MOCK-UP

PROPOSED AMENDMENT 3463 TO SENATE BILL NO. 420 SECOND REPRINT

PREPARED FOR SENATOR CANNIZZARO
MAY 27, 2021

PREPARED BY THE LEGAL DIVISION

NOTE: THIS DOCUMENT SHOWS PROPOSED AMENDMENTS IN CONCEPTUAL FORM. THE LANGUAGE AND ITS PLACEMENT IN THE OFFICIAL AMENDMENT MAY DIFFER.

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

Legislative Counsel's Digest:

Existing law requires the Department of Health and Human Services to administer the Medicaid program, which is a joint program of the state and federal governments to provide health coverage to indigent persons. (NRS 422.270, 439B.120) Existing law also creates the Silver State Health Insurance Exchange to assist natural persons and small businesses in purchasing health coverage. (Chapter 695I of NRS) **Section 10** of this bill requires the Director of the Department, in consultation with the Executive Director of the Exchange and the Commissioner of Insurance, to design, establish and operate a public health benefit plan known as the Public Option. **Section 2** of this bill sets forth the purposes of the Public Option, and **sections 3.5-9** of this bill define terms relevant to the Public Option. **Section 10** requires the Public Option to be available ~~[to all natural persons who reside in this State]~~ through the Exchange and for direct purchase and authorizes the Director to make the Public Option available to small employers in this State or their employees. **Section 10** requires the Public Option to meet the requirements established by federal and state law for individual health insurance or health insurance for small employers where applicable. **Section 10** also establishes requirements governing the levels of coverage provided by the Public Option and the premiums for the Public Option. **Sections 38 and 41** of this bill remove the requirements relating to premiums on January 1, 2030. **Section 11** of this bill requires the Director, the Commissioner and the Executive Director of the Exchange to apply for certain waivers to obtain federal financial support for the Public Option. **Section 39** of this bill requires the Director, the Commissioner and the Executive Director of the Exchange to contract for the performance of an actuarial study before submitting the initial waiver application. **Section 12** of this bill requires the Director to use a statewide competitive bidding process to solicit and enter into contracts with health carriers and other qualified persons to administer the Public Option. **Section 12** requires a health carrier that provides health care services to recipients of Medicaid through managed care to participate

in the competitive bidding process. **Section 12** additionally authorizes the Director to directly administer the Public Option if necessary. **Sections 13, 21 and 29** of this bill require providers of health care, including health care facilities, who participate in Medicaid or the Public Employees' Benefits Program or provide care to injured employees under the State's workers' compensation program to enroll in the Public Option as a participating provider of health care. **Section 14** of this bill prescribes requirements governing the establishment of networks and the reimbursement of providers under the Public Option. **Section 15** of this bill establishes the Public Option Trust Fund to hold certain funds for the purpose of implementing the Public Option. **Section 20** of this bill exempts rules and policies governing the Public Option from provisions governing notice-and-comment rulemaking. **Sections 16, 19, 22, 32 and 34-37** of this bill make various changes so that the Public Option is treated similarly to comparable forms of public health insurance.

Section 16.5 of this bill requires the Executive Director of the Exchange to apply to the federal government for a waiver to authorize certain labor, agricultural and horticultural organizations to offer on the Exchange a policy of insurance to meet the unique needs of tradespersons that can serve as an alternative to the continuation of certain group health benefits. **Section 16.5** requires such a policy to be annually certified by the Executive Director in order to be offered on the Exchange. **Sections 16.3 and 16.8** of this bill make conforming changes to reflect the fact that a policy of insurance offered pursuant to **section 16.5** may not meet all requirements: (1) for individual health insurance prescribed by state law; or (2) to be considered a qualified health plan under federal law. **Section 39.5** of this bill requires the Executive Director to apply for the waiver and submit certain recommendations concerning such policies to the Legislature on or before January 1, 2025.

Sections 24-28 of this bill expand coverage under Medicaid in various manners. Specifically, **section 24** of this bill requires the Director of the Department to expand coverage under the State Plan for Medicaid for pregnant women by: (1) providing coverage for pregnant women whose household income is between 165 percent and 200 percent of the federally designated level signifying poverty if money is available; (2) providing that pregnant women who are determined by certain entities to qualify for Medicaid are presumptively eligible for Medicaid for a prescribed period of time, without submitting an application for enrollment in Medicaid which includes additional proof of eligibility ; [, if money is available;] and (3) prohibiting the imposition of a requirement that a pregnant woman who is otherwise eligible for Medicaid must reside in the United States for a prescribed period of time before enrolling in Medicaid. **Section 25** of this bill requires Medicaid to cover the services of a community health worker who provides services under the supervision of a physician, physician assistant or advanced practice registered nurse. **Section 26** of this bill requires Medicaid to cover certain costs for doula services provided to Medicaid recipients by a doula who has enrolled with the Division of Health Care Financing and Policy of the Department. **Sections 17 and 33** of this bill require a registered doula to report the suspected abuse, neglect, exploitation, isolation or abandonment of older or vulnerable persons or the suspected abuse or neglect of a child. **Section 27** of this bill requires Medicaid to reimburse services provided to recipients of Medicaid who do not receive services through managed care by an advanced practice registered nurse to the same extent as if those services were provided by a physician if money is available to reimburse those services at those rates. If money is available, **section 28** of this bill requires Medicaid to cover breastfeeding supplies, certain prenatal screenings and tests and lactation consultation and support. **Section 18** of this bill makes a conforming change to indicate the proper placement of **sections 24-28** in the Nevada Revised Statutes.

Existing law establishes certain requirements that apply if a Medicaid managed care program is established in this State. (NRS 422.273) To the extent that money is available, **section 30** of this bill requires the Department to: (1) establish such a program to provide health care services to recipients of Medicaid in all geographic areas of this State; and (2) conduct a statewide procurement process to select health maintenance organizations to

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1 provide such services. To the extent that money is available, **section 30** requires the
2 Medicaid managed care program to include a state-directed payment arrangement to require
3 Medicaid managed care organizations to reimburse critical access hospitals and any
4 affiliated federally-qualified health centers or rural health clinics for covered services at a
5 rate that is equal to or greater than the rate those facilities receive for services provided to
6 recipients of Medicaid on a fee-for-service basis.
7 **Section 38.3** of this bill appropriates money to the Division of Welfare and Supportive
8 Services of the Department to pay the costs of making enhancements to its information
9 technology system that are necessary to carry out the provisions of **sections 24-28** of this
10 bill. **Section 38.6** of this bill appropriates money to the Public Option Trust Fund to
11 implement the Public Option.

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

12 **Section 1.** Title 57 of NRS is hereby amended by adding thereto a
13 new chapter to consist of the provisions set forth as sections 2 to 15,
14 inclusive, of this act.
15 **Sec. 2.** ***It is hereby declared to be the purpose and policy of the***
16 ***Legislature in enacting this chapter to:***
17 ***1. Leverage the combined purchasing power of the State to lower***
18 ***premiums and costs relating to health insurance for residents of this***
19 ***State;***
20 ***2. Improve access to high-quality, affordable health care for***
21 ***residents of this State, including residents of this State who are employed***
22 ***by small businesses;***
23 ***3. Reduce disparities in access to health care and health outcomes***
24 ***and increase access to health care for historically marginalized***
25 ***communities; and***
26 ***4. Increase competition in the market for individual health***
27 ***insurance in this State to improve the availability of coverage for***
28 ***residents of rural areas of this State.***
29 **Sec. 3.** ***As used in this chapter, unless the context otherwise***
30 ***requires, the words and terms defined in sections 3.5 to 9, inclusive, of***
31 ***this act have the meanings ascribed to them in those sections.***
32 **Sec. 3.5.** ***"Certified community behavioral health clinic" means a***
33 ***community behavioral health clinic certified in accordance with section***
34 ***223 of the Protecting Access to Medicare Act of 2014, Public Law No.***
35 ***113-93.***
36 **Sec. 4.** ***"Commissioner" means the Commissioner of Insurance.***

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1 **Sec. 5.** ***"Director" means the Director of the Department of Health***
2 ***and Human Services.***
3 **Sec. 6.** ***"Exchange" means the Silver State Health Insurance***
4 ***Exchange.***
5 **Sec. 6.5.** ***"Federally qualified health center" has the meaning***
6 ***ascribed to it in 42 C.F.R. § 405.2401.***
7 **Sec. 7.** ***"Provider of health care" has the meaning ascribed to it in***
8 ***NRS 695G.070.***
9 **Sec. 8.** ***"Public Option" means the Public Option established***
10 ***pursuant to section 10 of this act.***
11 **Sec. 8.5.** ***"Rural health clinic" has the meaning ascribed to it in 42***
12 ***C.F.R. § 405.2401.***
13 **Sec. 9.** ***"Trust Fund" means the Public Option Trust Fund created***
14 ***by section 15 of this act.***
15 **Sec. 10.** ***1. The Director, in consultation with the Commissioner***
16 ***and the Executive Director of the Exchange, shall design, establish and***
17 ***operate a health benefit plan known as the Public Option.***
18 ***2. The Director:***
19 ***(a) Shall make the Public Option available [to all natural persons***
20 ***who reside in this State as a policy of individual health insurance] :***
21 ***(1) As a qualified health plan through the Exchange to natural***
22 ***persons who reside in this State and are eligible to enroll in such a plan***
23 ***under the provisions of 45 C.F.R. § 155.305; and [for] (2) For direct***
24 ***purchase [.] as a policy of individual health insurance by any natural***
25 ***person who resides in this State. The provisions of chapter 689A of NRS***
26 ***and other applicable provisions of this title apply to the Public Option***
27 ***when offered as a policy of individual health insurance.***
28 ***(b) May make the Public Option available to small employers in this***
29 ***State or their employees to the extent authorized by federal law. The***
30 ***provisions of chapter 689C of NRS and other applicable provisions of***
31 ***this title apply to the Public Option when it is offered as a policy of***
32 ***health insurance for small employers.***
33 ***(c) Shall comply with all state and federal laws and regulations***
34 ***applicable to insurers when carrying out the provisions of sections 2 to***
35 ***15, inclusive, of this act, to the extent that such laws and regulations are***
36 ***not waived.***
37 ***3. The Public Option must:***
38 ***(a) Be a qualified health plan, as defined in 42 U.S.C. § 18021; and***
39 ***(b) Provide at least levels of coverage consistent with the actuarial***
40 ***value of one silver plan and one gold plan.***
41 ***4. Except as otherwise provided in this section, the premiums for the***
42 ***Public Option:***
43 ***(a) Must be at least 5 percent lower than the reference premium for***
44 ***that zip code; and***

