which cover prescription
2 drugs and outpatient care to also include coverage for contraceptive drugs and
3 devices without an additional copay, coinsurance or a higher deductible than that
4 which may be charged for other prescription drugs and outpatient care under the
5 plan. (NRS 689A.0415, 689A.0417, 689B.0376, 689B.0377, 695B.1916,
6 695B.1918, 695C.1694, 695C.1695) Certain plans, including small employer plans,
7 benefit contracts provided by fraternal benefit societies, plans issued by a managed
8 care organization and certain plans offered by governmental entities of this State



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9 are not currently subject to these requirements. (Chapters 287, 689C, 695A and
10 695G of NRS)

11 The federal Patient Protection and Affordable Care Act, Pub. L. 111-148, as
12 amended, requires certain contraceptive drugs, devices and services to be covered
13 by every health insurance plan without any copay, coinsurance or higher
14 deductible. (42 U.S.C. § 300gg-13(a)(4); 45 C.F.R. § 147.130) **Sections 3, 4 and**
15 **6-25** of this bill align Nevada law with federal law, requiring all public and private
16 health insurance plans made available in this State to provide coverage for certain
17 benefits relating to contraception without any copay, coinsurance or a higher
18 deductible. **Sections 3, 4 and 6-25** require certain additional forms of contraceptive
19 drugs, devices and services to be covered by a health insurance plan, including,
20 without limitation, up to a 12-month supply of contraceptives or its therapeutic
21 equivalent, insertion or removal of a contraceptive device, education and
22 counseling relating to contraception, management of side effects relating to
23 contraception and voluntary sterilization for men and women. **Sections 3, 4 and**
24 **6-25** prohibit the use of a program of step therapy or prior authorization
25 requirements relating to the contraceptive drugs, devices and services required by
26 this bill. **Sections 3, 4 and 6-25** also require a health insurance plan to provide
27 coverage for certain therapeutic equivalent drugs and devices relating to
28 contraception when a therapeutic equivalent covered by the plan is deemed to be
29 medically inappropriate by a provider of health care. Additionally, **sections 3, 4**
30 **and 6-25** require that benefits provided by a health insurance plan relating to
31 contraception which are provided to the insured must also be provided to the spouse
32 or dependent of an insured.

33 Existing law allows an insurer that is affiliated with a religious organization
34 and which objects on religious grounds to providing coverage for contraceptive
35 drugs and devices to exclude coverage in its policies, plans or contracts for such
36 drugs and devices. (NRS 689A.0415, 689B.0376, 695B.1916, 695C.1694) **Sections**
37 **7, 11, 14, 16, 17, 20 and 25** of this bill remove the religious exemption and require
38 all insurers to provide coverage for the contraceptive drugs, devices and services
39 required by this bill.

40 Existing law requires this State to develop a State Plan for Medicaid which
41 includes, without limitation, a list of the medical services provided to Medicaid
42 beneficiaries. (42 U.S.C. § 1396a; NRS 422.063) Existing federal law authorizes a
43 state to charge a copay, coinsurance or deductible for most Medicaid services, but
44 prohibits any copay, coinsurance or deductible for certain family planning services
45 and supplies. (42 U.S.C. § 1396o-1) Existing federal law also authorizes a state to
46 define the parameters of contraceptive coverage provided under Medicaid. (42
47 U.S.C. § 1396u-7) Existing Nevada law requires a number of specific medical
48 services to be covered under Medicaid. (NRS 422.2717-422.2724) **Sections 1 and**
49 **2** of this bill require the State Plan for Medicaid to include certain benefits relating
50 to contraception currently required to be covered by private health insurance plans
51 pursuant to existing Nevada law and the Patient Protection and Affordable Care
52 Act, Pub. L. 111-148, as amended, as well as the additional benefits related to
53 contraception required by **sections 3, 4 and 6-25** without any copay, coinsurance or
54 deductible. **Sections 1 and 2** also prohibit the use of a program of step therapy and
55 any requirement to obtain prior authorization relating to such benefits which are
56 covered under the State Plan for Medicaid.

57 Existing law authorizes a pharmacist to dispense up to a 90-day supply of a
58 drug pursuant to a valid prescription in certain circumstances. (NRS 639.2396)
59 **Section 5** of this bill requires a pharmacist to dispense up to a 12-month supply of
60 contraceptives or a therapeutic equivalent upon the request of a patient and
61 pursuant to a valid prescription.



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

1 **Section 1.** Chapter 422 of NRS is hereby amended by adding
2 thereto a new section to read as follows:

3 1. *The Director shall include in the State Plan for Medicaid a*
4 *requirement that the State pay the nonfederal share of*
5 *expenditures for family planning services and supplies, including,*
6 *without limitation:*

7 (a) *Up to a 12-month supply, per prescription, of any type of*
8 *drug for contraception or its therapeutic equivalent which is*
9 *lawfully prescribed or ordered and which has been approved by*
10 *the Food and Drug Administration;*

11 (b) *Any type of device for contraception or its therapeutic*
12 *equivalent which is lawfully prescribed or ordered and which has*
13 *been approved by the Food and Drug Administration;*

14 (c) *Insertion or removal of a device for contraception;*

15 (d) *Education and counseling relating to contraception;*

16 (e) *Management of side effects relating to contraception; and*

17 (f) *Voluntary sterilization for men and women.*

18 2. *If a covered therapeutic equivalent listed in subsection 1 is*
19 *not available or a provider of health care deems a covered*
20 *therapeutic equivalent to be medically inappropriate, an alternate*
21 *therapeutic equivalent prescribed by a provider of health care*
22 *must be covered by the Plan.*

23 3. *To obtain any benefit included in the Plan pursuant to*
24 *subsection 1, a person enrolled in Medicaid must not be required*
25 *to:*

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

27 (b) *Use a program of step therapy;*

28 (c) *Obtain prior authorization; or*

29 (d) *Be subject to a longer waiting period or any other*
30 *condition.*

31 **Sec. 2.** NRS 422.403 is hereby amended to read as follows:

32 422.403 1. ~~The~~ *Except as otherwise provided in section 1*
33 *of this act, the* Department shall, by regulation, establish and
34 manage the use by the Medicaid program of step therapy and prior
35 authorization for prescription drugs.

36 2. ~~The~~ *Except as otherwise provided in section 1 of this act,*
37 *the* Drug Use Review Board shall:

38 (a) Advise the Department concerning the use by the Medicaid
39 program of step therapy and prior authorization for prescription
40 drugs;



1 (b) Develop step therapy protocols and prior authorization
2 policies and procedures for use by the Medicaid program for
3 prescription drugs; and

4 (c) Review and approve, based on clinical evidence and best
5 clinical practice guidelines and without consideration of the cost of
6 the prescription drugs being considered, step therapy protocols used
7 by the Medicaid program for prescription drugs.

8 3. The Department shall not require the Drug Use Review
9 Board to develop, review or approve prior authorization policies or
10 procedures necessary for the operation of the list of preferred
11 prescription drugs developed for the Medicaid program pursuant to
12 NRS 422.4025.

13 4. The Department shall accept recommendations from the
14 Drug Use Review Board as the basis for developing or revising step
15 therapy protocols and prior authorization policies and procedures
16 used by the Medicaid program for prescription drugs.

17 **Sec. 3.** NRS 287.010 is hereby amended to read as follows:

18 287.010 1. The governing body of any county, school
19 district, municipal corporation, political subdivision, public
20 corporation or other local governmental agency of the State of
21 Nevada may:

22 (a) Adopt and carry into effect a system of group life, accident
23 or health insurance, or any combination thereof, for the benefit of its
24 officers and employees, and the dependents of officers and
25 employees who elect to accept the insurance and who, where
26 necessary, have authorized the governing body to make deductions
27 from their compensation for the payment of premiums on the
28 insurance.

