

ASSEMBLY BILL NO. 408—ASSEMBLYMEN JOINER, SPIEGEL, BILBRAY-AXELROD, FUMO, SPRINKLE; ARAUJO, BENITEZ-THOMPSON, BROOKS, BUSTAMANTE ADAMS, CARLTON, CARRILLO, COHEN, DALY, DIAZ, FLORES, FRIERSON, MCCURDY II, MONROE-MORENO, NEAL, OHRENSCHALL, SWANK AND THOMPSON

MARCH 20, 2017

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to Medicaid and health insurance. (BDR 38-957)

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

CONTAINS UNFUNDED MANDATE (§ 9)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

AN ACT relating to health care; requiring the State Plan for Medicaid to cover certain preventive health care services and maternity and newborn care; requiring insurers to offer health insurance coverage regardless of the health status of a person; requiring insurers to allow the covered adult child of an insured to remain covered by the health insurance of the insured until 26 years of age; requiring insurers to provide coverage for certain preventive health care services for women, adults and children at no cost; requiring insurers to provide coverage for maternity and newborn care; prohibiting providers of health care and insurers from discriminating against a person on certain grounds; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

- 1 Existing law provides that an insurer may not deny, limit or exclude a benefit
- 2 provided by a health care plan in certain limited circumstances, including, without
- 3 limitation, when a person has contracted for a blanket policy of accident or health
- 4 insurance or in certain cases relating to adoption. (NRS 689B.500, 689C.190,



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5 695A.159, 695B.193, 695C.173, 695F.480) The Patient Protection and Affordable
6 Care Act (Public Law 111-148, as amended) prohibits an insurer from establishing
7 rules for eligibility for a health care plan based on sex or certain health status
8 factors, including, without limitation, preexisting conditions, claims history or
9 genetic information, and also prohibits an insurer from charging a higher premium,
10 deductible or copay based on sex or these health status factors. (42 U.S.C. § 300gg-
11 4) **Sections 15, 31, 41, 48, 57, 68, 80, 83 and 94** of this bill align Nevada law with
12 federal law and require all insurers to offer health insurance coverage regardless of
13 the health status of a person and prohibits an insurer from denying, limiting or
14 excluding a benefit or requiring an insured to pay a higher premium, deductible,
15 coinsurance or copay based on the health status of the insured or the covered
16 spouse or dependent of the insured.

17 The Patient Protection and Affordable Care Act (Public Law 111-148, as
18 amended) requires all insurers to extend coverage for the covered adult child of an
19 insured until such child reaches 26 years of age. (42 U.S.C. § 300gg-14) **Sections**
20 **16, 25, 34, 49, 58, 69, 81 and 84** of this bill align Nevada law with federal law in
21 this manner.

22 The Patient Protection and Affordable Care Act (Public Law 111-148, as
23 amended) requires all health insurance plans to include coverage for maternity and
24 newborn care. (42 U.S.C. § 18022(b)) **Sections 21, 32, 43, 53, 62, 73 and 88** of this
25 bill align Nevada law with federal law in this manner. **Section 5** of this bill also
26 requires the State Plan for Medicaid to include coverage for maternity and newborn
27 care.

28 The Patient Protection and Affordable Care Act (Public Law 111-148, as
29 amended) requires all health insurance plans to include coverage, without any
30 higher deductible or any copay or coinsurance, for certain preventive health care
31 services for women, adults and children, including, without limitation, screenings
32 and tests for certain diseases, counseling, contraceptive drugs, devices and services
33 as well as vaccinations. (42 U.S.C. § 300gg-13; 45 C.F.R. § 147.130) **Sections 17-**
34 **20, 22, 26-30, 35-39, 50-52, 54, 55, 59-61, 63, 64, 70-72, 76, 77, 85-87, 89 and 90**
35 of this bill align Nevada law with federal law in this manner, and extend these
36 requirements to health insurance purchased by local governments and the Public
37 Employees' Benefits Program. **Sections 2, 3, 4, 6 and 7** of this bill also require the
38 State Plan for Medicaid to include these preventive health care services for women,
39 adults and children. **Section 93** of this bill requires the Director of the Department
40 of Health and Human Services to adopt regulations specifying the preventive health
41 care services which are required to be covered by insurers and that these
42 requirements must include, without limitation, the preventive health care services
43 currently required by federal law.

44 The Patient Protection and Affordable Care Act (Public Law 111-148, as
45 amended) prohibits a provider of health care or state health insurance exchange
46 who receives federal money from discriminating against a person on the basis of
47 race, color, national origin, sex, age, or disability in providing health care services
48 to the person. The Act also prohibits an insurer who receives federal money from
49 discriminating against a person on those same grounds, as well as gender identity or
50 expression. (42 U.S.C. § 18116; 45 C.F.R. § 92.207) The federal regulation that
51 prohibits insurers from discriminating on the basis of gender identity or expression
52 is no longer enforceable, however, because it was recently held to exceed the
53 statutory authority granted by the Act. (*Franciscan Alliance Inc., v. Burwell*, 2016
54 WL 7638311 (N.D. Tex. Dec. 31, 2016)) Federal regulations also require providers
55 of health care, state health insurance exchanges and insurers to provide certain
56 assistive services and notice of these nondiscrimination provisions to all persons
57 who receive health care services. (45 C.F.R. §§ 92.8, 92.201, 92.202) **Sections 11**
58 **and 12** of this bill generally align Nevada law with federal law, and prohibit a
59 provider of health care or an insurer from discriminating against a person on these



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60 grounds, including, without limitation, discrimination based on gender identity or
61 expression or sexual orientation.