1 *(b) Must not increase in any year by a percentage greater than the*
2 *increase in the Medicare Economic Index for that year.*
3 *5. The Director, in consultation with the Commissioner and the*
4 *Executive Director of the Exchange, may revise the requirements of*
5 *subsection 4, provided that the average premiums for the Public Option*
6 *must be at least 15 percent lower than the average reference premium in*
7 *this State over the first 4 years in which the Public Option is in*
8 *operation.*
9 *6. As used in this section:*
10 *(a) "Gold plan" means a qualified health plan that meets the*
11 *requirements established by 42 U.S.C. § 18022 for a gold level plan.*
12 *(b) "Health benefit plan" means a policy, contract, certificate or*
13 *agreement to provide, deliver, arrange for, pay for or reimburse any of*
14 *the costs of health care services.*
15 *(c) "Medicare Economic Index" means the Medicare Economic*
16 *Index, as designated by the Centers for Medicare and Medicaid Services*
17 *of the United States Department of Health and Human Services*
18 *pursuant to 42 C.F.R. § 405.504.*
19 *(d) "Reference premium" means, for any zip code, the lower of:*
20 *(1) The premium for the second-lowest cost silver level plan*
21 *available through the Exchange in the zip code during the 2024 plan*
22 *year, adjusted by the percentage change in the Medicare Economic*
23 *Index between January 1, 2024, and January 1 of the year to which a*
24 *premium applies; or*
25 *(2) The premium for the second-lowest cost silver level plan*
26 *available through the Exchange in the zip code during the year*
27 *immediately preceding the year to which a premium applies.*
28 *(e) "Silver plan" means a qualified health plan that meets the*
29 *requirements established by 42 U.S.C. § 18022 for a silver level plan.*
30 *(f) "Small employer" has the meaning ascribed to it in 42 U.S.C. §*
31 *18024(b)(2).*
32 **Sec. 11.** *1. The Director, the Commissioner and the Executive*
33 *Director of the Exchange:*
34 *(a) Shall collaborate to apply to the Secretary of Health and Human*
35 *Services for a waiver pursuant to 42 U.S.C. § 18052 to obtain pass-*
36 *through federal funding to carry out the provisions of sections 2 to 15,*
37 *inclusive, of this act; and*
38 *(b) Except as otherwise provided in subsection 4, may collaboratively*
39 *apply to the Secretary of Health and Human Services for any other*
40 *federal waivers or approval necessary to carry out the provisions of*
41 *sections 2 to 15, inclusive, of this act, including, without limitation, and*
42 *to the extent necessary, a waiver pursuant to 42 U.S.C. § 1315 of Title*
43 *XIX of the Social Security Act. Such waivers or approval may include,*
44 *without limitation, any waiver or approval necessary to:*

1 *(1) Combine risk pools for the Public Option with risk pools*
2 *established for Medicaid, if the Director can demonstrate that doing so*
3 *would lower costs, result in savings to the federal and state governments*
4 *and not increase the costs of private insurance or Medicaid; or*
5 *(2) Obtain federal financial participation to subsidize the cost of*
6 *health insurance for residents of this State with low incomes.*
7 *2. In preparing an application for any waiver described in*
8 *subsection 1, the Director, the Commissioner and the Executive Director*
9 *of the Exchange may contract with an independent actuary to assess the*
10 *impact of the Public Option on the markets for health care and health*
11 *insurance in this State and health coverage for natural persons, families*
12 *and small businesses. The actuary must have specialized expertise or*
13 *experience with state health insurance exchanges, the type of waiver for*
14 *which the application is being made, measures to contain the costs of*
15 *providing health coverage, reforming procedures for the purchasing and*
16 *delivery of government services and Medicaid managed care programs.*
17 *A contract pursuant to this subsection is exempt from the provisions of*
18 *chapter 333 of NRS.*
19 *3. The Director, the Commissioner and the Executive Director of*
20 *the Exchange shall:*
21 *(a) Cooperate with the Federal Government in obtaining any waiver*
22 *for which he or she applies pursuant to this section.*
23 *(b) Deposit any money received from the Federal Government*
24 *pursuant to such a waiver in the Trust Fund.*
25 *4. The Director, the Commissioner and the Executive Director of*
26 *the Exchange shall not apply under the provisions of subsection 1 to*
27 *waive any provision of federal law prescribing conditions of eligibility to*
28 *purchase a qualified health plan, as defined in 42 U.S.C. § 18021,*
29 *through the Exchange or receive federal advanced payment of premium*
30 *tax credits pursuant to 42 U.S.C. § 18082 for such a purchase.*
31 *5. The Director may:*
32 *(a) Accept gifts, grants and donations to carry out the provisions of*
33 *sections 2 to 15, inclusive, of this act. The Director shall deposit any such*
34 *gifts, grants or donations in the Trust Fund.*
35 *(b) Employ or enter into contracts with actuaries and other*
36 *professionals and may enter into contracts with other state agencies,*
37 *health carriers or other qualified persons and entities as are necessary to*
38 *carry out the provisions of sections 2 to 15, inclusive, of this act. Such*
39 *contracts are exempt from the requirements of chapter 333 of NRS.*
40 **Sec. 12.** *1. The Director, in consultation with the Commissioner*
41 *and the Executive Director of the Exchange, shall use a statewide*
42 *competitive bidding process, including, without limitation, a request for*
43 *proposals, to solicit and enter into contracts with health carriers or other*
44 *qualified persons or entities to administer the Public Option. If a*
45 *statewide Medicaid managed care program is established pursuant to*

subsection 1 of NRS 422.273, the competitive bidding process must coincide with the statewide procurement process for that Medicaid managed care program.

2. Each health carrier that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program shall, as a condition of continued participation in any Medicaid managed care program established in this State, submit a good faith proposal in response to a request for proposals issued pursuant to subsection 1.

3. Each proposal submitted pursuant to subsection 2 must demonstrate that the applicant is able to meet the requirements of section 10 of this act.

4. When selecting a health carrier or other qualified person or entity to administer the Public Option, the Director shall prioritize applicants whose proposals:

(a) Demonstrate alignment of networks of providers between the Public Option and Medicaid managed care, where applicable;

(b) Provide for the inclusion of critical access hospitals, rural health clinics, certified community behavioral health clinics and federally-qualified health centers in the networks of providers for the Public Option and Medicaid managed care, where applicable;

(c) Include proposals for strengthening the workforce in this State and particularly in rural areas of this State for providers of primary care, mental health care and treatment for substance use disorders;

(d) Use payment models for providers included in the networks of providers for the Public Option that increase value for persons enrolled in the Public Option and the State; and

(e) Include proposals to contract with providers of health care in a manner that decreases disparities among different populations in this State with regard to access to health care and health outcomes and supports culturally competent care.

5. Notwithstanding the provisions of subsections 1 to 4, inclusive, the Director may directly administer the Public Option if necessary to carry out the provisions of sections 2 to 15, inclusive, of this act.

6. Any health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to this section or the Director, if the Director directly administers the Public Option pursuant to subsection 5, shall take any measures necessary to make the Public Option available as described in paragraph (a) of subsection 2 of section 10 of this act and, if required by the Director, paragraph (b) of that subsection. Such measures include, without limitation:

(a) Filing rates and supporting information with the Commissioner of Insurance as required by NRS 686B.010 to 686B.1799, inclusive; and

1 ***(b) Obtaining certification as a qualified health plan pursuant to 42***
2 ***U.S.C. § 18031.***
3 ***7. The Director shall deposit into the Trust Fund any money***
4 ***received from:***
5 ***(a) A health carrier or other person or entity with which the Director***
6 ***contracts to administer the Public Option pursuant to subsection 1 which***
7 ***relates to duties performed under the contract; or***
8 ***(b) If the Director directly administers the Public Option pursuant to***
9 ***subsection 5, any money received from any person or entity in the course***
10 ***of administering the Public Option.***
11 ***[7.] 8. As used in this section:***
12 ***(a) "Critical access hospital" means a hospital which has been***
13 ***certified as a critical access hospital by the Secretary of Health and***
14 ***Human Services pursuant to 42 U.S.C. § 1395i-4(e).***
15 ***(b) "Health carrier" means an entity subject to the insurance laws***
16 ***and regulations of this State, or subject to the jurisdiction of the***
17 ***Commissioner, that contracts or offers to contract to provide, deliver,***
18 ***arrange for, pay for or reimburse any of the costs of health care services,***
19 ***including, without limitation, a sickness and accident health insurance***
20 ***company, a health maintenance organization, a nonprofit hospital and***
21 ***health service corporation or any other entity providing a plan of health***
22 ***insurance, health benefits or health care services.***
23 **Sec. 13.** ***1. Except as otherwise provided in subsection 2, each***
24 ***provider of health care who participates in the Public Employees'***
25 ***Benefits Program established pursuant to subsection 1 of NRS 287.043***
26 ***or the Medicaid program, or who provides care to an injured employee***
27 ***pursuant to the provisions of chapters 616A to 616D, inclusive, or***
28 ***chapter 617 of NRS, shall:***
29 ***(a) Enroll as a participating provider in at least one network of***
30 ***providers established for the Public Option; and***
31 ***(b) Accept new patients who are enrolled in the Public Option to the***
32 ***same extent as the provider or facility accepts new patients who are not***
33 ***enrolled in the Public Option.***
34 ***2. The Director and the Executive Officer of the Public Employees'***
35 ***Benefits Program may waive the requirements of subsection 1 when***
36 ***necessary to ensure that recipients of Medicaid and officers, employees***
37 ***and retirees of this State who receive benefits under the Public***
38 ***Employees' Benefits Program have sufficient access to covered services.***
39 **Sec. 14.** ***1. In establishing networks for the Public Option and***
40 ***reimbursing providers of health care that participate in the Public***
41 ***Option, the Director shall, to the extent practicable:***
42 ***(a) Ensure that care for persons who were previously covered by***
43 ***Medicaid or the Children's Health Insurance Program and enroll in the***
44 ***Public Option is minimally disrupted;***

(b) Encourage the use of payment models that increase value for persons enrolled in the Public Option and the State;

(c) Improve health outcomes for persons enrolled in the Public Option;

(d) Reward providers of health care and medical facilities for delivering high-quality services; and

(e) Lower the cost of care in both urban and rural areas of this State.