29 (b) Purchase group policies of life, accident or health insurance,
30 or any combination thereof, for the benefit of such officers and
31 employees, and the dependents of such officers and employees, as
32 have authorized the purchase, from insurance companies authorized
33 to transact the business of such insurance in the State of Nevada,
34 and, where necessary, deduct from the compensation of officers and
35 employees the premiums upon insurance and pay the deductions
36 upon the premiums.

37 (c) Provide group life, accident or health coverage through a
38 self-insurance reserve fund and, where necessary, deduct
39 contributions to the maintenance of the fund from the compensation
40 of officers and employees and pay the deductions into the fund.
41 The money accumulated for this purpose through deductions from
42 the compensation of officers and employees and contributions of the
43 governing body must be maintained as an internal service fund as
44 defined by NRS 354.543. The money must be deposited in a state or
45 national bank or credit union authorized to transact business in the



1 State of Nevada. Any independent administrator of a fund created
2 under this section is subject to the licensing requirements of chapter
3 683A of NRS, and must be a resident of this State. Any contract
4 with an independent administrator must be approved by the
5 Commissioner of Insurance as to the reasonableness of
6 administrative charges in relation to contributions collected and
7 benefits provided. The provisions of NRS 687B.408, 689B.030 to
8 689B.050, inclusive, *and section 11 of this act* and 689B.287 apply
9 to coverage provided pursuant to this paragraph.

10 (d) Defray part or all of the cost of maintenance of a self-
11 insurance fund or of the premiums upon insurance. The money for
12 contributions must be budgeted for in accordance with the laws
13 governing the county, school district, municipal corporation,
14 political subdivision, public corporation or other local governmental
15 agency of the State of Nevada.

16 2. If a school district offers group insurance to its officers and
17 employees pursuant to this section, members of the board of trustees
18 of the school district must not be excluded from participating in the
19 group insurance. If the amount of the deductions from compensation
20 required to pay for the group insurance exceeds the compensation to
21 which a trustee is entitled, the difference must be paid by the trustee.

22 3. In any county in which a legal services organization exists,
23 the governing body of the county, or of any school district,
24 municipal corporation, political subdivision, public corporation or
25 other local governmental agency of the State of Nevada in the
26 county, may enter into a contract with the legal services
27 organization pursuant to which the officers and employees of the
28 legal services organization, and the dependents of those officers and
29 employees, are eligible for any life, accident or health insurance
30 provided pursuant to this section to the officers and employees, and
31 the dependents of the officers and employees, of the county, school
32 district, municipal corporation, political subdivision, public
33 corporation or other local governmental agency.

34 4. If a contract is entered into pursuant to subsection 3, the
35 officers and employees of the legal services organization:

36 (a) Shall be deemed, solely for the purposes of this section, to be
37 officers and employees of the county, school district, municipal
38 corporation, political subdivision, public corporation or other local
39 governmental agency with which the legal services organization has
40 contracted; and

41 (b) Must be required by the contract to pay the premiums or
42 contributions for all insurance which they elect to accept or of which
43 they authorize the purchase.

44 5. A contract that is entered into pursuant to subsection 3:



1 (a) Must be submitted to the Commissioner of Insurance for
2 approval not less than 30 days before the date on which the contract
3 is to become effective.

4 (b) Does not become effective unless approved by the
5 Commissioner.

6 (c) Shall be deemed to be approved if not disapproved by the
7 Commissioner within 30 days after its submission.

8 6. As used in this section, "legal services organization" means
9 an organization that operates a program for legal aid and receives
10 money pursuant to NRS 19.031.

11 **Sec. 4.** NRS 287.04335 is hereby amended to read as follows:

12 287.04335 If the Board provides health insurance through a
13 plan of self-insurance, it shall comply with the provisions of NRS
14 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645,
15 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177,
16 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive,
17 and 695G.405, *and section 25 of this act* in the same manner as an
18 insurer that is licensed pursuant to title 57 of NRS is required to
19 comply with those provisions.

20 **Sec. 5.** NRS 639.2396 is hereby amended to read as follows:

21 639.2396 1. Except as otherwise provided by subsection 2, a
22 prescription which bears specific authorization to refill, given by the
23 prescribing practitioner at the time he or she issued the original
24 prescription, or a prescription which bears authorization permitting
25 the pharmacist to refill the prescription as needed by the patient,
26 may be refilled for the number of times authorized or for the period
27 authorized if it was refilled in accordance with the number of doses
28 ordered and the directions for use.

29 2. ~~1A~~ *Except as otherwise provided by subsection 3, a*
30 pharmacist may, in his or her professional judgment and pursuant to
31 a valid prescription that specifies an initial amount of less than a
32 90-day supply of a drug other than a controlled substance followed
33 by periodic refills of the initial amount of the drug, dispense not
34 more than a 90-day supply of the drug if:

35 (a) The patient has used an initial 30-day supply of the drug or
36 the drug has previously been prescribed to the patient in a 90-day
37 supply;

38 (b) The total number of dosage units that are dispensed pursuant
39 to the prescription does not exceed the total number of dosage units,
40 including refills, that are authorized on the prescription by the
41 prescribing practitioner; and

42 (c) The prescribing practitioner has not specified on the
43 prescription that dispensing the prescription in an initial amount of
44 less than a 90-day supply followed by periodic refills of the initial
45 amount of the drug is medically necessary.



1 3. *A pharmacist shall, upon the request of a patient and*
2 *pursuant to a valid prescription for a drug to be used for*
3 *contraception or its therapeutic equivalent which has been*
4 *approved by the Food and Drug Administration that specifies an*
5 *initial amount of less than a 12-month supply followed by periodic*
6 *refills of the initial amount of the drug, dispense up to the amount*
7 *authorized in the prescription including refills, not to exceed a*
8 *12-month supply of the drug or its therapeutic equivalent.*

9 4. Nothing in this section shall be construed to alter the
10 coverage provided under any contract or policy of health insurance,
11 health plan or program or other agreement arrangement that
12 provides health coverage.

13 **Sec. 6.** NRS 687B.225 is hereby amended to read as follows:

14 687B.225 1. Except as otherwise provided in NRS
15 689A.0405, 689A.0413, 689A.044, 689A.0445, 689B.031,
16 689B.0313, 689B.0317, 689B.0374, 695B.1912, 695B.1914,
17 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1745,
18 695C.1751, 695G.170, 695G.171 , ~~and~~ 695G.177 ~~;~~ *and sections*
19 *7, 11, 14, 16, 17, 20 and 25 of this act*, any contract for group,
20 blanket or individual health insurance or any contract by a nonprofit
21 hospital, medical or dental service corporation or organization for
22 dental care which provides for payment of a certain part of medical
23 or dental care may require the insured or member to obtain prior
24 authorization for that care from the insurer or organization. The
25 insurer or organization shall:

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

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

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

33 **Sec. 7.** Chapter 689A of NRS is hereby amended by adding
34 thereto a new section to read as follows:

35 *1. An insurer that offers or issues a policy of health*
36 *insurance shall include in the policy coverage for:*

37 (a) *Up to a 12-month supply, per prescription, of any type of*
38 *drug for contraception or its therapeutic equivalent which is*
39 *lawfully prescribed or ordered and which has been approved by*
40 *the Food and Drug Administration;*

41 (b) *Any type of device for contraception or its therapeutic*
42 *equivalent, which is lawfully prescribed or ordered and which has*
43 *been approved by the Food and Drug Administration;*

44 (c) *Insertion or removal of a device for contraception;*

45 (d) *Education and counseling relating to contraception;*



- 1 (e) *Management of side effects relating to contraception; and*
- 2 (f) *Voluntary sterilization for men and women.*

3 2. *If a covered therapeutic equivalent listed in subsection 1 is*
4 *not available or a provider of health care deems a covered*
5 *therapeutic equivalent to be medically inappropriate, an alternate*
6 *therapeutic equivalent prescribed by a provider of health care*
7 *must be covered by the insurer.*