1 WHEREAS, Passage of the Patient Protection and Affordable
2 Care Act, Public Law 111-148, as amended by Congress in 2010,
3 granted all Nevadans certain rights relating to health insurance
4 coverage and provided greater access to health care benefits in this
5 State; and

6 WHEREAS, Congress currently is considering the repeal of the
7 Patient Protection and Affordable Care Act; and

8 WHEREAS, The Nevada Legislature wishes to ensure that all
9 Nevadans continue to have access to certain rights and health care
10 benefits currently guaranteed by the Patient Protection and
11 Affordable Care Act; and

12 WHEREAS, The Nevada Legislature intends to maintain, not
13 expand, those rights and health care benefits as they existed on
14 January 1, 2017; now, therefore,

15
16 THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
17 SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:
18

19 **Section 1.** Chapter 422 of NRS is hereby amended by adding
20 thereto the provisions set forth as sections 2 to 6, inclusive, of this
21 act.

22 **Sec. 2. 1.** *The Director shall include in the State Plan for*
23 *Medicaid a requirement that the State pay the nonfederal share of*
24 *expenditures incurred for such preventive health care services*
25 *relating to women as the Director establishes by regulation, which*
26 *must include, without limitation:*

27 *(a) Such prenatal screenings and tests as recommended by the*
28 *American College of Obstetricians and Gynecologists or its*
29 *successor organization;*

30 *(b) Screening and counseling for interpersonal and domestic*
31 *violence;*

32 *(c) Screening, tests and counseling for such other health*
33 *conditions and diseases as recommended by the Health Resources*
34 *and Services Administration;*

35 *(d) Contraceptive drugs, devices and services;*

36 *(e) Such well-woman preventive visits as recommended by the*
37 *Health Resources and Services Administration;*

38 *(f) Any supplements, drugs or devices recommended by the*
39 *Health Resources and Services Administration; and*

40 *(g) All vaccinations recommended by the Advisory Committee*
41 *on Immunization Practices of the Centers for Disease Control and*



1 *Prevention of the United States Department of Health and Human*
2 *Services or its successor organization.*

3 2. *A person enrolled in Medicaid must not be required pay a*
4 *higher deductible, any copayment or coinsurance to obtain the*
5 *services required by this section.*

6 **Sec. 3.** 1. *The Director shall include in the State Plan for*
7 *Medicaid a requirement that the State pay the nonfederal share of*
8 *expenditures incurred for such preventive health care services*
9 *relating to persons 18 years of age or older as the Director*
10 *establishes by regulation, which must include, without limitation:*

11 (a) *Screening, tests and counseling for such other health*
12 *conditions and diseases as recommended by the United States*
13 *Preventive Services Task Force or its successor organization;*

14 (b) *Counseling relating to the dietary needs of certain adults*
15 *who are at high-risk of chronic diseases;*

16 (c) *Smoking cessation programs;*

17 (d) *Any supplements, drugs or devices recommended by the*
18 *United States Preventive Services Task Force or its successor*
19 *organization; and*

20 (e) *All vaccinations recommended by the Advisory Committee*
21 *on Immunization Practices of the Centers for Disease Control and*
22 *Prevention of the United States Department of Health and Human*
23 *Services or its successor organization.*

24 2. *A person enrolled in Medicaid must not be required pay a*
25 *higher deductible, any copayment or coinsurance to obtain the*
26 *services required by this section.*

27 **Sec. 4.** 1. *The Director shall include in the State Plan for*
28 *Medicaid a requirement that the State pay the nonfederal share of*
29 *expenditures incurred for such preventive health care services*
30 *relating to persons less than 18 years of age as the Director*
31 *establishes by regulation, which must include, without limitation:*

32 (a) *Screening, tests and counseling for such other health*
33 *conditions and diseases as recommended by the Health Resources*
34 *and Services Administration;*

35 (b) *Assessments relating to height, weight, body mass index*
36 *and medical history;*

37 (c) *Any supplements, drugs or devices recommended by the*
38 *Health Resources and Services Administration; and*

39 (d) *All vaccinations recommended by the Advisory Committee*
40 *on Immunization Practices of the Centers for Disease Control and*
41 *Prevention of the United States Department of Health and Human*
42 *Services or its successor organization.*

43 2. *A person enrolled in Medicaid must not be required pay a*
44 *higher deductible, any copayment or coinsurance to obtain the*
45 *services required by this section.*



1 **Sec. 5.** *The Director shall include in the State Plan for*
2 *Medicaid a requirement that the State pay the nonfederal share of*
3 *expenditures incurred for such maternal and newborn care as the*
4 *Director establishes by regulation.*

5 **Sec. 6. 1.** *The Director shall include in the State Plan for*
6 *Medicaid a requirement that the State pay the nonfederal share of*
7 *expenditures incurred for:*

8 *(a) An annual cytologic screening test for women 18 years of*
9 *age or older;*

10 *(b) A baseline mammogram for women between the ages of 35*
11 *and 40 years;*

12 *(c) An annual mammogram for women 40 years of age or*
13 *older;*

14 *(d) Counseling concerning genetic testing for breast cancer;*
15 *and*

16 *(e) Counseling concerning breast cancer chemoprevention.*

17 **2.** *A person enrolled in Medicaid must not be required pay a*
18 *higher deductible, any copayment or coinsurance or obtain prior*
19 *authorization for any service required by this section.*

20 **Sec. 7.** NRS 422.2718 is hereby amended to read as follows:

21 422.2718 1. The Director shall include in the State Plan for
22 Medicaid a requirement that the State shall pay the nonfederal share
23 of expenses incurred for ~~administering~~ :

24 *(a) Deoxyribonucleic acid testing for high-risk strains of the*
25 *human papillomavirus; and*

26 *(b) Administering* the human papillomavirus vaccine to women
27 and girls at such ages as recommended for vaccination by a
28 competent authority, including, without limitation, the Centers for
29 Disease Control and Prevention of the United States Department of
30 Health and Human Services, the Food and Drug Administration or
31 the manufacturer of the vaccine.