2. Except as otherwise provided in subsections 3 to 6, inclusive, reimbursement rates under the Public Option must be, in the aggregate, comparable to or better than reimbursement rates available under Medicare. For the purposes of this section, the aggregate reimbursement rate under Medicare:

(a) Includes any add-on payments or other subsidies that a provider receives under Medicare; and

(b) Does not include payments under Medicare for a patient encounter or a cost-based payment rate under Medicare.

3. If a provider of health care currently receives reimbursement under Medicare at rates that are cost-based, the reimbursement rates for that provider of health care under the Public Option must be comparable to or better than the cost-based reimbursement rates provided for that provider of health care by Medicare.

4. The reimbursement rates for a federally-qualified health center or a rural health clinic under the Public Option must be comparable to or better than the reimbursement rates established for patient encounters under the applicable Prospective Payment System established for Medicare by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.

5. The reimbursement rates for a certified community behavioral health clinic under the Public Option must be comparable to or better than the reimbursement rates established for community behavioral health clinics under the State Plan for Medicaid.

6. The requirements of subsections 2 to 5, inclusive, do not apply to a payment model described in paragraph (b) of subsection 1.

7. As used in this section, "Medicare" means the program of health insurance for aged persons and persons with disabilities established pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq.

Sec. 15. *1. There is hereby created in the State Treasury the Public Option Trust Fund as a nonreverting trust fund. The Trust Fund must be administered by the State Treasurer.*

2. The Trust Fund consists of:

(a) Any money deposited in the Trust Fund pursuant to sections 11 and 12 of this act;

1 ***(b) Any money appropriated by the Legislature for the purpose of***
2 ***carrying out the provisions of sections 2 to 15, inclusive, of this act; and***
3 ***(c) All income and interest earned on the money in the Trust Fund.***
4 ***3. Any interest earned on money in the Trust Fund, after deducting***
5 ***any applicable charges, must be credited to the Trust Fund. Money that***
6 ***remains in the Trust Fund at the end of a fiscal year does not revert to***
7 ***the State General Fund, and the balance in the Trust Fund must be***
8 ***carried forward to the next fiscal year.***
9 ***4. Except as otherwise provided in subsection 5, the money in the***
10 ***Trust Fund must be used to carry out the provisions of sections 2 to 15,***
11 ***inclusive, of this act. Such money must not be used to pay administrative***
12 ***costs that are not directly related to the operations of the Public Option.***
13 ***5. If the State Treasurer determines that there is sufficient money in***
14 ***the Trust Fund to carry out the provisions of sections 2 to 15, inclusive,***
15 ***of this act, for the current fiscal year, the Director may use a portion***
16 ***determined by the State Treasurer of any additional money in the Trust***
17 ***Fund to increase the affordability of the Public Option.***
18 **Sec. 16.** NRS 683A.176 is hereby amended to read as follows:
19 683A.176 "Third party" means:
20 1. An insurer, as that term is defined in NRS 679B.540;
21 2. A health benefit plan, as that term is defined in NRS 687B.470, for
22 employees which provides a pharmacy benefits plan;
23 3. A participating public agency, as that term is defined in NRS
24 287.04052, and any other local governmental agency of the State of
25 Nevada which provides a system of health insurance for the benefit of its
26 officers and employees, and the dependents of officers and employees,
27 pursuant to chapter 287 of NRS; ~~[or]~~
28 4. ***The Public Option established pursuant to section 10 of this act;***
29 ***or***
30 ***5.*** Any other insurer or organization that provides health coverage or
31 benefits or coverage of prescription drugs as part of workers'
32 compensation insurance in accordance with state or federal law.
33 ➥ The term does not include an insurer that provides coverage under a
34 policy of casualty or property insurance.
35 **Sec. 16.3.** NRS 689A.020 is hereby amended to read as follows:
36 689A.020 Nothing in this chapter applies to or affects:
37 1. Any policy of liability or workers' compensation insurance with or
38 without supplementary expense coverage therein.
39 2. Any group or blanket policy.
40 3. Life insurance, endowment or annuity contracts, or contracts
41 supplemental thereto which contain only such provisions relating to health
42 insurance as to:
43 (a) Provide additional benefits in case of death or dismemberment or
44 loss of sight by accident or accidental means; or

1 (b) Operate to safeguard such contracts against lapse, or to give a
2 special surrender value or special benefit or an annuity if the insured or
3 annuitant becomes totally and permanently disabled, as defined by the
4 contract or supplemental contract.
5 4. Reinsurance, except as otherwise provided in NRS 689A.470 to
6 689A.740, inclusive, and 689C.610 to 689C.940, inclusive, relating to the
7 program of reinsurance.
8 ***5. Any policy of insurance offered on the Silver State Health***
9 ***Insurance Exchange in accordance with section 16.5 of this act.***
10 **Sec. 16.5.** Chapter 695I of NRS is hereby amended by adding thereto
11 a new section to read as follows:
12 ***1. The Executive Director, in collaboration with the Director of the***
13 ***Department of Health and Human Services, shall apply to the Secretary***
14 ***of Health and Human Services for a waiver pursuant to 42 U.S.C. §***
15 ***18052 to authorize an organization described in section 501(c)(5) of the***
16 ***Internal Revenue Code that processes health claims in this State to offer***
17 ***on the Exchange a policy of insurance to meet the unique needs of***
18 ***tradespersons, including, without limitation, persons who work***
19 ***temporary or seasonal jobs, that is capable of serving as an alternative to***
20 ***the continuation of group health benefits under the Consolidated***
21 ***Omnibus Budget Reconciliation Act of 1985.***
22 ***2. The application for a waiver submitted pursuant to subsection 1***
23 ***must include, without limitation, an application for a waiver of any***
24 ***provisions of federal law or regulations that would otherwise require a***
25 ***policy described in subsection 1 to meet the requirements of chapter***
26 ***689A of NRS in order to be offered on the Exchange or for persons who***
27 ***purchase the plan on the Exchange to receive applicable federal***
28 ***subsidies.***
29 ***3. To be offered on the Exchange, a policy of insurance described in***
30 ***subsection 1 must:***
31 ***(a) Meet all requirements established by the Federal Act for a***
32 ***qualified health plan, to the extent that those requirements do not***
33 ***prevent an organization described in section 501(c)(5) of the Internal***
34 ***Revenue Code from offering such a policy; and***
35 ***(b) Be certified by the Executive Director. Such certification must be***
36 ***renewed annually.***
37 ***4. The Executive Director shall prescribe:***
38 ***(a) Requirements for certification of a policy of insurance pursuant***
39 ***to paragraph (b) of subsection 3; and***
40 ***(b) Criteria to determine when a person becomes eligible for a policy***
41 ***of insurance described in subsection 1. Those criteria must address:***
42 ***(1) Persons who recently began employment but have not yet met***
43 ***the requirements concerning hours of work necessary to receive***
44 ***insurance through their employer; and***
45 ***(2) Persons who have recently lost their jobs.***

1 ***5. When performing the duties described in subsections 1 and 4, the***
2 ***Executive Director shall consult with organizations described in section***
3 ***501(c)(5) of the Internal Revenue Code and other interested persons and***
4 ***entities concerning the requirements for certification of a policy of***
5 ***insurance described in subsection 1 and the criteria described in***
6 ***paragraph (b) of subsection 4.***
7 **Sec. 16.8.** NRS 695I.210 is hereby amended to read as follows:
8 695I.210 1. The Exchange shall:
9 (a) Create and administer a health insurance exchange;
10 (b) Facilitate the purchase and sale of qualified health plans consistent
11 with established patterns of care within the State;
12 (c) Provide for the establishment of a program to assist qualified small
13 employers in Nevada in facilitating the enrollment of their employees in
14 qualified health plans offered in the small group market;
15 (d) [Make] ***Except as otherwise authorized by a waiver obtained***
16 ***pursuant to section 16.5 of this act, make*** only qualified health plans
17 available to qualified individuals and qualified small employers ***;*** [on or
18 after January 1, 2014;] and
19 (e) Unless the Federal Act is repealed or is held to be unconstitutional
20 or otherwise invalid or unlawful, perform all duties that are required of the
21 Exchange to implement the requirements of the Federal Act.
22 2. The Exchange may:
23 (a) Enter into contracts with any person, including, without limitation,
24 a local government, a political subdivision of a local government and a
25 governmental agency, to assist in carrying out the duties and powers of the
26 Exchange or the Board; and
27 (b) Apply for and accept any gift, donation, bequest, grant or other
28 source of money to carry out the duties and powers of the Exchange or the
29 Board.
30 3. The Exchange is subject to the provisions of chapter 333 of NRS.
31 **Sec. 17.** NRS 200.5093 is hereby amended to read as follows:
32 200.5093 1. Any person who is described in subsection 4 and who,
33 in a professional or occupational capacity, knows or has reasonable cause
34 to believe that an older person or vulnerable person has been abused,
35 neglected, exploited, isolated or abandoned shall:
36 (a) Except as otherwise provided in subsection 2, report the abuse,
37 neglect, exploitation, isolation or abandonment of the older person or
38 vulnerable person to:
39 (1) The local office of the Aging and Disability Services Division
40 of the Department of Health and Human Services;
41 (2) A police department or sheriff's office; or
42 (3) A toll-free telephone service designated by the Aging and
43 Disability Services Division of the Department of Health and Human
44 Services; and

(b) Make such a report as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the older person or vulnerable person has been abused, neglected, exploited, isolated or abandoned.

2. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that the abuse, neglect, exploitation, isolation or abandonment of the older person or vulnerable person involves an act or omission of the Aging and Disability Services Division, another division of the Department of Health and Human Services or a law enforcement agency, the person shall make the report to an agency other than the one alleged to have committed the act or omission.

3. Each agency, after reducing a report to writing, shall forward a copy of the report to the Aging and Disability Services Division of the Department of Health and Human Services and the Unit for the Investigation and Prosecution of Crimes.

4. A report must be made pursuant to subsection 1 by the following persons:

(a) Every physician, dentist, dental hygienist, chiropractor, optometrist, podiatric physician, medical examiner, resident, intern, professional or practical nurse, physician assistant licensed pursuant to chapter 630 or 633 of NRS, perfusionist, psychiatrist, psychologist, marriage and family therapist, clinical professional counselor, clinical alcohol and drug counselor, alcohol and drug counselor, music therapist, athletic trainer, driver of an ambulance, paramedic, licensed dietitian, holder of a license or a limited license issued under the provisions of chapter 653 of NRS or other person providing medical services licensed or certified to practice in this State, who examines, attends or treats an older person or vulnerable person who appears to have been abused, neglected, exploited, isolated or abandoned.

(b) Any personnel of a hospital or similar institution engaged in the admission, examination, care or treatment of persons or an administrator, manager or other person in charge of a hospital or similar institution upon notification of the suspected abuse, neglect, exploitation, isolation or abandonment of an older person or vulnerable person by a member of the staff of the hospital.

(c) A coroner.

(d) Every person who maintains or is employed by an agency to provide personal care services in the home.

(e) Every person who maintains or is employed by an agency to provide nursing in the home.

(f) Every person who operates, who is employed by or who contracts to provide services for an intermediary service organization as defined in NRS 449.4304.

(g) Any employee of the Department of Health and Human Services, except the State Long-Term Care Ombudsman appointed pursuant to NRS 427A.125 and any of his or her advocates or volunteers where prohibited from making such a report pursuant to 45 C.F.R. § 1321.11.

(h) Any employee of a law enforcement agency or a county's office for protective services or an adult or juvenile probation officer.

(i) Any person who maintains or is employed by a facility or establishment that provides care for older persons or vulnerable persons.

(j) Any person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding the abuse, neglect, exploitation, isolation or abandonment of an older person or vulnerable person and refers them to persons and agencies where their requests and needs can be met.

(k) Every social worker.

(l) Any person who owns or is employed by a funeral home or mortuary.

(m) Every person who operates or is employed by a peer support recovery organization, as defined in NRS 449.01563.

(n) Every person who operates or is employed by a community health worker pool, as defined in NRS 449.0028, or with whom a community health worker pool contracts to provide the services of a community health worker, as defined in NRS 449.0027.

(o) Every person who is enrolled with the Division of Health Care Financing and Policy of the Department of Health and Human Services to provide doula services to recipients of Medicaid pursuant to section 26 of this act.

5. A report may be made by any other person.

6. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that an older person or vulnerable person has died as a result of abuse, neglect, isolation or abandonment, the person shall, as soon as reasonably practicable, report this belief to the appropriate medical examiner or coroner, who shall investigate the cause of death of the older person or vulnerable person and submit to the appropriate local law enforcement agencies, the appropriate prosecuting attorney, the Aging and Disability Services Division of the Department of Health and Human Services and the Unit for the Investigation and Prosecution of Crimes his or her written findings. The written findings must include the information required pursuant to the provisions of NRS 200.5094, when possible.

7. A division, office or department which receives a report pursuant to this section shall cause the investigation of the report to commence within 3 working days. A copy of the final report of the investigation conducted by a division, office or department, other than the Aging and Disability Services Division of the Department of Health and Human

Services, must be forwarded within 30 days after the completion of the report to the:

(a) Aging and Disability Services Division;

(b) Repository for Information Concerning Crimes Against Older Persons or Vulnerable Persons created by NRS 179A.450; and

(c) Unit for the Investigation and Prosecution of Crimes.

8. If the investigation of a report results in the belief that an older person or vulnerable person is abused, neglected, exploited, isolated or abandoned, the Aging and Disability Services Division of the Department of Health and Human Services or the county's office for protective services may provide protective services to the older person or vulnerable person if the older person or vulnerable person is able and willing to accept them.

9. A person who knowingly and willfully violates any of the provisions of this section is guilty of a misdemeanor.

10. As used in this section, "Unit for the Investigation and Prosecution of Crimes" means the Unit for the Investigation and Prosecution of Crimes Against Older Persons or Vulnerable Persons in the Office of the Attorney General created pursuant to NRS 228.265.

Sec. 18. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, ***and sections 24 to 28, inclusive, of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department.

Sec. 19. NRS 232.459 is hereby amended to read as follows:

232.459 1. The Advocate shall:

(a) Respond to written and telephonic inquiries received from consumers and injured employees regarding concerns and problems related to health care and workers' compensation;

(b) Assist consumers and injured employees in understanding their rights and responsibilities under health care plans, including, without limitation, the Public Employees' Benefits Program [,] ***and the Public Option,*** and policies of industrial insurance;

(c) Identify and investigate complaints of consumers and injured employees regarding their health care plans, including, without limitation, the Public Employees' Benefits Program ~~[,]~~ ***and the Public Option,*** and policies of industrial insurance and assist those consumers and injured employees to resolve their complaints, including, without limitation:

(1) Referring consumers and injured employees to the appropriate agency, department or other entity that is responsible for addressing the specific complaint of the consumer or injured employee; and

(2) Providing counseling and assistance to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program ~~[,]~~ ***and the Public Option,*** and policies of industrial insurance;

(d) Provide information to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program ~~[,]~~ ***and the Public Option,*** and policies of industrial insurance in this State;

(e) Establish and maintain a system to collect and maintain information pertaining to the written and telephonic inquiries received by the Office for Consumer Health Assistance;

(f) Take such actions as are necessary to ensure public awareness of the existence and purpose of the services provided by the Advocate pursuant to this section;

(g) In appropriate cases and pursuant to the direction of the Advocate, refer a complaint or the results of an investigation to the Attorney General for further action;

(h) Provide information to and applications for prescription drug programs for consumers without insurance coverage for prescription drugs or pharmaceutical services;

(i) Establish and maintain an Internet website which includes:

(1) Information concerning purchasing prescription drugs from Canadian pharmacies that have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328;

(2) Links to websites of Canadian pharmacies which have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328; and

(3) A link to the website established and maintained pursuant to NRS 439A.270 which provides information to the general public concerning the charges imposed and the quality of the services provided by the hospitals and surgical centers for ambulatory patients in this State;

(j) Assist consumers with accessing a navigator, case manager or facilitator to help the consumer obtain health care services;

(k) Assist consumers with scheduling an appointment with a provider of health care who is in the network of providers under contract to provide

services to participants in the health care plan under which the consumer is covered;

(l) Assist consumers with filing complaints against health care facilities and health care professionals;

(m) Assist consumers with filing complaints with the Commissioner of Insurance against issuers of health care plans; and

(n) On or before January 31 of each year, compile a report of aggregated information submitted to the Office for Consumer Health Assistance pursuant to NRS 687B.675, aggregated for each type of provider of health care for which such information is provided and submit the report to the Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the Legislative Committee on Health Care; and

(2) In odd-numbered years, the next regular session of the Legislature.

2. The Advocate may adopt regulations to carry out the provisions of this section and NRS 232.461 and 232.462.

3. As used in this section:

(a) "Health care facility" has the meaning ascribed to it in NRS 162A.740.

(b) "Navigator, case manager or facilitator" has the meaning ascribed to it in NRS 687B.675.

(c) "Public Option" means the Public Option established pursuant to section 10 of this act.

Sec. 20. NRS 233B.039 is hereby amended to read as follows:

233B.039 1. The following agencies are entirely exempted from the requirements of this chapter:

(a) The Governor.

(b) Except as otherwise provided in NRS 209.221, the Department of Corrections.

(c) The Nevada System of Higher Education.

(d) The Office of the Military.

(e) The Nevada Gaming Control Board.

(f) Except as otherwise provided in NRS 368A.140 and 463.765, the Nevada Gaming Commission.

(g) Except as otherwise provided in NRS 425.620, the Division of Welfare and Supportive Services of the Department of Health and Human Services.

(h) Except as otherwise provided in NRS 422.390, the Division of Health Care Financing and Policy of the Department of Health and Human Services.

(i) Except as otherwise provided in NRS 533.365, the Office of the State Engineer.

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(j) The Division of Industrial Relations of the Department of Business and Industry acting to enforce the provisions of NRS 618.375.

(k) The Administrator of the Division of Industrial Relations of the Department of Business and Industry in establishing and adjusting the schedule of fees and charges for accident benefits pursuant to subsection 2 of NRS 616C.260.

(l) The Board to Review Claims in adopting resolutions to carry out its duties pursuant to NRS 445C.310.

(m) The Silver State Health Insurance Exchange.

(n) The Cannabis Compliance Board.

2. Except as otherwise provided in subsection 5 and NRS 391.323, the Department of Education, the Board of the Public Employees' Benefits Program and the Commission on Professional Standards in Education are subject to the provisions of this chapter for the purpose of adopting regulations but not with respect to any contested case.

3. The special provisions of:

(a) Chapter 612 of NRS for the adoption of an emergency regulation or the distribution of regulations by and the judicial review of decisions of the Employment Security Division of the Department of Employment, Training and Rehabilitation;

(b) Chapters 616A to 617, inclusive, of NRS for the determination of contested claims;

(c) Chapter 91 of NRS for the judicial review of decisions of the Administrator of the Securities Division of the Office of the Secretary of State; and

(d) NRS 90.800 for the use of summary orders in contested cases,

➥ prevail over the general provisions of this chapter.

4. The provisions of NRS 233B.122, 233B.124, 233B.125 and 233B.126 do not apply to the Department of Health and Human Services in the adjudication of contested cases involving the issuance of letters of approval for health facilities and agencies.