8 3. *An insurer that offers or issues a policy of health*
9 *insurance shall not:*

10 (a) *Require an insured to pay a higher deductible, any*
11 *copayment or coinsurance or require a longer waiting period or*
12 *other condition for coverage to obtain any benefit included in the*
13 *policy pursuant to subsection 1;*

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

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

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

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

27 (f) *Impose any other restrictions or delays on the access of an*
28 *insured to the services listed in subsection 1, including, without*
29 *limitation, a program of step therapy or prior authorization.*

30 4. *Coverage pursuant to this section for a covered spouse or*
31 *the covered dependent of an insured must be the same as for the*
32 *insured.*

33 5. *A policy subject to the provisions of this chapter that is*
34 *delivered, issued for delivery or renewed on or after January 1,*
35 *2018, has the legal effect of including the coverage required by*
36 *subsection 1, and any provision of the policy or the renewal which*
37 *is in conflict with this section is void.*

38 6. *As used in this section, "provider of health care" has the*
39 *meaning ascribed to it in NRS 629.031.*

40 **Sec. 8.** NRS 689A.0415 is hereby amended to read as follows:
41 689A.0415 1. ~~Except as otherwise provided in subsection 5,~~

42 ~~an~~ **An** insurer that offers or issues a policy of health insurance
43 which provides coverage for prescription drugs or devices shall
44 include in the policy coverage for ~~†~~

45 ~~—(a) Any type of drug or device for contraception; and~~



- 1 ~~—(b) Any~~ **any** type of hormone replacement therapy ~~f;~~
2 ~~→~~ which is lawfully prescribed or ordered and which has been
3 approved by the Food and Drug Administration.
- 4 2. An insurer that offers or issues a policy of health insurance
5 that provides coverage for prescription drugs shall not:
- 6 (a) Require an insured to pay a higher deductible, copayment or
7 coinsurance or require a longer waiting period or other condition for
8 coverage for a prescription for ~~fa contraceptive or~~ hormone
9 replacement therapy than is required for other prescription drugs
10 covered by the policy;
- 11 (b) Refuse to issue a policy of health insurance or cancel a
12 policy of health insurance solely because the person applying for or
13 covered by the policy uses or may use in the future ~~any of the~~
14 ~~services listed in subsection 1;~~ **hormone replacement therapy;**
- 15 (c) Offer or pay any type of material inducement or financial
16 incentive to an insured to discourage the insured from accessing
17 ~~any of the services listed in subsection 1;~~ **hormone replacement**
18 **therapy;**
- 19 (d) Penalize a provider of health care who provides ~~any of the~~
20 ~~services listed in subsection 1~~ **hormone replacement therapy** to an
21 insured, including, without limitation, reducing the reimbursement
22 of the provider of health care; or
- 23 (e) Offer or pay any type of material inducement, bonus or other
24 financial incentive to a provider of health care to deny, reduce,
25 withhold, limit or delay ~~any of the services listed in subsection 1~~
26 **hormone replacement therapy** to an insured.
- 27 3. ~~Except as otherwise provided in subsection 5, a~~ **A** policy
28 subject to the provisions of this chapter that is delivered, issued for
29 delivery or renewed on or after October 1, 1999, has the legal effect
30 of including the coverage required by subsection 1, and any
31 provision of the policy or the renewal which is in conflict with this
32 section is void.
- 33 4. The provisions of this section do not:
- 34 (a) Require an insurer to provide coverage for fertility drugs.
35 (b) Prohibit an insurer from requiring an insured to pay a
36 deductible, copayment or coinsurance for the coverage required by
37 ~~paragraphs (a) and (b) of~~ subsection 1 that is the same as the
38 insured is required to pay for other prescription drugs covered by the
39 policy.
- 40 5. ~~An insurer which offers or issues a policy of health~~
41 ~~insurance and which is affiliated with a religious organization is not~~
42 ~~required to provide the coverage required by paragraph (a) of~~
43 ~~subsection 1 if the insurer objects on religious grounds. Such an~~
44 ~~insurer shall, before the issuance of a policy of health insurance and~~
45 ~~before the renewal of such a policy, provide to the prospective~~



1 ~~insured, written notice of the coverage that the insurer refuses to~~
2 ~~provide pursuant to this subsection.~~

3 ~~—6.~~ As used in this section, “provider of health care” has the
4 meaning ascribed to it in NRS 629.031.

5 **Sec. 9.** NRS 689A.0417 is hereby amended to read as follows:

6 689A.0417 1. ~~{Except as otherwise provided in subsection 5,~~
7 ~~an}~~ **An** insurer that offers or issues a policy of health insurance
8 which provides coverage for outpatient care shall include in the
9 policy coverage for any health care service related to ~~{contraceptives~~
10 ~~or}~~ hormone replacement therapy.

11 2. An insurer that offers or issues a policy of health insurance
12 that provides coverage for outpatient care shall not:

13 (a) Require an insured to pay a higher deductible, copayment or
14 coinsurance or require a longer waiting period or other condition for
15 coverage for outpatient care related to ~~{contraceptives or}~~ hormone
16 replacement therapy than is required for other outpatient care
17 covered by the policy;

18 (b) Refuse to issue a policy of health insurance or cancel a
19 policy of health insurance solely because the person applying for or
20 covered by the policy uses or may use in the future ~~{any of the~~
21 ~~services listed in subsection 1;}~~ **hormone replacement therapy;**

22 (c) Offer or pay any type of material inducement or financial
23 incentive to an insured to discourage the insured from accessing
24 ~~{any of the services listed in subsection 1;}~~ **hormone replacement**
25 **therapy;**

26 (d) Penalize a provider of health care who provides ~~{any of the~~
27 ~~services listed in subsection 1;}~~ **hormone replacement therapy** to an
28 insured, including, without limitation, reducing the reimbursement
29 of the provider of health care; or

30 (e) Offer or pay any type of material inducement, bonus or other
31 financial incentive to a provider of health care to deny, reduce,
32 withhold, limit or delay ~~{any of the services listed in subsection 1;}~~
33 **hormone replacement therapy** to an insured.

34 3. ~~{Except as otherwise provided in subsection 5, a}~~ **A** policy
35 subject to the provisions of this chapter that is delivered, issued for
36 delivery or renewed on or after October 1, 1999, has the legal effect
37 of including the coverage required by subsection 1, and any
38 provision of the policy or the renewal which is in conflict with this
39 section is void.

40 4. The provisions of this section do not prohibit an insurer from
41 requiring an insured to pay a deductible, copayment or coinsurance
42 for the coverage required by subsection 1 that is the same as the
43 insured is required to pay for other outpatient care covered by the
44 policy.



1 5. ~~{An insurer which offers or issues such a policy of health~~
2 ~~insurance and which is affiliated with a religious organization is not~~
3 ~~required to provide the coverage for health care service related to~~
4 ~~contraceptives required by this section if the insurer objects on~~
5 ~~religious grounds. Such an insurer shall, before the issuance of a~~
6 ~~policy of health insurance and before the renewal of such a policy,~~
7 ~~provide to the prospective insured written notice of the coverage~~
8 ~~that the insurer refuses to provide pursuant to this subsection.~~

9 —6.† As used in this section, “provider of health care” has the
10 meaning ascribed to it in NRS 629.031.