32 **2.** *A person enrolled in Medicaid must not be required pay a*
33 *higher deductible, any copayment or coinsurance or obtain prior*
34 *authorization for any service required by this section.*

35 **3.** For the purposes of this section, "human papillomavirus
36 vaccine" means the Quadrivalent Human Papillomavirus
37 Recombinant Vaccine or its successor which is approved by the
38 Food and Drug Administration to be used for the prevention of
39 human papillomavirus infection and cervical cancer.

40 **Sec. 8.** NRS 422.403 is hereby amended to read as follows:

41 422.403 1. ~~The~~ *Except as otherwise provided in NRS*
42 *422.2718, the* Department shall, by regulation, establish and manage
43 the use by the Medicaid program of step therapy and prior
44 authorization for prescription drugs.



1 2. ~~The~~ *Except as otherwise provided in NRS 422.2718, the*
2 Drug Use Review Board shall:

3 (a) Advise the Department concerning the use by the Medicaid
4 program of step therapy and prior authorization for prescription
5 drugs;

6 (b) Develop step therapy protocols and prior authorization
7 policies and procedures for use by the Medicaid program for
8 prescription drugs; and

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

13 3. The Department shall not require the Drug Use Review
14 Board to develop, review or approve prior authorization policies or
15 procedures necessary for the operation of the list of preferred
16 prescription drugs developed for the Medicaid program pursuant to
17 NRS 422.4025.

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

22 **Sec. 9.** NRS 287.010 is hereby amended to read as follows:

23 287.010 1. The governing body of any county, school
24 district, municipal corporation, political subdivision, public
25 corporation or other local governmental agency of the State of
26 Nevada may:

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

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

42 (c) Provide group life, accident or health coverage through a
43 self-insurance reserve fund and, where necessary, deduct
44 contributions to the maintenance of the fund from the compensation
45 of officers and employees and pay the deductions into the fund. The



1 money accumulated for this purpose through deductions from the
2 compensation of officers and employees and contributions of the
3 governing body must be maintained as an internal service fund as
4 defined by NRS 354.543. The money must be deposited in a state or
5 national bank or credit union authorized to transact business in the
6 State of Nevada. Any independent administrator of a fund created
7 under this section is subject to the licensing requirements of chapter
8 683A of NRS, and must be a resident of this State. Any contract
9 with an independent administrator must be approved by the
10 Commissioner of Insurance as to the reasonableness of
11 administrative charges in relation to contributions collected and
12 benefits provided. The provisions of NRS 687B.408, 689B.030 to
13 689B.050, inclusive, *and sections 25 to 28, inclusive, of this act*
14 *and 689B.287 and 689B.500 and 689B.520* apply to coverage
15 provided pursuant to this paragraph.

16 (d) Defray part or all of the cost of maintenance of a self-
17 insurance fund or of the premiums upon insurance. The money for
18 contributions must be budgeted for in accordance with the laws
19 governing the county, school district, municipal corporation,
20 political subdivision, public corporation or other local governmental
21 agency of the State of Nevada.

22 2. If a school district offers group insurance to its officers and
23 employees pursuant to this section, members of the board of trustees
24 of the school district must not be excluded from participating in the
25 group insurance. If the amount of the deductions from compensation
26 required to pay for the group insurance exceeds the compensation to
27 which a trustee is entitled, the difference must be paid by the trustee.

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

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

42 (a) Shall be deemed, solely for the purposes of this section, to be
43 officers and employees of the county, school district, municipal
44 corporation, political subdivision, public corporation or other local



1 governmental agency with which the legal services organization has
2 contracted; and

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

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

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

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

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

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

17 **Sec. 10.** NRS 287.04335 is hereby amended to read as
18 follows:

19 287.04335 If the Board provides health insurance through a
20 plan of self-insurance, it shall comply with the provisions of NRS
21 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645,
22 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177,
23 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive,
24 and 695G.405, *and sections 83 to 89, inclusive, of this act*, in the
25 same manner as an insurer that is licensed pursuant to title 57 of
26 NRS is required to comply with those provisions.

27 **Sec. 11.** Chapter 629 of NRS is hereby amended by adding
28 thereto a new section to read as follows:

29 *1. Except as otherwise provided in subsection 2, a provider of*
30 *health care shall not discriminate in providing a health care*
31 *service to a person on the basis of race, color, national origin, sex,*
32 *age, physical or mental disability, sexual orientation or gender*
33 *identity or expression.*

34 *2. A provider of health care may make distinctions in*
35 *providing health care services based on sex or gender identity or*
36 *expression if the provider has an exceedingly persuasive*
37 *justification for the distinction, which may include, without*
38 *limitation, that the distinction is substantially related to the*
39 *achievement of an important health or scientific objective.*

40 *3. A provider of health care must provide reasonable notice to*
41 *a person who receives health care services relating to the*
42 *provisions of this section.*