5. The provisions of this chapter do not apply to:

(a) Any order for immediate action, including, but not limited to, quarantine and the treatment or cleansing of infected or infested animals, objects or premises, made under the authority of the State Board of Agriculture, the State Board of Health, or any other agency of this State in the discharge of a responsibility for the preservation of human or animal health or for insect or pest control;

(b) An extraordinary regulation of the State Board of Pharmacy adopted pursuant to NRS 453.2184;

(c) A regulation adopted by the State Board of Education pursuant to NRS 388.255 or 394.1694;

(d) The judicial review of decisions of the Public Utilities Commission of Nevada;

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(e) The adoption, amendment or repeal of policies by the Rehabilitation Division of the Department of Employment, Training and Rehabilitation pursuant to NRS 426.561 or 615.178;

(f) The adoption or amendment of a rule or regulation to be included in the State Plan for Services for Victims of Crime by the Department of Health and Human Services pursuant to NRS 217.130;

(g) The adoption, amendment or repeal of rules governing the conduct of contests and exhibitions of unarmed combat by the Nevada Athletic Commission pursuant to NRS 467.075; ~~[or]~~

(h) The adoption, amendment or repeal of regulations by the Director of the Department of Health and Human Services pursuant to NRS 447.335 to 447.350, inclusive ~~[.]~~ ***; or***

(i) The adoption, amendment or repeal of any rule or policy governing the Public Option established pursuant to the chapter created by sections 2 to 15, inclusive, of this act.

6. The State Board of Parole Commissioners is subject to the provisions of this chapter for the purpose of adopting regulations but not with respect to any contested case.

Sec. 21. NRS 287.0434 is hereby amended to read as follows:

287.0434 The Board may:

1. Use its assets only to pay the expenses of health care for its members and covered dependents, to pay its employees' salaries and to pay administrative and other expenses.

2. Enter into contracts relating to the administration of the Program, including, without limitation, contracts with licensed administrators and qualified actuaries. Each such contract with a licensed administrator:

(a) Must be submitted to the Commissioner of Insurance not less than 30 days before the date on which the contract is to become effective for approval as to the licensing and fiscal status of the licensed administrator and status of any legal or administrative actions in this State against the licensed administrator that may impair his or her ability to provide the services in the contract.

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

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

3. Enter into contracts with physicians, surgeons, hospitals, health maintenance organizations and rehabilitative facilities for medical, surgical and rehabilitative care and the evaluation, treatment and nursing care of members and covered dependents. The Board shall not enter into a contract pursuant to this subsection unless:

(a) Provision is made by the Board to offer all the services specified in the request for proposals, either by a health maintenance organization or through separate action of the Board.

(b) The rates set forth in the contract are based on:

1 (1) For active and retired state officers and employees and their
2 dependents, the commingled claims experience of such active and retired
3 officers and employees and their dependents for whom the Program
4 provides primary health insurance coverage in a single risk pool; and
5 (2) For active and retired officers and employees of public agencies
6 enumerated in NRS 287.010 that contract with the Program to obtain group
7 insurance by participation in the Program and their dependents, the
8 commingled claims experience of such active and retired officers and
9 employees and their dependents for whom the Program provides primary
10 health insurance coverage in a single risk pool.
11 ***(c) For a contract with a physician, surgeon, hospital or***
12 ***rehabilitative facility, the physician, surgeon, hospital or rehabilitative***
13 ***facility has also complied with the requirements of section 13 of this act.***
14 4. Enter into contracts for the services of other experts and specialists
15 as required by the Program.
16 5. Charge and collect from an insurer, health maintenance
17 organization, organization for dental care or nonprofit medical service
18 corporation, a fee for the actual expenses incurred by the Board or a
19 participating public agency in administering a plan of insurance offered by
20 that insurer, organization or corporation.
21 6. Charge and collect the amount due from local governments
22 pursuant to paragraph (b) of subsection 4 of NRS 287.023. If the payment
23 of a local government pursuant to that provision is delinquent by more than
24 90 days, the Board shall notify the Executive Director of the Department
25 of Taxation pursuant to
26 NRS 354.671.
27 **Sec. 22.** NRS 333.705 is hereby amended to read as follows:
28 333.705 1. Except as otherwise provided in this section, a using
29 agency shall not enter into a contract with a person to provide services for
30 the using agency if:
31 (a) The person is a current employee of an agency of this State;
32 (b) The person is a former employee of an agency of this State and less
33 than 2 years have expired since the termination of the person's
34 employment with the State; or
35 (c) The person is employed by the Department of Transportation for a
36 transportation project that is entirely funded by federal money and the term
37 of the contract is for more than 4 years,
38 ➥ unless the using agency submits a written disclosure to the State Board
39 of Examiners indicating the services to be provided pursuant to the
40 contract and the person who will be providing those services and, after
41 reviewing the disclosure, the State Board of Examiners approves entering
42 into a contract with the person. The requirements of this subsection apply
43 to any person employed by a business or other entity that enters into a
44 contract to provide services for a using agency if the person will be

1 performing or producing the services for which the business or entity is
2 employed.
3 2. The provisions of paragraph (b) of subsection 1 apply to
4 employment through a temporary employment service. A temporary
5 employment service providing employees for a using agency shall provide
6 the using agency with the names of the employees to be provided to the
7 agency. The State Board of Examiners shall not approve a contract
8 pursuant to paragraph (b) of subsection 1 unless the Board determines that
9 one or more of the following circumstances exist:
10 (a) The person provides services that are not provided by any other
11 employee of the using agency or for which a critical labor shortage exists;
12 or
13 (b) A short-term need or unusual economic circumstance exists for the
14 using agency to contract with the person.
15 3. The approval by the State Board of Examiners to contract with a
16 person pursuant to subsection 1:
17 (a) May occur at the same time and in the same manner as the approval
18 by the State Board of Examiners of a proposed contract pursuant to
19 subsection 7 of NRS 333.700; and
20 (b) Must occur before the date on which the contract becomes binding
21 on the using agency.
22 4. A using agency may contract with a person pursuant to paragraph
23 (a) or (b) of subsection 1 without obtaining the approval of the State Board
24 of Examiners if the term of the contract is for less than 4 months and the
25 head of the using agency determines that an emergency exists which
26 necessitates the contract. If a using agency contracts with a person
27 pursuant to this subsection, the using agency shall submit a copy of the
28 contract and a description of the emergency to the State Board of
29 Examiners, which shall review the contract and the description of the
30 emergency and notify the using agency whether the State Board of
31 Examiners would have approved the contract if it had not been entered into
32 pursuant to this subsection.
33 5. Except as otherwise provided in subsection 9, a using agency shall,
34 not later than 10 days after the end of each fiscal quarter, report to the
35 Interim Finance Committee concerning all contracts to provide services for
36 the using agency that were entered into by the using agency during the
37 fiscal quarter with a person who is a current or former employee of a
38 department, division or other agency of this State.
39 6. Except as otherwise provided in subsection 9, a using agency shall
40 not contract with a temporary employment service unless the contracting
41 process is controlled by rules of open competitive bidding.
42 7. Each board or commission of this State and each institution of the
43 Nevada System of Higher Education that employs a consultant shall, at
44 least once every 6 months, submit to the Interim Finance Committee a
45 report setting forth:

1 (a) The number of consultants employed by the board, commission or
2 institution;
3 (b) The purpose for which the board, commission or institution
4 employs each consultant;
5 (c) The amount of money or other remuneration received by each
6 consultant from the board, commission or institution; and
7 (d) The length of time each consultant has been employed by the
8 board, commission or institution.
9 8. A using agency, board or commission of this State and each
10 institution of the Nevada System of Higher Education:
11 (a) Shall make every effort to limit the number of contracts it enters
12 into with persons to provide services which have a term of more than 2
13 years and which are in the amount of less than $1,000,000; and
14 (b) Shall not enter into a contract with a person to provide services
15 without ensuring that the person is in active and good standing with the
16 Secretary of State.
17 9. The provisions of subsections 1 to 6, inclusive, do not apply to:
18 (a) The Nevada System of Higher Education or a board or commission
19 of this State.
20 (b) The employment of professional engineers by the Department of
21 Transportation if those engineers are employed for a transportation project
22 that is entirely funded by federal money.
23 (c) Contracts in the amount of $1,000,000 or more entered into:
24 (1) Pursuant to the State Plan for Medicaid established pursuant to
25 NRS 422.063.
26 (2) For financial services.
27 (3) Pursuant to the Public Employees' Benefits Program.
28 ***(4) Pursuant to the Public Option established pursuant to section***
29 ***10 of this act.***
30 (d) The employment of a person by a business or entity which is a
31 provider of services under the State Plan for Medicaid and which provides
32 such services on a fee-for-service basis or through managed care.
33 (e) The employment of a former employee of an agency of this State
34 who is not receiving retirement benefits under the Public Employees'
35 Retirement System during the duration of the contract.
36 **Sec. 23.** Chapter 422 of NRS is hereby amended by adding thereto
37 the provisions set forth as sections 24 to 28, inclusive, of this act.
38 **Sec. 24.** ***1.*** ~~***[To the extent that money is available, the]***~~ ***The***
39 ***Director shall, to the extent authorized by federal law, include in the***
40 ***State Plan for Medicaid authorization for*** ~~***[:***~~
41 ~~***(a) A pregnant woman whose household income is at or below 200***~~
42 ~~***percent of the federally designated level signifying poverty to enroll in***~~
43 ~~***Medicaid.***~~
44 ~~***(b) A]***~~ ***a pregnant woman who is determined by a qualified provider***
45 ***to be presumptively eligible for Medicaid to enroll in Medicaid until the***

last day of the month immediately following the month of enrollment without submitting an application for enrollment in Medicaid which includes additional proof of eligibility.

2. To the extent that money is available, the Director shall, to the extent authorized by federal law, include in the State Plan for Medicaid authorization for a pregnant woman whose household income is at or below 200 percent of the federally designated level signifying poverty to enroll in Medicaid.

3. Unless otherwise required by federal law, the Director shall not include in the State Plan for Medicaid a requirement that a pregnant woman who is otherwise eligible for Medicaid must reside in the United States for a prescribed period of time before enrolling in Medicaid.

[3.] 4. As used in this section, "qualified provider" has the meaning ascribed to it in 42 U.S.C. § 1396r-1(b)(2).