11 **Sec. 10.** NRS 689A.330 is hereby amended to read as follows:

12 689A.330 If any policy is issued by a domestic insurer for
13 delivery to a person residing in another state, and if the insurance
14 commissioner or corresponding public officer of that other state has
15 informed the Commissioner that the policy is not subject to approval
16 or disapproval by that officer, the Commissioner may by ruling
17 require that the policy meet the standards set forth in NRS 689A.030
18 to 689A.320, inclusive **††**, and *section 7 of this act.*

19 **Sec. 11.** Chapter 689B of NRS is hereby amended by adding
20 thereto a new section to read as follows:

21 1. *An insurer that offers or issues a policy of group health*
22 *insurance shall include in the policy coverage for:*

23 (a) *Up to a 12-month supply, per prescription, of any type of*
24 *drug for contraception or its therapeutic equivalent which is*
25 *lawfully prescribed or ordered and which has been approved by*
26 *the Food and Drug Administration;*

27 (b) *Any type of device for contraception or its therapeutic*
28 *equivalent, which is lawfully prescribed or ordered and which has*
29 *been approved by the Food and Drug Administration;*

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

31 (d) *Education and counseling relating to contraception;*

32 (e) *Management of side effects relating to contraception; and*

33 (f) *Voluntary sterilization for men and women.*

34 2. *If a covered therapeutic equivalent listed in subsection 1 is*
35 *not available or a provider of health care deems a covered*
36 *therapeutic equivalent to be medically inappropriate, an alternate*
37 *therapeutic equivalent prescribed by a provider of health care*
38 *must be covered by the insurer.*

39 3. *An insurer that offers or issues a policy of group health*
40 *insurance shall not:*

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



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

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

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

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

15 (f) Impose any other restrictions or delays on the access of an
16 insured to any such benefit, including, without limitation, a
17 program of step therapy or prior authorization.

18 4. Coverage pursuant to this section for a covered spouse or
19 the covered dependent of an insured must be the same as for the
20 insured.

21 5. A policy subject to the provisions of this chapter that is
22 delivered, issued for delivery or renewed on or after January 1,
23 2018, has the legal effect of including the coverage required by
24 subsection 1, and any provision of the policy or the renewal which
25 is in conflict with this section is void.

26 6. As used in this section, "provider of health care" has the
27 meaning ascribed to it in NRS 629.031.

28 **Sec. 12.** NRS 689B.0376 is hereby amended to read as
29 follows:

30 689B.0376 1. ~~Except as otherwise provided in subsection 5,~~
31 ~~an~~ An insurer that offers or issues a policy of group health
32 insurance which provides coverage for prescription drugs or devices
33 shall include in the policy coverage for ~~f~~

34 ~~—(a) Any type of drug or device for contraception; and~~

35 ~~—(b) Any~~ any type of hormone replacement therapy ~~f~~

36 ~~h~~ which is lawfully prescribed or ordered and which has been
37 approved by the Food and Drug Administration.

38 2. An insurer that offers or issues a policy of group health
39 insurance that provides coverage for prescription drugs shall not:

40 (a) Require an insured to pay a higher deductible, copayment or
41 coinsurance or require a longer waiting period or other condition for
42 coverage for a prescription for ~~h~~ ~~hormone replacement therapy~~ ~~or~~ ~~hormone~~
43 replacement therapy than is required for other prescription drugs
44 covered by the policy;



1 (b) Refuse to issue a policy of group health insurance or cancel a
2 policy of group health insurance solely because the person applying
3 for or covered by the policy uses or may use in the future ~~any of the~~
4 ~~services listed in subsection 1;~~ *hormone replacement therapy;*

5 (c) Offer or pay any type of material inducement or financial
6 incentive to an insured to discourage the insured from accessing
7 ~~any of the services listed in subsection 1;~~ *hormone replacement*
8 *therapy;*

9 (d) Penalize a provider of health care who provides ~~any of the~~
10 ~~services listed in subsection 1;~~ *hormone replacement therapy* to an
11 insured, including, without limitation, reducing the reimbursement
12 of the provider of health care; or

13 (e) Offer or pay any type of material inducement, bonus or other
14 financial incentive to a provider of health care to deny, reduce,
15 withhold, limit or delay ~~any of the services listed in subsection 1;~~
16 *hormone replacement therapy* to an insured.

17 3. ~~Except as otherwise provided in subsection 5, a~~ A policy
18 subject to the provisions of this chapter that is delivered, issued for
19 delivery or renewed on or after October 1, 1999, has the legal effect
20 of including the coverage required by subsection 1, and any
21 provision of the policy or the renewal which is in conflict with this
22 section is void.

23 4. The provisions of this section do not:

24 (a) Require an insurer to provide coverage for fertility drugs.

25 (b) Prohibit an insurer from requiring an insured to pay a
26 deductible, copayment or coinsurance for the coverage required by
27 ~~paragraphs (a) and (b) of~~ subsection 1 that is the same as the
28 insured is required to pay for other prescription drugs covered by the
29 policy.

30 5. ~~An insurer which offers or issues a policy of group health~~
31 ~~insurance and which is affiliated with a religious organization is not~~
32 ~~required to provide the coverage required by paragraph (a) of~~
33 ~~subsection 1 if the insurer objects on religious grounds. Such an~~
34 ~~insurer shall, before the issuance of a policy of group health~~
35 ~~insurance and before the renewal of such a policy, provide to the~~
36 ~~group policyholder or prospective insured, as applicable, written~~
37 ~~notice of the coverage that the insurer refuses to provide pursuant to~~
38 ~~this subsection. The insurer shall provide notice to each insured, at~~
39 ~~the time the insured receives his or her certificate of coverage or~~
40 ~~evidence of coverage, that the insurer refused to provide coverage~~
41 ~~pursuant to this subsection.~~

42 ~~6. If an insurer refuses, pursuant to subsection 5, to provide the~~
43 ~~coverage required by paragraph (a) of subsection 1, an employer~~
44 ~~may otherwise provide for the coverage for the employees of the~~
45 ~~employer.~~



1 ~~—7.]~~ As used in this section, “provider of health care” has the
2 meaning ascribed to it in NRS 629.031.

3 **Sec. 13.** NRS 689B.0377 is hereby amended to read as
4 follows:

5 689B.0377 1. ~~{Except as otherwise provided in subsection 5,~~
6 ~~an}~~ An insurer that offers or issues a policy of group health
7 insurance which provides coverage for outpatient care shall include
8 in the policy coverage for any health care service related to
9 ~~{contraceptives or}~~ hormone replacement therapy.

10 2. An insurer that offers or issues a policy of group health
11 insurance that provides coverage for outpatient care shall not:

12 (a) Require an insured to pay a higher deductible, copayment or
13 coinsurance or require a longer waiting period or other condition for
14 coverage for outpatient care related to ~~{contraceptives or}~~ hormone
15 replacement therapy than is required for other outpatient care
16 covered by the policy;

17 (b) Refuse to issue a policy of group health insurance or cancel a
18 policy of group health insurance solely because the person applying
19 for or covered by the policy uses or may use in the future ~~{any of the~~
20 ~~services listed in subsection 1;}~~ *hormone replacement therapy;*

21 (c) Offer or pay any type of material inducement or financial
22 incentive to an insured to discourage the insured from accessing
23 ~~{any of the services listed in subsection 1;}~~ *hormone replacement*
24 *therapy;*

25 (d) Penalize a provider of health care who provides ~~{any of the~~
26 ~~services listed in subsection 1}~~ *hormone replacement therapy* to an
27 insured, including, without limitation, reducing the reimbursement
28 of the provider of health care; or

29 (e) Offer or pay any type of material inducement, bonus or other
30 financial incentive to a provider of health care to deny, reduce,
31 withhold, limit or delay ~~{any of the services listed in subsection 1}~~
32 *hormone replacement therapy* to an insured.

33 3. ~~{Except as otherwise provided in subsection 5, a}~~ A policy
34 subject to the provisions of this chapter that is delivered, issued for
35 delivery or renewed on or after October 1, 1999, has the legal effect
36 of including the coverage required by subsection 1, and any
37 provision of the policy or the renewal which is in conflict with this
38 section is void.

39 4. The provisions of this section do not prohibit an insurer from
40 requiring an insured to pay a deductible, copayment or coinsurance
41 for the coverage required by subsection 1 that is the same as the
42 insured is required to pay for other outpatient care covered by the
43 policy.