43 *4. A provider of health care must take reasonable steps to*
44 *ensure that a person with limited English proficiency or physical*
45 *or mental disabilities who receives health care services from the*



1 *provider has access to any assistance services which may be*
2 *needed for the person to communicate effectively with the*
3 *provider.*

4 *5. As used in this section:*

5 *(a) "Gender identity or expression" has the meaning ascribed*
6 *to it in NRS 193.0148.*

7 *(b) "Health care service" means the care and observation of*
8 *patients, the diagnosis of human diseases, the treatment and*
9 *rehabilitation of patients, or related services.*

10 *(c) "Sexual orientation" has the meaning ascribed to it in*
11 *NRS 118.093.*

12 **Sec. 12.** Chapter 679A of NRS is hereby amended by adding
13 thereto a new section to read as follows:

14 *1. Except as otherwise provided in subsection 2, an insurer*
15 *who offers a policy of health insurance shall not refuse to provide*
16 *coverage to or discriminate against a person based on race, color,*
17 *national origin, sex, age, physical or mental disability, sexual*
18 *orientation or gender identity or expression. Such discriminatory*
19 *actions include, without limitation:*

20 *(a) Cancelling a policy;*

21 *(b) Refusing to provide a benefit which is available under a*
22 *policy to other similarly situated persons;*

23 *(c) Limiting coverage of a claim; or*

24 *(d) Imposing an additional deductible, premium, copay,*
25 *coinsurance or any other limitation or restriction on coverage.*

26 *2. An insurer may include distinctions in a policy of health*
27 *insurance based on sex or gender identity or expression if*
28 *the insurer has an exceedingly persuasive justification for the*
29 *distinction, which may include, without limitation, that the*
30 *distinction is substantially related to the achievement of an*
31 *important health or scientific objective.*

32 *3. An insurer must provide reasonable notice to an insured*
33 *relating to the provisions of this section.*

34 *4. An insurer must take reasonable steps to ensure that an*
35 *insured with limited English proficiency or physical or mental*
36 *disabilities has access to any assistance services which may be*
37 *needed for the insured to communicate effectively with the*
38 *insurer.*

39 *5. Nothing in this section may be construed as preventing an*
40 *insurer from determining whether a benefit is medically necessary*
41 *or whether any such benefit meets any other requirement for*
42 *coverage included in a policy of health insurance which is not*
43 *prohibited by this section or any other provision of law.*

44 *6. As used in this section:*



1 (a) *“Gender identity or expression” has the meaning ascribed*
2 *to it in NRS 193.0148.*

3 (b) *“Sexual orientation” has the meaning ascribed to it in*
4 *NRS 118.093.*

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

6 687B.225 1. Except as otherwise provided in NRS
7 689A.0405, 689A.0413, 689A.044, 689A.0445, 689B.031,
8 689B.0313, 689B.0317, 689B.0374, 695B.1912, 695B.1914,
9 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1745,
10 695C.1751, 695G.170, 695G.171 and 695G.177, *and sections 38,*
11 *39, 54, 55 and 89 of this act,* any contract for group, blanket or
12 individual health insurance or any contract by a nonprofit hospital,
13 medical or dental service corporation or organization for dental care
14 which provides for payment of a certain part of medical or dental
15 care may require the insured or member to obtain prior authorization
16 for that care from the insurer or organization. The insurer or
17 organization shall:

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

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

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

25 **Sec. 14.** Chapter 689A of NRS is hereby amended by adding
26 thereto the provisions set forth as sections 15 to 19, inclusive, of this
27 act.

28 **Sec. 15. 1.** *An insurer shall offer or issue a policy of health*
29 *insurance to any person regardless of the health status of the*
30 *person, the spouse of the person or any dependent of the person.*
31 *Such health status includes, without limitation:*

32 (a) *Any preexisting medical condition of the person, including,*
33 *without limitation, any physical or mental illness;*

34 (b) *The claims history of the person, including, without*
35 *limitation, any prior health care services received by the person;*

36 (c) *Genetic information relating to the person; and*

37 (d) *Any increased risk for illness, injury or any other medical*
38 *condition of the person, including, without limitation, any medical*
39 *condition caused by an act of domestic violence.*

40 2. *An insurer that offers or issues a policy of health*
41 *insurance shall not:*

42 (a) *Deny, limit or exclude a benefit based on the health status*
43 *of an insured; or*

44 (b) *Require an insured, as a condition of enrollment or*
45 *renewal, to pay a premium, deductible, copay or coinsurance*



1 based on his or her health status which is greater than the
2 premium, deductible, copay or coinsurance charged to a similarly
3 situated insured or the covered spouse or dependent of such an
4 insured who does not have such a health status.

5 3. An insurer that offers or issues a policy of health
6 insurance shall not adjust a premium, deductible, copay or
7 coinsurance for any insured on the basis of genetic information
8 relating to the insured or the covered spouse or dependent of the
9 insured.

10 **Sec. 16.** 1. An insurer that offers or issues a policy of
11 health insurance which provides coverage for dependent children
12 shall continue to make such coverage available for an adult child
13 of an insured until such child reaches 26 years of age.

14 2. Nothing in this section shall be construed as requiring an
15 insurer to make coverage available for a dependent of an adult
16 child of an insured.

17 **Sec. 17.** 1. An insurer that offers or issues a policy of
18 health insurance shall include in the policy coverage for such
19 preventive health care services relating to women as the Director
20 of the Department of Health and Human Services requires.