Sec. 25. *1. The Director shall include in the State Plan for Medicaid a requirement that the State, to the extent authorized by federal law, pay the nonfederal share of expenditures incurred for the services of a community health worker who provides services under the supervision of a physician, physician assistant or advanced practice registered nurse.*

2. As used in this section, "community health worker" has the meaning ascribed to it in NRS 449.0027.

Sec. 26. *1. The Director shall, to the extent authorized by federal law, include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for doula services provided by an enrolled doula.*

2. The Department shall apply to the Secretary of Health and Human Services for a waiver granted pursuant to 42 U.S.C. § 1315 or apply for an amendment of the State Plan for Medicaid that authorizes the Department to receive federal funding to include in the State Plan for Medicaid coverage of doula services provided by an enrolled doula. The Department shall fully cooperate in good faith with the Federal Government during the application process to satisfy the requirements of the Federal Government for obtaining a waiver or amendment pursuant to this section.

3. A person who wishes to receive reimbursement through the Medicaid program for doula services provided to a recipient of Medicaid must submit to the Division:

(a) An application for enrollment in the form prescribed by the Division; and

(b) Proof that he or she possesses the required training and qualifications prescribed by the Division pursuant to subsection 4.

4. The Division, in consultation with community-based organizations that provide services to pregnant women in this State, shall prescribe the required training and qualifications for enrollment

pursuant to subsection 3 to receive reimbursement through Medicaid for doula services.

5. As used in this section:

(a) "Doula services" means services to provide education and support relating to childbirth, including, without limitation, emotional and physical support provided during pregnancy, labor, birth and the postpartum period.

(b) "Enrolled doula" means a doula who is enrolled with the Division pursuant to this section to receive reimbursement through Medicaid for doula services.

Sec. 27. *1. To the extent that money is available, the Director shall include in the State Plan for Medicaid a requirement that, except as otherwise provided in subsection 2, the State must provide reimbursement for the services of an advanced practice registered nurse, including, without limitation, a certified nurse-midwife, to the same extent as if the services were provided by a physician.*

2. The provisions of subsection 1 do not apply to services provided to a recipient of Medicaid who receives health care services through a Medicaid managed care program.

3. As used in this section, "certified nurse-midwife" means a person who is:

(a) Certified as a nurse-midwife by the American Midwifery Certification Board, or its successor organization; and

(b) Licensed as an advanced practice registered nurse pursuant to NRS 632.237.

Sec. 28. *1. To the extent that money is available, the Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:*

(a) Supplies for breastfeeding a child until the child's first birthday. Such supplies include, without limitation, electric or hospital-grade breast pumps that:

(1) Have been prescribed or ordered by a qualified provider of health care; and

(2) Are medically necessary ~~[or are necessary]~~ *for the mother* ~~[of]~~ *or the child .* ~~[to return to work.]~~

(b) Such prenatal screenings and tests as are recommended by the American College of Obstetricians and Gynecologists, or its successor organization.

2. The Director shall include in the State Plan for Medicaid a requirement that, to the extent that money and federal financial participation are available, the State must pay the nonfederal share of expenditures incurred for lactation consultation and support.

3. As used in this section:

(a) "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

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

Sec. 29. NRS 422.2372 is hereby amended to read as follows:

422.2372 The Administrator shall:

1. Supply the Director with material on which to base proposed legislation.

2. Cooperate with the Federal Government and state governments for the more effective attainment of the purposes of this chapter.

3. Coordinate the activities of the Division with other agencies, both public and private, with related or similar activities.

4. Keep a complete and accurate record of all proceedings, record and file all bonds and contracts, and assume responsibility for the custody and preservation of all papers and documents pertaining to the office of the Administrator.

5. Inform the public in regard to the activities and operation of the Division, and provide other information which will acquaint the public with the financing of Medicaid programs.

6. Conduct studies into the causes of the social problems with which the Division is concerned.

7. Invoke any legal, equitable or special procedures for the enforcement of orders issued by the Administrator or the enforcement of the provisions of this chapter.

8. ***Exclude from participation in Medicaid any provider of health care that fails to comply with the requirements of section 13 of this act.***

9. Exercise any other powers that are necessary and proper for the standardization of state work, to expedite business and to promote the efficiency of the service provided by the Division.

Sec. 30. NRS 422.273 is hereby amended to read as follows:

422.273 1. ***To the extent that money is available, the Department shall:***

(a) Establish a Medicaid managed care program to provide health care services to recipients of Medicaid in all geographic areas of this State. The program is not required to provide services to recipients of Medicaid who are aged, blind or disabled pursuant to Title XVI of the Social Security Act, 42 U.S.C. §§ 1381 et seq.

(b) Conduct a statewide procurement process to select health maintenance organizations to provide the services described in paragraph (a).

2. For any Medicaid managed care program established in the State of Nevada, the Department shall contract only with a health maintenance organization that has:

(a) Negotiated in good faith with a federally-qualified health center to provide health care services for the health maintenance organization;

1 (b) Negotiated in good faith with the University Medical Center of
2 Southern Nevada to provide inpatient and ambulatory services to recipients
3 of Medicaid; [and]
4 (c) Negotiated in good faith with the University of Nevada School of
5 Medicine to provide health care services to recipients of Medicaid [.] ***; and***
6 ***(d) Complied with the provisions of subsection 2 of section 12 of this***
7 ***act.***
8 ➥ Nothing in this section shall be construed as exempting a federally-
9 qualified health center, the University Medical Center of Southern Nevada
10 or the University of Nevada School of Medicine from the requirements for
11 contracting with the health maintenance organization.
12 [2.] ***3.*** During the development and implementation of any Medicaid
13 managed care program, the Department shall cooperate with the University
14 of Nevada School of Medicine by assisting in the provision of an adequate
15 and diverse group of patients upon which the school may base its
16 educational programs.
17 [3.] ***4.*** The University of Nevada School of Medicine may establish a
18 nonprofit organization to assist in any research necessary for the
19 development of a Medicaid managed care program, receive and accept
20 gifts, grants and donations to support such a program and assist in
21 establishing educational services about the program for recipients of
22 Medicaid.
23 [4.] ***5.*** For the purpose of contracting with a Medicaid managed care
24 program pursuant to this section, a health maintenance organization is
25 exempt from the provisions of
26 NRS 695C.123.
27 [5.] ***6. To the extent that money is available, a Medicaid managed***
28 ***care program must include, without limitation, a state-directed payment***
29 ***arrangement established in accordance with 42 C.F.R. § 438.6(c) to***
30 ***require a Medicaid managed care organization to reimburse a critical***
31 ***access hospital and any federally-qualified health center or rural health***
32 ***clinic affiliated with a critical access hospital for covered services at a***
33 ***rate that is equal to or greater than the rate received by the critical access***
34 ***hospital, federally-qualified health center or rural health clinic, as***
35 ***applicable, for services provided to recipients of Medicaid on a fee-for-***
36 ***service basis.***
37 ***7.*** The provisions of this section apply to any managed care
38 organization, including a health maintenance organization, that provides
39 health care services to recipients of Medicaid under the State Plan for
40 Medicaid or the Children's Health Insurance Program pursuant to a
41 contract with the Division. Such a managed care organization or health
42 maintenance organization is not required to establish a system for
43 conducting external reviews of adverse determinations in accordance with
44 chapter 695B, 695C or 695G of NRS. This subsection does not exempt

such a managed care organization or health maintenance organization for services provided pursuant to any other contract.

~~[6.]~~ *8.* As used in this section, unless the context otherwise requires:

(a) ***"Critical access hospital" means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).***

(b) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

~~[(b)]~~ ***(c)*** "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

~~[(c)]~~ ***(d)*** "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

(e) "Rural health clinic" has the meaning ascribed to it in 42 C.F.R. § 405.2401.

Sec. 31. (Deleted by amendment.)

Sec. 32. NRS 427A.605 is hereby amended to read as follows:

427A.605 1. The Director may establish a program to negotiate discounts and rebates for hearing devices and related costs, including, without limitation, ear molds, batteries and FM systems, for children in this State who are deaf or hard of hearing on behalf of entities described in subsection 2 who participate in the program.

2. The following persons and entities may participate in a program established pursuant to subsection 1:

(a) The Public Employees' Benefits Program;

(b) A governing body of a county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency that provides health coverage to employees through a self-insurance reserve fund pursuant to NRS 287.010;

(c) An insurer that holds a certificate of authority to transact insurance in this State pursuant to chapter 680A of NRS;

(d) An employer or employee organization based in this State that provides health coverage to employees through a self-insurance reserve fund;

(e) A governmental agency or nonprofit organization that purchases hearing devices for children in this State who are deaf or hard of hearing;

(f) A resident of this State who does not have coverage for hearing devices; ~~[and]~~

(g) ***The Public Option established pursuant to section 10 of this act; and***

(h) Any other person or entity that provides health coverage or otherwise purchases hearing devices for children in this State who are deaf or hard of hearing.

3. A person or entity described in subsection 2 may participate in any program established pursuant to subsection 1 by submitting an application to the Department in the form prescribed by the Department.