44 5. ~~{An insurer which 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 for health care service related to
2 contraceptives required by this section if the insurer objects on
3 religious grounds. Such an insurer shall, before the issuance of a
4 policy of group health insurance and before the renewal of such a
5 policy, provide to the group policyholder or prospective insured, as
6 applicable, written notice of the coverage that the insurer refuses to
7 provide pursuant to this subsection. The insurer shall provide notice
8 to each insured, at the time the insured receives his or her certificate
9 of coverage or evidence of coverage, that the insurer refused to
10 provide coverage pursuant to this subsection.~~

~~11 — 6. If an insurer refuses, pursuant to subsection 5, to provide the
12 coverage required by paragraph (a) of subsection 1, an employer
13 may otherwise provide for the coverage for the employees of the
14 employer.~~

~~15 — 7.1~~ As used in this section, “provider of health care” has the
16 meaning ascribed to it in NRS 629.031.

17 **Sec. 14.** Chapter 689C of NRS is hereby amended by adding
18 thereto a new section to read as follows:

19 *1. A carrier that offers or issues a health benefit plan shall
20 include in the plan coverage for:*

21 *(a) Up to a 12-month supply, per prescription, of any type of
22 drug for contraception or its therapeutic equivalent which is
23 lawfully prescribed or ordered and which has been approved by
24 the Food and Drug Administration;*

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

28 *(c) Insertion or removal of a device for contraception;*

29 *(d) Education and counseling relating to contraception;*

30 *(e) Management of side effects relating to contraception; and*

31 *(f) Voluntary sterilization for men and women.*

32 *2. If a covered therapeutic equivalent listed in subsection 1 is
33 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
36 must be covered by the carrier.*

37 *3. A carrier that offers or issues a health benefit plan shall
38 not:*

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

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



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

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

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

11 (f) Impose any other restrictions or delays on the access of an
12 insured to any such benefit, including, without limitation, a
13 program of step therapy or prior authorization.

14 4. Coverage pursuant to this section for a covered spouse or
15 the covered dependent of an insured must be the same as for the
16 insured.

17 5. A health benefit plan subject to the provisions of this
18 chapter that is delivered, issued for delivery or renewed on or after
19 January 1, 2018, has the legal effect of including the coverage
20 required by subsection 1, and any provision of the plan or the
21 renewal which is in conflict with this section is void.

22 6. As used in this section, "provider of health care" has the
23 meaning ascribed to it in NRS 629.031.

24 **Sec. 15.** NRS 689C.425 is hereby amended to read as follows:

25 689C.425 A voluntary purchasing group and any contract
26 issued to such a group pursuant to NRS 689C.360 to 689C.600,
27 inclusive, are subject to the provisions of NRS 689C.015 to
28 689C.355, inclusive, *and section 14 of this act*, to the extent
29 applicable and not in conflict with the express provisions of NRS
30 687B.408 and 689C.360 to 689C.600, inclusive.

31 **Sec. 16.** Chapter 695A of NRS is hereby amended by adding
32 thereto a new section to read as follows:

33 1. A society that offers or issues a benefit contract which
34 provides coverage for prescription drugs or devices shall include
35 in the contract coverage for:

36 (a) Up to a 12-month supply, per prescription, of any type of
37 drug for contraception or its therapeutic equivalent which is
38 lawfully prescribed or ordered and which has been approved by
39 the Food and Drug Administration;

40 (b) Any type of device for contraception or its therapeutic
41 equivalent which is lawfully prescribed or ordered and which has
42 been approved by the Food and Drug Administration;

43 (c) Insertion or removal of a device for contraception;

44 (d) Education and counseling relating to contraception;

45 (e) Management of side effects relating to contraception; and



1 (f) *Voluntary sterilization for men and women.*

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

7 3. *A society that offers or issues a benefit contract shall not:*

8 (a) *Require an insured to pay a higher deductible, any*
9 *copayment or coinsurance or require a longer waiting period or*
10 *other condition for coverage for any benefit included in the benefit*
11 *contract pursuant to subsection 1;*

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

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

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

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

25 (f) *Impose any other restrictions or delays on the access of an*
26 *insured to any such benefit, including, without limitation, a*
27 *program of step therapy or prior authorization.*

28 4. *Coverage pursuant to this section for a covered spouse or*
29 *the covered dependent of an insured must be the same as for the*
30 *insured.*

31 5. *A benefit contract subject to the provisions of this chapter*
32 *that is delivered, issued for delivery or renewed on or after*
33 *January 1, 2018, has the legal effect of including the coverage*
34 *required by subsection 1, and any provision of the contract or the*
35 *renewal which is in conflict with this section is void.*

36 6. *As used in this section, "provider of health care" has the*
37 *meaning ascribed to it in NRS 629.031.*

38 **Sec. 17.** Chapter 695B of NRS is hereby amended by adding
39 thereto a new section to read as follows:

40 1. *An insurer that offers or issues a contract for hospital or*
41 *medical service shall include in the contract coverage for:*

42 (a) *Up to a 12-month supply, per prescription, of any type of*
43 *drug for contraception or its therapeutic equivalent which is*
44 *lawfully prescribed or ordered and which has been approved by*
45 *the Food and Drug Administration;*



1 ***(b) Any type of device for contraception or its therapeutic***
2 ***equivalent which is lawfully prescribed or ordered and which has***
3 ***been approved by the Food and Drug Administration;***

4 ***(c) Insertion or removal of a device for contraception;***

5 ***(d) Education and counseling relating to contraception;***

6 ***(e) Management of side effects relating to contraception; and***

7 ***(f) Voluntary sterilization for men and women.***

8 ***2. If a covered therapeutic equivalent listed in subsection 1 is***
9 ***not available or a provider of health care deems a covered***
10 ***therapeutic equivalent to be medically inappropriate, an alternate***
11 ***therapeutic equivalent prescribed by a provider of health care***
12 ***must be covered by the insurer.***

13 ***3. An insurer that offers or issues a contract for hospital or***
14 ***medical service shall not:***

15 ***(a) Require an insured to pay a higher deductible, any***
16 ***copayment or coinsurance or require a longer waiting period or***
17 ***other condition to obtain any benefit included in the contract for***
18 ***hospital or medical service pursuant to subsection 1;***

19 ***(b) Refuse to issue a contract for hospital or medical service or***
20 ***cancel a contract for hospital or medical service solely because the***
21 ***person applying for or covered by the contract uses or may use any***
22 ***such benefit;***

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

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

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

33 ***(f) Impose any other restrictions or delays on the access of an***
34 ***insured to any such benefit, including, without limitation, a***
35 ***program of step therapy or prior authorization.***

36 ***4. Coverage pursuant to this section for a covered spouse or***
37 ***the covered dependent of an insured must be the same as for the***
38 ***insured.***

39 ***5. A contract for hospital or medical service subject to the***
40 ***provisions of this chapter that is delivered, issued for delivery or***
41 ***renewed on or after January 1, 2018, has the legal effect of***
42 ***including the coverage required by subsection 1, and any***
43 ***provision of the contract or the renewal which is in conflict with***
44 ***this section is void.***



1 **6. As used in this section, "provider of health care" has the**
2 **meaning ascribed to it in NRS 629.031.**

3 **Sec. 18.** NRS 695B.1916 is hereby amended to read as
4 follows:

5 695B.1916 1. ~~Except as otherwise provided in subsection 5,~~
6 ~~an~~ **An** insurer that offers or issues a contract for hospital or medical
7 service which provides coverage for prescription drugs or devices
8 shall include in the contract coverage for ~~†~~

9 ~~—(a) Any type of drug or device for contraception; and~~

10 ~~—(b) Any~~ **any** type of hormone replacement therapy ~~†~~

11 ~~†~~ which is lawfully prescribed or ordered and which has been
12 approved by the Food and Drug Administration.