21 2. An insurer that offers or issues a policy of health
22 insurance shall not:

23 (a) Require an insured to pay a higher deductible, any
24 copayment or coinsurance or require a longer waiting period or
25 other condition to obtain any benefit provided in the policy of
26 health insurance pursuant to subsection 1;

27 (b) Refuse to issue a policy of health insurance or cancel a
28 policy of health insurance solely because the person applying for
29 or covered by the policy uses or may use a benefit provided in the
30 policy of health insurance pursuant to subsection 1;

31 (c) Offer or pay any type of material inducement or financial
32 incentive to an insured to discourage the insured from obtaining
33 any such benefit;

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

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

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

43 3. A policy of health insurance subject to the provisions of
44 this chapter that is delivered, issued for delivery or renewed on or
45 after January 1, 2018, has the legal effect of including the



1 *coverage required by subsection 1, and any provision of the policy*
2 *or the renewal which is in conflict with this section is void.*

3 *4. The Director of the Department of Health and Human*
4 *Services shall adopt regulations to establish the preventive health*
5 *care services which must be covered by a policy of health*
6 *insurance pursuant to subsection 1, including, without limitation:*

7 *(a) Such prenatal screenings and tests as recommended by the*
8 *American College of Obstetricians and Gynecologists or its*
9 *successor organization;*

10 *(b) Screening and counseling for interpersonal and domestic*
11 *violence;*

12 *(c) Screening, tests and counseling for such other health*
13 *conditions and diseases as recommended by the Health Resources*
14 *and Services Administration;*

15 *(d) Contraceptive drugs, devices and services;*

16 *(e) Such well-woman preventive visits as recommended by the*
17 *Health Resources and Services Administration;*

18 *(f) Any supplements, drugs or devices recommended by the*
19 *Health Resources and Services Administration; and*

20 *(g) All vaccinations recommended by the Advisory Committee*
21 *on Immunization Practices of the Centers for Disease Control and*
22 *Prevention of the United States Department of Health and Human*
23 *Services or its successor organization.*

24 *5. As used in this section, "provider of health care" has the*
25 *meaning ascribed to it in NRS 629.031.*

26 **Sec. 18. 1.** *An insurer that offers or issues a policy of*
27 *health insurance shall include in the policy coverage for such*
28 *preventive health care services relating to persons 18 years of age*
29 *or older as the Director of the Department of Health and Human*
30 *Services requires.*

31 *2. An insurer that offers or issues a policy of health*
32 *insurance shall not:*

33 *(a) Require an insured to pay a higher deductible, any*
34 *copayment or coinsurance or require a longer waiting period or*
35 *other condition to obtain any benefit provided in the policy of*
36 *health insurance pursuant to subsection 1;*

37 *(b) Refuse to issue a policy of health insurance or cancel a*
38 *policy of health insurance solely because the person applying for*
39 *or covered by the policy uses or may use a benefit provided in the*
40 *policy of health insurance pursuant to subsection 1;*

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



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

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

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

10 3. A policy of health insurance subject to the provisions of
11 this chapter that is delivered, issued for delivery or renewed on or
12 after January 1, 2018, has the legal effect of including the
13 coverage required by subsection 1, and any provision of the policy
14 or the renewal which is in conflict with this section is void.

15 4. The Director of the Department of Health and Human
16 Services shall adopt regulations to establish the preventive health
17 care services which must be covered by a policy of health
18 insurance pursuant to subsection 1, including, without limitation:

19 (a) Screening, tests and counseling for such other health
20 conditions and diseases as recommended by the United States
21 Preventive Services Task Force or its successor organization;

22 (b) Counseling relating to the dietary needs of certain adults
23 who are at high-risk of chronic diseases;

24 (c) Smoking cessation programs;

25 (d) Any supplements, drugs or devices recommended by the
26 United States Preventive Services Task Force or its successor
27 organization; and

28 (e) All vaccinations recommended by the Advisory Committee
29 on Immunization Practices of the Centers for Disease Control and
30 Prevention of the United States Department of Health and Human
31 Services or its successor organization.

32 5. As used in this section, "provider of health care" has the
33 meaning ascribed to it in NRS 629.031.

34 **Sec. 19. 1.** An insurer that offers or issues a policy of
35 health insurance shall include in the policy coverage for such
36 preventive health care services relating to persons less than 18
37 years of age as the Director of the Department of Health and
38 Human Services requires.

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

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



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

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

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

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

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

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

22 4. The Director of the Department of Health and Human
23 Services shall adopt regulations to establish the preventive health
24 care services which must be covered by a policy of health
25 insurance pursuant to subsection 1, including, without limitation:

26 (a) Screening, tests and counseling for such other health
27 conditions and diseases as recommended by the Health Resources
28 and Services Administration;

29 (b) Assessments relating to height, weight, body mass index
30 and medical history;

31 (c) Any supplements, drugs or devices recommended by the
32 Health Resources and Services Administration; and

33 (d) All vaccinations recommended by the Advisory Committee
34 on Immunization Practices of the Centers for Disease Control and
35 Prevention of the United States Department of Health and Human
36 Services or its successor organization.

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

39 **Sec. 20.** NRS 689A.0405 is hereby amended to read as
40 follows:

41 689A.0405 1. A policy of health insurance must provide
42 coverage for benefits payable for expenses incurred for:

43 (a) An annual cytologic screening test for women 18 years of
44 age or older;



1 (b) A baseline mammogram for women between the ages of 35
2 and 40; ~~and~~

3 (c) An annual mammogram for women 40 years of age or
4 older ~~+~~;

5 *(d) Counseling concerning genetic testing for breast cancer;*
6 *and*

7 *(e) Counseling concerning breast cancer chemoprevention.*

8 2. A policy of health insurance must not require an insured to
9 obtain prior authorization for any service provided pursuant to
10 subsection 1.