1 **Sec. 33.** NRS 432B.220 is hereby amended to read as follows:
2 432B.220 1. Any person who is described in subsection 4 and who,
3 in his or her professional or occupational capacity, knows or has
4 reasonable cause to believe that a child has been abused or neglected shall:
5 (a) Except as otherwise provided in subsection 2, report the abuse or
6 neglect of the child to an agency which provides child welfare services or
7 to a law enforcement agency; and
8 (b) Make such a report as soon as reasonably practicable but not later
9 than 24 hours after the person knows or has reasonable cause to believe
10 that the child has been abused or neglected.
11 2. If a person who is required to make a report pursuant to subsection
12 1 knows or has reasonable cause to believe that the abuse or neglect of the
13 child involves an act or omission of:
14 (a) A person directly responsible or serving as a volunteer for or an
15 employee of a public or private home, institution or facility where the child
16 is receiving child care outside of the home for a portion of the day, the
17 person shall make the report to a law enforcement agency.
18 (b) An agency which provides child welfare services or a law
19 enforcement agency, the person shall make the report to an agency other
20 than the one alleged to have committed the act or omission, and the
21 investigation of the abuse or neglect of the child must be made by an
22 agency other than the one alleged to have committed the act or omission.
23 3. Any person who is described in paragraph (a) of subsection 4 who
24 delivers or provides medical services to a newborn infant and who, in his
25 or her professional or occupational capacity, knows or has reasonable
26 cause to believe that the newborn infant has been affected by a fetal
27 alcohol spectrum disorder or prenatal substance use disorder or has
28 withdrawal symptoms resulting from prenatal substance exposure shall, as
29 soon as reasonably practicable but not later than 24 hours after the person
30 knows or has reasonable cause to believe that the newborn infant is so
31 affected or has such symptoms, notify an agency which provides child
32 welfare services of the condition of the infant and refer each person who is
33 responsible for the welfare of the infant to an agency which provides child
34 welfare services for appropriate counseling, training or other services. A
35 notification and referral to an agency which provides child welfare services
36 pursuant to this subsection shall not be construed to require prosecution for
37 any illegal action.
38 4. A report must be made pursuant to subsection 1 by the following
39 persons:
40 (a) A person providing services licensed or certified in this State
41 pursuant to, without limitation, chapter 450B, 630, 630A, 631, 632, 633,
42 634, 634A, 635, 636, 637, 637B, 639, 640, 640A, 640B, 640C, 640D,
43 640E, 641, 641A, 641B, 641C or 653 of NRS.
44 (b) Any personnel of a medical facility licensed pursuant to chapter
45 449 of NRS who are engaged in the admission, examination, care or

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1 treatment of persons or an administrator, manager or other person in
2 charge of such a medical facility upon notification of suspected abuse or
3 neglect of a child by a member of the staff of the medical facility.
4 (c) A coroner.
5 (d) A member of the clergy, practitioner of Christian Science or
6 religious healer, unless the person has acquired the knowledge of the abuse
7 or neglect from the offender during a confession.
8 (e) A person employed by a public school or private school and any
9 person who serves as a volunteer at such a school.
10 (f) Any person who maintains or is employed by a facility or
11 establishment that provides care for children, children's camp or other
12 public or private facility, institution or agency furnishing care to a child.
13 (g) Any person licensed pursuant to chapter 424 of NRS to conduct a
14 foster home.
15 (h) Any officer or employee of a law enforcement agency or an adult
16 or juvenile probation officer.
17 (i) Except as otherwise provided in NRS 432B.225, an attorney.
18 (j) Any person who maintains, is employed by or serves as a volunteer
19 for an agency or service which advises persons regarding abuse or neglect
20 of a child and refers them to persons and agencies where their requests and
21 needs can be met.
22 (k) Any person who is employed by or serves as a volunteer for a
23 youth shelter. As used in this paragraph, "youth shelter" has the meaning
24 ascribed to it in NRS 244.427.
25 (l) Any adult person who is employed by an entity that provides
26 organized activities for children, including, without limitation, a person
27 who is employed by a school district or public school.
28 ***(m) Any person who is enrolled with the Division of Health Care***
29 ***Financing and Policy of the Department of Health and Human Services***
30 ***to provide doula services to recipients of Medicaid pursuant to section 26***
31 ***of this act.***
32 5. A report may be made by any other person.
33 6. If a person who is required to make a report pursuant to subsection
34 1 knows or has reasonable cause to believe that a child has died as a result
35 of abuse or neglect, the person shall, as soon as reasonably practicable,
36 report this belief to an agency which provides child welfare services or a
37 law enforcement agency. If such a report is made to a law enforcement
38 agency, the law enforcement agency shall notify an agency which provides
39 child welfare services and the appropriate medical examiner or coroner of
40 the report. If such a report is made to an agency which provides child
41 welfare services, the agency which provides child welfare services shall
42 notify the appropriate medical examiner or coroner of the report. The
43 medical examiner or coroner who is notified of a report pursuant to this
44 subsection shall investigate the report and submit his or her written
45 findings to the appropriate agency which provides child welfare services,

1 the appropriate district attorney and a law enforcement agency. The written
2 findings must include, if obtainable, the information required pursuant to
3 the provisions of subsection 2 of NRS 432B.230.
4 7. The agency, board, bureau, commission, department, division or
5 political subdivision of the State responsible for the licensure, certification
6 or endorsement of a person who is described in subsection 4 and who is
7 required in his or her professional or occupational capacity to be licensed,
8 certified or endorsed in this State shall, at the time of initial licensure,
9 certification or endorsement:
10 (a) Inform the person, in writing or by electronic communication, of
11 his or her duty as a mandatory reporter pursuant to this section;
12 (b) Obtain a written acknowledgment or electronic record from the
13 person that he or she has been informed of his or her duty pursuant to this
14 section; and
15 (c) Maintain a copy of the written acknowledgment or electronic
16 record for as long as the person is licensed, certified or endorsed in this
17 State.
18 8. The employer of a person who is described in subsection 4 and
19 who is not required in his or her professional or occupational capacity to
20 be licensed, certified or endorsed in this State must, upon initial
21 employment of the person:
22 (a) Inform the person, in writing or by electronic communication, of
23 his or her duty as a mandatory reporter pursuant to this section;
24 (b) Obtain a written acknowledgment or electronic record from the
25 person that he or she has been informed of his or her duty pursuant to this
26 section; and
27 (c) Maintain a copy of the written acknowledgment or electronic
28 record for as long as the person is employed by the employer.
29 9. Before a person may serve as a volunteer at a public school or
30 private school, the school must:
31 (a) Inform the person, in writing or by electronic communication, of
32 his or her duty as a mandatory reporter pursuant to this section and NRS
33 392.303;
34 (b) Obtain a written acknowledgment or electronic record from the
35 person that he or she has been informed of his or her duty pursuant to this
36 section and NRS 392.303; and
37 (c) Maintain a copy of the written acknowledgment or electronic
38 record for as long as the person serves as a volunteer at the school.
39 10. As used in this section:
40 (a) "Private school" has the meaning ascribed to it in
41 NRS 394.103.
42 (b) "Public school" has the meaning ascribed to it in
43 NRS 385.007.

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Sec. 34. NRS 439B.260 is hereby amended to read as follows:

439B.260 1. A major hospital shall reduce or discount the total billed charge by at least 30 percent for hospital services provided to an inpatient who:

(a) Has no policy of health insurance or other contractual agreement with a third party that provides health coverage for the charge;

(b) Is not eligible for coverage by a state or federal program of public assistance that would provide for the payment of the charge; and

(c) Makes reasonable arrangements within 30 days after the date that notice was sent pursuant to subsection 2 to pay the hospital bill.

2. A major hospital shall include on or with the first statement of the hospital bill provided to the patient after his or her discharge a notice of the reduction or discount available pursuant to this section, including, without limitation, notice of the criteria a patient must satisfy to qualify for a reduction or discount.

3. A major hospital or patient who disputes the reasonableness of arrangements made pursuant to paragraph (c) of subsection 1 may submit the dispute to the Bureau for Hospital Patients for resolution as provided in NRS 232.462.

4. A major hospital shall reduce or discount the total billed charge of its outpatient pharmacy by at least 30 percent to a patient who is eligible for Medicare.

5. As used in this section, "third party" means:

(a) An insurer, as that term is defined in NRS 679B.540;

(b) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for services and care at a hospital;

(c) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; [or]

(d) ***The Public Option established pursuant to section 10 of this act; or***

(e) Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.

➥ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

Sec. 35. NRS 439B.665 is hereby amended to read as follows:

439B.665 1. On or before February 1 of each year, a nonprofit organization that advocates on behalf of patients or funds medical research in this State and has received a payment, donation, subsidy or anything else of value from a manufacturer, third party or pharmacy benefit manager or a trade or advocacy group for manufacturers, third parties or pharmacy benefit managers during the immediately preceding calendar year shall:

1 (a) Compile a report which includes:
2 (1) For each such contribution, the amount of the contribution and
3 the manufacturer, third party or pharmacy benefit manager or group that
4 provided the payment, donation, subsidy or other contribution; and
5 (2) The percentage of the total gross income of the organization
6 during the immediately preceding calendar year attributable to payments,
7 donations, subsidies or other contributions from each manufacturer, third
8 party, pharmacy benefit manager or group; and
9 (b) Except as otherwise provided in this paragraph, post the report on
10 an Internet website that is maintained by the nonprofit organization and
11 accessible to the public. If the nonprofit organization does not maintain an
12 Internet website that is accessible to the public, the nonprofit organization
13 shall submit the report compiled pursuant to paragraph (a) to the
14 Department.
15 2. As used in this section, "third party" means:
16 (a) An insurer, as that term is defined in NRS 679B.540;
17 (b) A health benefit plan, as that term is defined in NRS 687B.470, for
18 employees which provides coverage for prescription drugs;
19 (c) A participating public agency, as that term is defined in NRS
20 287.04052, and any other local governmental agency of the State of
21 Nevada which provides a system of health insurance for the benefit of its
22 officers and employees, and the dependents of officers and employees,
23 pursuant to chapter 287 of NRS; ~~[or]~~
24 (d) ***The Public Option established pursuant to section 10 of this act;***
25 ***or***
26 ***(e)*** Any other insurer or organization that provides health coverage or
27 benefits in accordance with state or federal law.
28 ➥ The term does not include an insurer that provides coverage under a
29 policy of casualty or property insurance.
30 **Sec. 36.** NRS 439B.736 is hereby amended to read as follows:
31 439B.736 1. "Third party" includes, without limitation:
32 (a) The issuer of a health benefit plan, as defined in NRS 695G.019,
33 which provides coverage for medically necessary emergency services;
34 (b) The Public Employees' Benefits Program established pursuant to
35 subsection 1 of NRS 287.043; ~~[and]~~
36 (c) ***The Public Option established pursuant to section 10 of this act;***
37 ***and***
38 ***(d)*** Any other entity or organization that elects pursuant to NRS
39 439B.757 for the provisions of NRS 439B.700 to 439B.760, inclusive, to
40 apply to the provision of medically necessary emergency services by out-
41 of-network providers to covered persons.
42 2. The term does not include the State Plan for Medicaid, the
43 Children's Health Insurance Program or a health maintenance
44 organization, as defined in NRS 695C.030, or managed care organization,
45 as defined in NRS 695G.050, when providing health care services through