13 2. An insurer that offers or issues a contract for hospital or
14 medical service that provides coverage for prescription drugs shall not:
15

16 (a) Require an insured to pay a higher deductible, copayment or
17 coinsurance or require a longer waiting period or other condition for
18 coverage for a prescription for ~~†a contraceptive or†~~ hormone
19 replacement therapy than is required for other prescription drugs
20 covered by the contract;

21 (b) Refuse to issue a contract for hospital or medical service or
22 cancel a contract for hospital or medical service solely because the
23 person applying for or covered by the contract uses or may use in
24 the future ~~†any of the services listed in subsection 1;†~~ **hormone**
25 **replacement therapy;**

26 (c) Offer or pay any type of material inducement or financial
27 incentive to an insured to discourage the insured from accessing
28 ~~†any of the services listed in subsection 1;†~~ **hormone replacement**
29 **therapy;**

30 (d) Penalize a provider of health care who provides ~~†any of the~~
31 ~~services listed in subsection 1†~~ **hormone replacement therapy** to an
32 insured, including, without limitation, reducing the reimbursement
33 of the provider of health care; or

34 (e) Offer or pay any type of material inducement, bonus or other
35 financial incentive to a provider of health care to deny, reduce,
36 withhold, limit or delay ~~†any of the services listed in subsection 1†~~
37 **hormone replacement therapy** to an insured.

38 3. ~~Except as otherwise provided in subsection 5, a†~~ **A** contract
39 subject to the provisions of this chapter that is delivered, issued for
40 delivery or renewed on or after October 1, 1999, has the legal effect
41 of including the coverage required by subsection 1, and any
42 provision of the contract or the renewal which is in conflict with this
43 section is void.

44 4. The provisions of this section do not:

45 (a) Require an insurer to provide coverage for fertility drugs.



1 (b) Prohibit an insurer from requiring an insured to pay a
2 deductible, copayment or coinsurance for the coverage required by
3 ~~paragraphs (a) and (b) of~~ subsection 1 that is the same as the
4 insured is required to pay for other prescription drugs covered by the
5 contract.

6 5. ~~{An insurer which offers or issues a contract for hospital or
7 medical service and which is affiliated with a religious organization
8 is not required to provide the coverage required by paragraph (a) of
9 subsection 1 if the insurer objects on religious grounds. Such an
10 insurer shall, before the issuance of a contract for hospital or
11 medical service and before the renewal of such a contract, provide
12 to the group policyholder or prospective insured, as applicable,
13 written notice of the coverage that the insurer refuses to provide
14 pursuant to this subsection. The insurer shall provide notice to each
15 insured, at the time the insured receives his or her certificate of
16 coverage or evidence of coverage, that the insurer refused to provide
17 coverage pursuant to this subsection.~~

18 ~~— 6. — If an insurer refuses, pursuant to subsection 5, to provide the
19 coverage required by paragraph (a) of subsection 1, an employer
20 may otherwise provide for the coverage for the employees of the
21 employer.~~

22 ~~— 7. —~~ As used in this section, “provider of health care” has the
23 meaning ascribed to it in NRS 629.031.

24 **Sec. 19.** NRS 695B.1918 is hereby amended to read as
25 follows:

26 695B.1918 1. ~~{Except as otherwise provided in subsection 5,
27 an}~~ An insurer that offers or issues a contract for hospital or medical
28 service which provides coverage for outpatient care shall include in
29 the contract coverage for any health care service related to
30 ~~{contraceptives or}~~ hormone replacement therapy.

31 2. An insurer that offers or issues a contract for hospital or
32 medical service that provides coverage for outpatient care shall not:

33 (a) Require an insured to pay a higher deductible, copayment or
34 coinsurance or require a longer waiting period or other condition for
35 coverage for outpatient care related to ~~{contraceptives or}~~ hormone
36 replacement therapy than is required for other outpatient care
37 covered by the contract;

38 (b) Refuse to issue a contract for hospital or medical service or
39 cancel a contract for hospital or medical service solely because the
40 person applying for or covered by the contract uses or may use in
41 the future ~~{any of the services listed in subsection 1;}~~ *hormone
42 replacement therapy;*

43 (c) Offer or pay any type of material inducement or financial
44 incentive to an insured to discourage the insured from accessing



1 ~~{any of the services listed in subsection 1;}~~ *hormone replacement*
2 *therapy;*

3 (d) Penalize a provider of health care who provides ~~{any of the~~
4 ~~services listed in subsection 1}~~ *hormone replacement therapy* to an
5 insured, including, without limitation, reducing the reimbursement
6 of the provider of health care; or

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 ~~{any of the services listed in subsection 1}~~
10 *hormone replacement therapy* to an insured.

11 3. ~~{Except as otherwise provided in subsection 5, a}~~ A contract
12 subject to the provisions of this chapter that is delivered, issued for
13 delivery or renewed on or after October 1, 1999, has the legal effect
14 of including the coverage required by subsection 1, and any
15 provision of the contract or the renewal which is in conflict with this
16 section is void.

17 4. The provisions of this section do not prohibit an insurer from
18 requiring an insured to pay a deductible, copayment or coinsurance
19 for the coverage required by subsection 1 that is the same as the
20 insured is required to pay for other outpatient care covered by the
21 contract.

22 5. ~~{An insurer which offers or issues a contract for hospital or~~
23 ~~medical service and which is affiliated with a religious organization~~
24 ~~is not required to provide the coverage for health care service related~~
25 ~~to contraceptives required by this section if the insurer objects on~~
26 ~~religious grounds. Such an insurer shall, before the issuance of a~~
27 ~~contract for hospital or medical service and before the renewal of~~
28 ~~such a contract, provide to the group policyholder or prospective~~
29 ~~insured, as applicable, written notice of the coverage that the insurer~~
30 ~~refuses to provide pursuant to this subsection. The insurer shall~~
31 ~~provide notice to each insured, at the time the insured receives his or~~
32 ~~her certificate of coverage or evidence of coverage, that the insurer~~
33 ~~refused to provide coverage pursuant to this subsection.~~

34 ~~—6.— If an insurer refuses, pursuant to subsection 5, to provide the~~
35 ~~coverage required by paragraph (a) of subsection 1, an employer~~
36 ~~may otherwise provide for the coverage for the employees of the~~
37 ~~employer.~~

38 ~~—7.—~~ As used in this section, “provider of health care” has the
39 meaning ascribed to it in NRS 629.031.

40 **Sec. 20.** Chapter 695C of NRS is hereby amended by adding
41 thereto a new section to read as follows:

42 1. *A health maintenance organization that offers or issues a*
43 *health care plan shall include in the plan coverage for:*

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



1 *lawfully prescribed or ordered and which has been approved by*
2 *the Food and Drug Administration;*

3 *(b) Any type of device for contraception or its therapeutic*
4 *equivalent which is lawfully prescribed or ordered and which has*
5 *been approved by the Food and Drug Administration;*

6 *(c) Insertion or removal of a device for contraception;*

7 *(d) Education and counseling relating to contraception;*

8 *(e) Management of side effects relating to contraception; and*

9 *(f) Voluntary sterilization for men and women.*

10 *2. If a covered therapeutic equivalent listed in subsection 1 is*
11 *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*
14 *must be covered by the health maintenance organization.*

15 *3. A health maintenance organization that offers or issues a*
16 *health care plan shall not:*

17 *(a) Require an enrollee to pay a higher deductible, any*
18 *copayment or coinsurance or require a longer waiting period or*
19 *other condition to obtain any benefit included in the health care*
20 *plan pursuant to subsection 1;*

21 *(b) Refuse to issue a health care plan or cancel a health care*
22 *plan solely because the person applying for or covered by the plan*
23 *uses or may use any such benefit;*

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

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

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

34 *(f) Impose any other restrictions or delays on the access of an*
35 *enrollee to any such benefit, including, without limitation, a*
36 *program of step therapy or prior authorization.*

37 *4. Coverage pursuant to this section for a covered spouse or*
38 *the covered dependent of an enrollee must be the same as for the*
39 *insured.*

40 *5. A health care plan subject to the provisions of this chapter*
41 *that is delivered, issued for delivery or renewed on or after*
42 *January 1, 2018, has the legal effect of including the coverage*
43 *required by subsection 1, and any provision of the plan or the*
44 *renewal which is in conflict with this section is void.*



1 **6. As used in this section, “provider of health care” has the**
2 **meaning ascribed to it in NRS 629.031.**

3 **Sec. 21.** NRS 695C.050 is hereby amended to read as follows:

4 695C.050 1. Except as otherwise provided in this chapter or
5 in specific provisions of this title, the provisions of this title are not
6 applicable to any health maintenance organization granted a
7 certificate of authority under this chapter. This provision does not
8 apply to an insurer licensed and regulated pursuant to this title
9 except with respect to its activities as a health maintenance
10 organization authorized and regulated pursuant to this chapter.