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

13 *(a) Require an insured to pay a higher deductible, any*
14 *copayment or coinsurance or require a longer waiting period or*
15 *other condition to obtain any benefit provided in the health benefit*
16 *plan pursuant to subsection 1;*

17 *(b) Refuse to issue a policy of health insurance or cancel a*
18 *policy of health insurance solely because the person applying for*
19 *or covered by the policy uses or may use a benefit provided in the*
20 *policy of health insurance pursuant to subsection 1;*

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

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

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

31 *(f) Impose any other restrictions or delays on the access of an*
32 *insured to any such benefit.*

33 4. A policy subject to the provisions of this chapter which is
34 delivered, issued for delivery or renewed on or after ~~October 1,~~
35 ~~1989,~~ *January 1, 2018*, has the legal effect of including the
36 coverage required by subsection 1, and any provision of the policy
37 or the renewal which is in conflict with subsection 1 is void.

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

40 **Sec. 21.** NRS 689A.0425 is hereby amended to read as
41 follows:

42 689A.0425 1. *An insurer that offers or issues a policy of*
43 *health insurance shall include in the policy coverage for such*
44 *health care services relating to maternal and newborn care as the*



1 *Director of the Department of Health and Human Services*
2 *requires.*

3 2. Except as otherwise provided in this subsection, an
4 individual health benefit plan issued pursuant to this chapter ~~{that~~
5 ~~includes coverage for maternity care and pediatric care for newborn~~
6 ~~infants}~~ may not restrict benefits for any length of stay in a hospital
7 in connection with childbirth for a mother or newborn infant
8 covered by the plan to:

9 (a) Less than 48 hours after a normal vaginal delivery; and

10 (b) Less than 96 hours after a cesarean section.

11 ➔ If a different length of stay is provided in the guidelines
12 established by the American College of Obstetricians and
13 Gynecologists, or its successor organization, and the American
14 Academy of Pediatrics, or its successor organization, the individual
15 health benefit plan may follow such guidelines in lieu of following
16 the length of stay set forth above. The provisions of this subsection
17 do not apply to any individual health benefit plan in any case in
18 which the decision to discharge the mother or newborn infant before
19 the expiration of the minimum length of stay set forth in this
20 subsection is made by the attending physician of the mother or
21 newborn infant.

22 ~~{2}~~ 3. Nothing in this section requires a mother to:

23 (a) Deliver her baby in a hospital; or

24 (b) Stay in a hospital for a fixed period following the birth of her
25 child.

26 ~~{3}~~ 4. An individual health benefit plan ~~{that offers coverage~~
27 ~~for maternity care and pediatric care of newborn infants}~~ may not:

28 (a) Deny a mother or her newborn infant coverage or continued
29 coverage under the terms of the plan or coverage if the sole purpose
30 of the denial of coverage or continued coverage is to avoid the
31 requirements of this section;

32 (b) Provide monetary payments or rebates to a mother to
33 encourage her to accept less than the minimum protection available
34 pursuant to this section;

35 (c) Penalize, or otherwise reduce or limit, the reimbursement of
36 an attending provider of health care because the attending provider
37 of health care provided care to a mother or newborn infant in
38 accordance with the provisions of this section;

39 (d) Provide incentives of any kind to an attending physician to
40 induce the attending physician to provide care to a mother or
41 newborn infant in a manner that is inconsistent with the provisions
42 of this section; or

43 (e) Except as otherwise provided in subsection ~~{4}~~ 5, restrict
44 benefits for any portion of a hospital stay required pursuant to the



1 provisions of this section in a manner that is less favorable than the
2 benefits provided for any preceding portion of that stay.

3 ~~4.1~~ 5. Nothing in this section:

4 (a) Prohibits an individual health benefit plan from imposing a
5 deductible, coinsurance or other mechanism for sharing costs
6 relating to benefits for hospital stays in connection with childbirth
7 for a mother or newborn child covered by the plan, except that such
8 coinsurance or other mechanism for sharing costs for any portion of
9 a hospital stay required by this section may not be greater than the
10 coinsurance or other mechanism for any preceding portion of that
11 stay.

12 (b) Prohibits an arrangement for payment between an individual
13 health benefit plan and a provider of health care that uses capitation
14 or other financial incentives, if the arrangement is designed to
15 provide services efficiently and consistently in the best interest of
16 the mother and her newborn infant.

17 (c) Prevents an individual health benefit plan from negotiating
18 with a provider of health care concerning the level and type of
19 reimbursement to be provided in accordance with this section.

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

25 *7. The Director of the Department of Health and Human*
26 *Services shall adopt regulations to establish the health care*
27 *services which must be covered by a policy of health insurance*
28 *pursuant to subsection 1.*

29 *8. As used in this section, "provider of health care" has the*
30 *meaning ascribed to it in NRS 629.031.*

31 **Sec. 22.** NRS 689A.044 is hereby amended to read as follows:

32 689A.044 1. A policy of health insurance must provide
33 coverage for benefits payable for expenses incurred for
34 ~~administering~~:

35 (a) *Deoxyribonucleic acid testing for high-risk strains of the*
36 *human papillomavirus; and*

37 (b) *Administering* the human papillomavirus vaccine as
38 recommended for vaccination by a competent authority, including,
39 without limitation, the Centers for Disease Control and Prevention
40 of the United States Department of Health and Human Services, the
41 Food and Drug Administration or the manufacturer of the vaccine.