1 managed care to recipients of Medicaid under the State Plan for Medicaid
2 or insurance pursuant to the Children's Health Insurance Program pursuant
3 to a contract with the Division of Health Care Financing and Policy of the
4 Department.
5 **Sec. 37.** NRS 449A.162 is hereby amended to read as follows:
6 449A.162 1. Except as otherwise provided in subsection 3, if a
7 hospital provides hospital care to a person who has a policy of health
8 insurance issued by a third party that provides health coverage for care
9 provided at that hospital and the hospital has a contractual agreement with
10 the third party, the hospital:
11 (a) Shall proceed with any efforts to collect on any amount owed to the
12 hospital for the hospital care in accordance with the provisions of NRS
13 449A.159.
14 (b) Shall not collect or attempt to collect from the patient or other
15 responsible party more than the sum of the amounts of any deductible,
16 copayment or coinsurance payable by or on behalf of the patient under the
17 policy of health insurance.
18 (c) Shall not collect or attempt to collect that amount from:
19 (1) Any proceeds or potential proceeds of a civil action brought by
20 or on behalf of the patient, including, without limitation, any amount
21 awarded for medical expenses; or
22 (2) An insurer other than an insurer that provides coverage under a
23 policy of health insurance or an insurer that provides coverage for medical
24 payments under a policy of casualty insurance.
25 2. If the hospital collects or receives any payments from an insurer
26 that provides coverage for medical payments under a policy of casualty
27 insurance, the hospital shall, not later than 30 days after a determination is
28 made concerning coverage, return to the patient any amount collected or
29 received that is in excess of the deductible, copayment or coinsurance
30 payable by or on behalf of the patient under the policy of health insurance.
31 3. This section does not apply to:
32 (a) Amounts owed to the hospital which are not covered under the
33 policy of health insurance; or
34 (b) Medicaid, Medicare, the Children's Health Insurance Program or
35 any other public program which may pay all or part of the bill.
36 4. This section does not limit any rights of a patient to contest an
37 attempt to collect an amount owed to a hospital, including, without
38 limitation, contesting a lien obtained by a hospital.
39 5. As used in this section, "third party" means:
40 (a) An insurer, as defined in NRS 679B.540;
41 (b) A health benefit plan, as defined in NRS 687B.470, for employees
42 which provides coverage for services and care at a hospital;
43 (c) A participating public agency, as defined in NRS 287.04052, and
44 any other local governmental agency of the State of Nevada which
45 provides a system of health insurance for the benefit of its officers and

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employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~[or]~~

(d) ***The Public Option established pursuant to section 10 of this act; or***

(e) Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.

Sec. 38. Section 10 of this act is hereby amended to read as follows:

Sec. 10. 1. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall design, establish and operate a health benefit plan known as the Public Option.

2. The Director:

(a) Shall make the Public Option available to all natural persons who reside in this State as a policy of individual health insurance through the Exchange and for direct purchase. The provisions of chapter 689A of NRS and other applicable provisions of this title apply to the Public Option when offered as a policy of individual health insurance.

(b) May make the Public Option available to small employers in this State or their employees to the extent authorized by federal law. The provisions of chapter 689C of NRS and other applicable provisions of this title apply to the Public Option when it is offered as a policy of health insurance for small employers.

(c) Shall comply with all state and federal laws and regulations applicable to insurers when carrying out the provisions of sections 2 to 15, inclusive, of this act, to the extent that such laws and regulations are not waived.

3. The Public Option must:

(a) Be a qualified health plan, as defined in 42 U.S.C. § 18021; and

(b) Provide at least levels of coverage consistent with the actuarial value of one silver plan and one gold plan.

4. ~~[Except as otherwise provided in this section, the premiums for the Public Option:~~

~~(a) Must be at least 5 percent lower than the reference premium for that zip code; and~~

~~(b) Must not increase in any year by a percentage greater than the increase in the Medicare Economic Index for that year.~~

~~5. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, may revise the requirements of subsection 4, provided that the average premiums for the Public Option must be at least 15 percent lower than the average reference premium in this State over the first 4 years in which the Public Option is in operation.~~

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

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1 (a) "Gold plan" means a qualified health plan that meets the
2 requirements established by 42 U.S.C. § 18022 for a gold level plan.
3 (b) "Health benefit plan" means a policy, contract, certificate or
4 agreement to provide, deliver, arrange for, pay for or reimburse any
5 of the costs of health care services.
6 (c) "Medicare Economic Index" means the Medicare Economic
7 Index, as designated by the Centers for Medicare and Medicaid
8 Services of the United States Department of Health and Human
9 Services pursuant to 42 C.F.R. § 405.504.
10 (d) "Reference premium" means, for any zip code, the lower of:
11 (1) The premium for the second-lowest cost silver level plan
12 available through the Exchange in the zip code during the 2024 plan
13 year, adjusted by the percentage change in the Medicare Economic
14 Index between January 1, 2024, and January 1 of the year to which a
15 premium applies; or
16 (2) The premium for the second-lowest cost silver level plan
17 available through the Exchange in the zip code during the year
18 immediately preceding the year to which a premium applies.
19 (e) "Silver plan" means a qualified health plan that meets the
20 requirements established by 42 U.S.C. § 18022 for a silver level
21 plan.
22 (f) "Small employer" has the meaning ascribed to it in 42 U.S.C.
23 § 18024(b)(2).
24 **Sec. 38.3.** 1. There is hereby appropriated from the State General
25 Fund to the Division of Welfare and Supportive Services of the
26 Department of Health and Human Services the sum of $167,850 to pay the
27 costs for enhancements to the information technology system of the
28 Division that are necessary to carry out the provisions of sections 24 to 28,
29 inclusive, of this act.
30 2. Any remaining balance of the appropriation made by subsection 1
31 must not be committed for expenditure after June 30, 2023, by the entity to
32 which the appropriation is made or any entity to which money from the
33 appropriation is granted or otherwise transferred in any manner, and any
34 portion of the appropriated money remaining must not be spent for any
35 purpose after
36 September 15, 2023, by either the entity to which the money was
37 appropriated or the entity to which the money was subsequently granted or
38 transferred, and must be reverted to the State General Fund on or before
39 September 15, 2023.
40 **Sec. 38.6.** 1. There is hereby appropriated from the State General
41 Fund to the Public Option Trust Fund created by section 15 of this act the
42 sum of $1,639,366 to pay the costs of carrying out the provisions of
43 sections 2 to 15, inclusive, of this act.
44 2. Any remaining balance of the appropriation made by subsection 1
45 must not be committed for expenditure after June 30, 2023, by the entity to

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which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 15, 2023, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 15, 2023.

Sec. 39. 1. The Director of the Department of Health and Human Services, the Commissioner of Insurance and the Executive Director of the Silver State Health Insurance Exchange shall apply for the waiver described in paragraph (a) of subsection 1 of section 11 of this act not later than January 1, 2024.

2. In preparing the initial application for the waiver described in paragraph (a) of subsection 1 of section 11 of this act, the Director of the Department of Health and Human Services, the Commissioner of Insurance and the Executive Director of the Silver State Health Insurance Exchange shall contract with an independent actuary to conduct an actuarial assessment pursuant to subsection 2 of section 11 of this act. The actuarial assessment:

(a) Must be completed before the application for the waiver is submitted; and

(b) Must include, without limitation, an analysis of the likely effect on premiums for health insurance in this State of:

(1) The provisions of subsection 1 of section 13 of this act, as those provisions apply to providers of health care, as defined in NRS 695G.070, who participate in the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043 or provide care to an injured employee pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, and the amendatory provisions of section 21 of this act; and

(2) Repealing the provisions described in subparagraph (1).

3. The Director of the Department of Health and Human Services shall make the Public Option available to natural persons who reside in this State in accordance with the provisions of section 10 of this act for the coverage year that begins on January 1, 2026.

4. As used in this section, "Public Option" has the meaning ascribed to it in section 8 of this act.

Sec. 39.5. On or before January 1, 2025, the Executive Director of the Silver State Health Insurance Exchange, in collaboration with the Department of Health and Human Services, shall:

1. Apply for the waiver described in subsection 1 of section 16.5 of this act; and

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1 2. Submit to the Director of the Legislative Counsel Bureau for
2 transmittal to the 83rd Session of the Legislature a report of
3 recommendations concerning any revisions to Nevada law necessary to:
4 (a) Authorize an organization described in section 501(c)(5) of the
5 Internal Revenue Code to offer a policy of insurance described in
6 subsection 1 of section 16.5 of this act for direct purchase outside the
7 Exchange as a policy of individual health insurance;
8 (b) Align state law concerning individual health insurance with the
9 requirements in the request for the waiver described in subsection 1 of
10 section 16.5 of this act; and
11 (c) Ensure that any state subsidies available to reduce the cost of
12 premiums for individual health insurance are available for a policy of
13 insurance described in subsection 1 of section 16.5 of this act.
14 **Sec. 40.** Notwithstanding the provisions of NRS 218D.430 and
15 218D.435, a committee, other than the Assembly Standing Committee on
16 Ways and Means and the Senate Standing Committee on Finance, may
17 vote on this act before the expiration of the period prescribed for the return
18 of a fiscal note in NRS 218D.475. This section applies retroactively from
19 and after March 22, 2021.
20 **Sec. 41.** 1. This section and sections 16.3, 16.5, 16.8, 39, 39.5 and
21 40 of this act become effective upon passage and approval.
22 2. Sections 1 to 14, inclusive, 16, 17, 19 to 22, inclusive, and 29 to
23 37, inclusive, of this act become effective:
24 (a) Upon passage and approval for the purposes of procurement and
25 any other preparatory administrative tasks necessary to carry out the
26 provisions of those sections; and
27 (b) On January 1, 2026, for all other purposes.
28 3. Sections 15, 38.3 and 38.6 of this act become effective on July 1,
29 2021.
30 4. Sections 18 and 23 to 28, inclusive, of this act become effective on
31 January 1, 2022.
32 5. Section 38 of this act becomes effective on January 1, 2030.

33 H

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