11 2. Solicitation of enrollees by a health maintenance
12 organization granted a certificate of authority, or its representatives,
13 must not be construed to violate any provision of law relating to
14 solicitation or advertising by practitioners of a healing art.

15 3. Any health maintenance organization authorized under this
16 chapter shall not be deemed to be practicing medicine and is exempt
17 from the provisions of chapter 630 of NRS.

18 4. The provisions of NRS 695C.110, 695C.125, 695C.1691,
19 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to
20 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734,
21 695C.1735 to 695C.1755, inclusive, 695C.176 to 695C.200,
22 inclusive, and 695C.265 do not apply to a health maintenance
23 organization that provides health care services through managed
24 care to recipients of Medicaid under the State Plan for Medicaid or
25 insurance pursuant to the Children’s Health Insurance Program
26 pursuant to a contract with the Division of Health Care Financing
27 and Policy of the Department of Health and Human Services. This
28 subsection does not exempt a health maintenance organization from
29 any provision of this chapter for services provided pursuant to any
30 other contract.

31 5. The provisions of NRS 695C.1694, 695C.1695, 695C.1708,
32 695C.1731, 695C.17345 , ~~and~~ 695C.1757 **and section 20 of this**
33 **act** apply to a health maintenance organization that provides health
34 care services through managed care to recipients of Medicaid under
35 the State Plan for Medicaid.

36 **Sec. 22.** NRS 695C.1694 is hereby amended to read as
37 follows:

38 695C.1694 1. ~~Except as otherwise provided in subsection 5;~~
39 ~~A~~ A health maintenance organization which offers or issues a health
40 care plan that provides coverage for prescription drugs or devices
41 shall include in the plan coverage for ~~;~~

42 ~~—(a) Any type of drug or device for contraception; and~~

43 ~~—(b) Any~~ any type of hormone replacement therapy ~~;~~

44 ~~→~~ which is lawfully prescribed or ordered and which has been
45 approved by the Food and Drug Administration.



1 2. A health maintenance organization that offers or issues a
2 health care plan that provides coverage for prescription drugs shall
3 not:

4 (a) Require an enrollee to pay a higher deductible, copayment or
5 coinsurance or require a longer waiting period or other condition for
6 coverage for ~~[/a prescription for a contraceptive or/]~~ hormone
7 replacement therapy than is required for other prescription drugs
8 covered by the plan;

9 (b) Refuse to issue a health care plan or cancel a health care plan
10 solely because the person applying for or covered by the plan uses
11 or may use in the future ~~[/any of the services listed in subsection 1;]~~
12 *hormone replacement therapy;*

13 (c) Offer or pay any type of material inducement or financial
14 incentive to an enrollee to discourage the enrollee from accessing
15 ~~[/any of the services listed in subsection 1;]~~ *hormone replacement*
16 *therapy;*

17 (d) Penalize a provider of health care who provides ~~[/any of the~~
18 ~~services listed in subsection 1]~~ *hormone replacement therapy* to an
19 enrollee, including, without limitation, reducing the reimbursement
20 of the provider of health care; or

21 (e) Offer or pay any type of material inducement, bonus or other
22 financial incentive to a provider of health care to deny, reduce,
23 withhold, limit or delay ~~[/any of the services listed in subsection 1]~~
24 *hormone replacement therapy* to an enrollee.

25 3. ~~[/Except as otherwise provided in subsection 5, evidence/]~~
26 *Evidence* of coverage subject to the provisions of this chapter that is
27 delivered, issued for delivery or renewed on or after October 1,
28 1999, has the legal effect of including the coverage required by
29 subsection 1, and any provision of the evidence of coverage or the
30 renewal which is in conflict with this section is void.

31 4. The provisions of this section do not:

32 (a) Require a health maintenance organization to provide
33 coverage for fertility drugs.

34 (b) Prohibit a health maintenance organization from requiring an
35 enrollee to pay a deductible, copayment or coinsurance for the
36 coverage required by ~~[/paragraphs (a) and (b) of/]~~ subsection 1 that is
37 the same as the enrollee is required to pay for other prescription
38 drugs covered by the plan.

39 5. ~~[/A health maintenance organization which offers or issues a~~
40 ~~health care plan and which is affiliated with a religious organization~~
41 ~~is not required to provide the coverage required by paragraph (a) of~~
42 ~~subsection 1 if the health maintenance organization objects on~~
43 ~~religious grounds. The health maintenance organization shall, before~~
44 ~~the issuance of a health care plan and before renewal of enrollment~~
45 ~~in such a plan, provide to the group policyholder or prospective~~



1 ~~enrollee, as applicable, written notice of the coverage that the health~~
2 ~~maintenance organization refuses to provide pursuant to this~~
3 ~~subsection. The health maintenance organization shall provide~~
4 ~~notice to each enrollee, at the time the enrollee receives his or her~~
5 ~~evidence of coverage, that the health maintenance organization~~
6 ~~refused to provide coverage pursuant to this subsection.~~

7 ~~— 6. If a health maintenance organization refuses, pursuant to~~
8 ~~subsection 5, to provide the coverage required by paragraph (a) of~~
9 ~~subsection 1, an employer may otherwise provide for the coverage~~
10 ~~for the employees of the employer.~~

11 ~~— 7.†~~ As used in this section, “provider of health care” has the
12 meaning ascribed to it in NRS 629.031.

13 **Sec. 23.** NRS 695C.1695 is hereby amended to read as
14 follows:

15 695C.1695 1. ~~{Except as otherwise provided in subsection 5,~~
16 ~~a} A health maintenance organization that offers or issues a health
17 care plan which provides coverage for outpatient care shall include
18 in the plan coverage for any health care service related to
19 ~~{contraceptives or}~~ hormone replacement therapy.~~

20 2. A health maintenance organization that offers or issues a
21 health care plan that provides coverage for outpatient care shall not:

22 (a) Require an enrollee to pay a higher deductible, copayment or
23 coinsurance or require a longer waiting period or other condition for
24 coverage for outpatient care related to ~~{contraceptives or}~~ hormone
25 replacement therapy than is required for other outpatient care
26 covered by the plan;

27 (b) Refuse to issue a health care plan or cancel a health care plan
28 solely because the person applying for or covered by the plan uses
29 or may use in the future ~~{any of the services listed in subsection 1;}~~
30 *hormone replacement therapy;*

31 (c) Offer or pay any type of material inducement or financial
32 incentive to an enrollee to discourage the enrollee from accessing
33 ~~{any of the services listed in subsection 1;}~~ *hormone replacement*
34 *therapy;*

35 (d) Penalize a provider of health care who provides ~~{any of the~~
36 ~~services listed in subsection 1}~~ *hormone replacement therapy* to an
37 enrollee, including, without limitation, reducing the reimbursement
38 of the provider of health care; or

39 (e) Offer or pay any type of material inducement, bonus or other
40 financial incentive to a provider of health care to deny, reduce,
41 withhold, limit or delay ~~{any of the services listed in subsection 1}~~
42 *hormone replacement therapy* to an enrollee.