42 2. A policy of health insurance must not require an insured to
43 obtain prior authorization for any service provided pursuant to
44 subsection 1.



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

3 (a) *Require an insured to pay a higher deductible, any*
4 *copayment or coinsurance or require a longer waiting period or*
5 *other condition to obtain any benefit provided in the health benefit*
6 *plan pursuant to subsection 1;*

7 (b) *Refuse to issue a policy of health insurance or cancel a*
8 *policy of health insurance solely because the person applying for*
9 *or covered by the policy uses or may use a benefit provided in the*
10 *policy of health insurance pursuant to subsection 1;*

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

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

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

21 (f) *Impose any other restrictions or delays on the access of an*
22 *insured to any such benefit.*

23 4. A policy subject to the provisions of this chapter which is
24 delivered, issued for delivery or renewed on or after ~~July 1, 2007,~~
25 *January 1, 2018*, has the legal effect of including the coverage
26 required by subsection 1, and any provision of the policy or the
27 renewal which is in conflict with subsection 1 is void.

28 ~~4. For the purposes of this section, "human~~

29 5. *As used in this section:*

30 (a) *"Human papillomavirus vaccine"* means the Quadrivalent
31 Human Papillomavirus Recombinant Vaccine or its successor which
32 is approved by the Food and Drug Administration for the prevention
33 of human papillomavirus infection and cervical cancer.

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

36 **Sec. 23.** NRS 689A.330 is hereby amended to read as follows:

37 689A.330 If any policy is issued by a domestic insurer for
38 delivery to a person residing in another state, and if the insurance
39 commissioner or corresponding public officer of that other state has
40 informed the Commissioner that the policy is not subject to approval
41 or disapproval by that officer, the Commissioner may by ruling
42 require that the policy meet the standards set forth in NRS 689A.030
43 to 689A.320, inclusive ~~4~~, *and sections 15 to 19, inclusive, of this*
44 *act.*



1 **Sec. 24.** Chapter 689B of NRS is hereby amended by adding
2 thereto the provisions set forth as sections 25 to 28, inclusive, of this
3 act.

4 **Sec. 25.** *1. An insurer that offers or issues a policy of*
5 *group health insurance which provides coverage for dependent*
6 *children shall continue to make such coverage available for an*
7 *adult child of an insured until such child reaches 26 years of age.*

8 *2. Nothing in this section shall be construed as requiring an*
9 *insurer to make coverage available for a dependent of an adult*
10 *child of an insured.*

11 **Sec. 26.** *1. An insurer that offers or issues a policy of*
12 *group health insurance shall include in the policy coverage for*
13 *such preventive health care services relating to women as the*
14 *Director of the Department of Health and Human Services*
15 *requires.*

16 *2. An insurer that offers or issues a policy of group health*
17 *insurance shall not:*

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

22 *(b) Refuse to issue a policy of group health insurance or*
23 *cancel a policy of group health insurance solely because the*
24 *person applying for or covered by the policy uses or may use a*
25 *benefit provided in the policy of group health insurance pursuant*
26 *to subsection 1;*

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

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

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

37 *(f) Impose any other restrictions or delays on the access of an*
38 *insured to any such benefit.*

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



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1 4. *The Director of the Department of Health and Human*
2 *Services shall adopt regulations to establish the preventive health*
3 *care services which must be covered by a policy of group health*
4 *insurance pursuant to subsection 1, including, without limitation:*

5 (a) *Such prenatal screenings and tests as recommended by the*
6 *American College of Obstetricians and Gynecologists or its*
7 *successor organization;*

8 (b) *Screening and counseling for interpersonal and domestic*
9 *violence;*

10 (c) *Screening, tests and counseling for such other health*
11 *conditions and diseases as recommended by the Health Resources*
12 *and Services Administration;*

13 (d) *Contraceptive drugs, devices and services;*

14 (e) *Such well-woman preventive visits as recommended by the*
15 *Health Resources and Services Administration;*

16 (f) *Any supplements, drugs or devices recommended by the*
17 *Health Resources and Services Administration; and*

18 (g) *All vaccinations recommended by the Advisory Committee*
19 *on Immunization Practices of the Centers for Disease Control and*
20 *Prevention of the United States Department of Health and Human*
21 *Services or its successor organization.*

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

24 **Sec. 27. 1.** *An insurer that offers or issues a policy of*
25 *group health insurance shall include in the policy coverage for*
26 *such preventive health care services relating to persons 18 years of*
27 *age or older as the Director of the Department of Health and*
28 *Human Services requires.*

29 2. *An insurer that offers or issues a policy of group health*
30 *insurance shall not:*

31 (a) *Require an insured to pay a higher deductible, any*
32 *copayment or coinsurance or require a longer waiting period or*
33 *other condition to obtain any benefit provided in the policy of*
34 *group health insurance pursuant to subsection 1;*

35 (b) *Refuse to issue a policy of group health insurance or*
36 *cancel a policy of group health insurance solely because the*
37 *person applying for or covered by the policy uses or may use a*
38 *benefit provided in the policy of group health insurance pursuant*
39 *to subsection 1;*

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

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



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

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

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

13 4. The Director of the Department of Health and Human
14 Services shall adopt regulations to establish the preventive health
15 care services which must be covered by a policy of group health
16 insurance pursuant to subsection 1, including, without limitation:

17 (a) Screening, tests and counseling for such other health
18 conditions and diseases as recommended by the United States
19 Preventive Services Task Force or its successor organization;

20 (b) Counseling relating to the dietary needs of certain adults
21 who are at high-risk of chronic diseases;

22 (c) Smoking cessation programs;

23 (d) Any supplements, drugs or devices recommended by the
24 United States Preventive Services Task Force or its successor
25 organization; and

26 (e) All vaccinations recommended by the Advisory Committee
27 on Immunization Practices of the Centers for Disease Control and
28 Prevention of the United States Department of Health and Human
29 Services or its successor organization.