43 3. ~~{Except as otherwise provided in subsection 5, evidence}~~
44 *Evidence* of coverage subject to the provisions of this chapter that is
45 delivered, issued for delivery or renewed on or after October 1,



1 1999, has the legal effect of including the coverage required by
2 subsection 1, and any provision of the evidence of coverage or the
3 renewal which is in conflict with this section is void.

4 4. The provisions of this section do not prohibit a health
5 maintenance organization from requiring an enrollee to pay a
6 deductible, copayment or coinsurance for the coverage required by
7 subsection 1 that is the same as the enrollee is required to pay for
8 other outpatient care covered by the plan.

9 ~~5. [A health maintenance organization which offers or issues a
10 health care plan and which is affiliated with a religious organization
11 is not required to provide the coverage for health care service related
12 to contraceptives required by this section if the health maintenance
13 organization objects on religious grounds. The health maintenance
14 organization shall, before the issuance of a health care plan and
15 before renewal of enrollment in such a plan, provide to the group
16 policyholder or prospective enrollee, as applicable, written notice of
17 the coverage that the health maintenance organization refuses to
18 provide pursuant to this subsection. The health maintenance
19 organization shall provide notice to each enrollee, at the time the
20 enrollee receives his or her evidence of coverage, that the health
21 maintenance organization refused to provide coverage pursuant to
22 this subsection.~~

23 ~~—6. If a health maintenance organization refuses, pursuant to
24 subsection 5, to provide the coverage required by paragraph (a) of
25 subsection 1, an employer may otherwise provide for the coverage
26 for the employees of the employer.~~

27 ~~—7.]~~ As used in this section, “provider of health care” has the
28 meaning ascribed to it in NRS 629.031.

29 **Sec. 24.** NRS 695C.330 is hereby amended to read as follows:

30 695C.330 1. The Commissioner may suspend or revoke any
31 certificate of authority issued to a health maintenance organization
32 pursuant to the provisions of this chapter if the Commissioner finds
33 that any of the following conditions exist:

34 (a) The health maintenance organization is operating
35 significantly in contravention of its basic organizational document,
36 its health care plan or in a manner contrary to that described in and
37 reasonably inferred from any other information submitted pursuant
38 to NRS 695C.060, 695C.070 and 695C.140, unless any amendments
39 to those submissions have been filed with and approved by the
40 Commissioner;

41 (b) The health maintenance organization issues evidence of
42 coverage or uses a schedule of charges for health care services
43 which do not comply with the requirements of NRS 695C.1691 to
44 695C.200, inclusive, *and section 20 of this act* or 695C.207;



1 (c) The health care plan does not furnish comprehensive health
2 care services as provided for in NRS 695C.060;

3 (d) The Commissioner certifies that the health maintenance
4 organization:

5 (1) Does not meet the requirements of subsection 1 of NRS
6 695C.080; or

7 (2) Is unable to fulfill its obligations to furnish health care
8 services as required under its health care plan;

9 (e) The health maintenance organization is no longer financially
10 responsible and may reasonably be expected to be unable to meet its
11 obligations to enrollees or prospective enrollees;

12 (f) The health maintenance organization has failed to put into
13 effect a mechanism affording the enrollees an opportunity to
14 participate in matters relating to the content of programs pursuant to
15 NRS 695C.110;

16 (g) The health maintenance organization has failed to put into
17 effect the system required by NRS 695C.260 for:

18 (1) Resolving complaints in a manner reasonably to dispose
19 of valid complaints; and

20 (2) Conducting external reviews of adverse determinations
21 that comply with the provisions of NRS 695G.241 to 695G.310,
22 inclusive;

23 (h) The health maintenance organization or any person on its
24 behalf has advertised or merchandised its services in an untrue,
25 misrepresentative, misleading, deceptive or unfair manner;

26 (i) The continued operation of the health maintenance
27 organization would be hazardous to its enrollees;

28 (j) The health maintenance organization fails to provide the
29 coverage required by NRS 695C.1691; or

30 (k) The health maintenance organization has otherwise failed to
31 comply substantially with the provisions of this chapter.

32 2. A certificate of authority must be suspended or revoked only
33 after compliance with the requirements of NRS 695C.340.

34 3. If the certificate of authority of a health maintenance
35 organization is suspended, the health maintenance organization shall
36 not, during the period of that suspension, enroll any additional
37 groups or new individual contracts, unless those groups or persons
38 were contracted for before the date of suspension.

39 4. If the certificate of authority of a health maintenance
40 organization is revoked, the organization shall proceed, immediately
41 following the effective date of the order of revocation, to wind up its
42 affairs and shall conduct no further business except as may be
43 essential to the orderly conclusion of the affairs of the organization.
44 It shall engage in no further advertising or solicitation of any kind.
45 The Commissioner may, by written order, permit such further



1 operation of the organization as the Commissioner may find to be in
2 the best interest of enrollees to the end that enrollees are afforded
3 the greatest practical opportunity to obtain continuing coverage for
4 health care.

5 **Sec. 25.** Chapter 695G of NRS is hereby amended by adding
6 thereto a new section to read as follows:

7 *1. A managed care organization that offers or issues a health*
8 *care plan shall include in the plan coverage for:*

9 *(a) Up to a 12-month supply, per prescription, of any type of*
10 *drug for contraception or its therapeutic equivalent which is*
11 *lawfully prescribed or ordered and which has been approved by*
12 *the Food and Drug Administration;*

13 *(b) Any type of device for contraception or its therapeutic*
14 *equivalent which is lawfully prescribed or ordered and which has*
15 *been approved by the Food and Drug Administration;*

16 *(c) Insertion or removal of a device for contraception;*

17 *(d) Education and counseling relating to contraception;*

18 *(e) Management of side effects relating to contraception; and*

19 *(f) Voluntary sterilization for men and women.*

20 *2. If a covered therapeutic equivalent listed in subsection 1 is*
21 *not available or a provider of health care deems a covered*
22 *therapeutic equivalent to be medically inappropriate, an alternate*
23 *therapeutic equivalent prescribed by a provider of health care*
24 *must be covered by the managed care organization.*

25 *3. A managed care organization that offers or issues a health*
26 *care plan shall not:*

27 *(a) Require an insured to pay a higher deductible, any*
28 *copayment or coinsurance or require a longer waiting period or*
29 *other condition to obtain any benefit included in the health care*
30 *plan pursuant to subsection 1;*

31 *(b) Refuse to issue a health care plan or cancel a health care*
32 *plan solely because the person applying for or covered by the plan*
33 *uses or may use any such benefits;*

34 *(c) Offer or pay any type of material inducement or financial*
35 *incentive to an insured to discourage the insured from obtaining*
36 *any such benefits;*

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

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



1 *(f) Impose any other restrictions or delays on the access of an*
2 *insured to any such benefits, including, without limitation, a*
3 *program of step therapy or prior authorization.*

4 *4. Coverage pursuant to this section for a covered spouse or*
5 *the covered dependent of an insured must be the same as for the*
6 *insured.*

7 *5. A health care plan subject to the provisions of this chapter*
8 *that is delivered, issued for delivery or renewed on or after*
9 *January 1, 2018, has the legal effect of including the coverage*
10 *required by subsection 1, and any provision of the plan or the*
11 *renewal which is in conflict with this section is void.*

12 *6. As used in this section, "provider of health care" has the*
13 *meaning ascribed to it in NRS 629.031.*

14 **Sec. 26.** The provisions of NRS 354.599 do not apply to any
15 additional expenses of a local government that are related to the
16 provisions of this act.

17 **Sec. 27.** This act becomes effective on January 1, 2018.