30 5. As used in this section, "provider of health care" has the
31 meaning ascribed to it in NRS 629.031.

32 **Sec. 28.** 1. An insurer that offers or issues a policy of
33 group health insurance shall include in the policy coverage for
34 such preventive health care services relating to persons less than
35 18 years of age as the Director of the Department of Health and
36 Human Services requires.

37 2. An insurer that offers or issues a policy of group health
38 insurance shall not:

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

43 (b) Refuse to issue a policy of group health insurance or
44 cancel a policy of group health insurance solely because the
45 person applying for or covered by the policy uses or may use a



1 *benefit provided in the policy of group health insurance pursuant*
2 *to subsection 1;*

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

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

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

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

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

21 *4. The Director of the Department of Health and Human*
22 *Services shall adopt regulations to establish the preventive health*
23 *care services which must be covered by a policy of group health*
24 *insurance pursuant to subsection 1, including, without limitation:*

25 *(a) Screening, tests and counseling for such other health*
26 *conditions and diseases as recommended by the Health Resources*
27 *and Services Administration;*

28 *(b) Assessments relating to height, weight, body mass index*
29 *and medical history;*

30 *(c) Any supplements, drugs or devices recommended by the*
31 *Health Resources and Services Administration; and*

32 *(d) All vaccinations recommended by the Advisory Committee*
33 *on Immunization Practices of the Centers for Disease Control and*
34 *Prevention of the United States Department of Health and Human*
35 *Services or its successor organization.*

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

38 **Sec. 29.** NRS 689B.0313 is hereby amended to read as
39 follows:

40 689B.0313 1. A policy of group health insurance must
41 provide coverage for benefits payable for expenses incurred for
42 ~~administering~~ :

43 *(a) Deoxyribonucleic acid testing for high-risk strains of the*
44 *human papillomavirus; and*



1 **(b) Administering** the human papillomavirus vaccine as
2 recommended for vaccination by a competent authority, including,
3 without limitation, the Centers for Disease Control and Prevention
4 of the United States Department of Health and Human Services, the
5 Food and Drug Administration or the manufacturer of the vaccine.

6 2. A policy of group health insurance must not require an
7 insured to obtain prior authorization for any service provided
8 pursuant to subsection 1.

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

11 **(a) Require an insured to pay a higher deductible, any
12 copayment or coinsurance or require a longer waiting period or
13 other condition to obtain any benefit provided in the policy of
14 group health insurance pursuant to subsection 1;**

15 **(b) Refuse to issue a policy of group health insurance or
16 cancel a policy of group health insurance solely because the
17 person applying for or covered by the policy uses or may use a
18 benefit provided in the policy of group health insurance pursuant
19 to subsection 1;**

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

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

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

30 **(f) Impose any other restrictions or delays on the access of an
31 insured to any such benefit.**

32 4. A policy of group health insurance subject to the
33 provisions of this chapter which is delivered, issued for delivery or
34 renewed on or after ~~July 1, 2007,~~ **January 1, 2018**, has the legal
35 effect of including the coverage required by subsection 1, and any
36 provision of the policy or the renewal which is in conflict with
37 subsection 1 is void.

38 ~~[4. For the purposes of this section, "human]~~

39 **5. As used in this section:**

40 **(a) "Human papillomavirus vaccine"** means the Quadrivalent
41 Human Papillomavirus Recombinant Vaccine or its successor which
42 is approved by the Food and Drug Administration for the prevention
43 of human papillomavirus infection and cervical cancer.

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



1 **Sec. 30.** NRS 689B.0374 is hereby amended to read as
2 follows:

3 689B.0374 1. A policy of group health insurance must
4 provide coverage for benefits payable for expenses incurred for:

5 (a) An annual cytologic screening test for women 18 years of
6 age or older;

7 (b) A baseline mammogram for women between the ages of 35
8 and 40; ~~and~~

9 (c) An annual mammogram for women 40 years of age or
10 older ~~;~~;

11 (d) *Counseling concerning genetic testing for breast cancer;*
12 *and*

13 (e) *Counseling concerning breast cancer chemoprevention.*

14 2. A policy of group health insurance must not require an
15 insured to obtain prior authorization for any service provided
16 pursuant to subsection 1.

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

19 (a) *Require an insured to pay a higher deductible, any*
20 *copayment or coinsurance or require a longer waiting period or*
21 *other condition to obtain any benefit provided in the policy of*
22 *group health insurance pursuant to subsection 1;*

23 (b) *Refuse to issue a policy of group health insurance or*
24 *cancel a policy of group health insurance solely because the*
25 *person applying for or covered by the policy uses or may use a*
26 *benefit provided in the policy of group health insurance pursuant*
27 *to subsection 1;*

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

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

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

38 (f) *Impose any other restrictions or delays on the access of an*
39 *insured to any such benefit.*

40 4. A policy of *group health insurance* subject to the
41 provisions of this chapter which is delivered, issued for delivery or
42 renewed on or after ~~October 1, 1989,~~ *January 1, 2018*, has the
43 legal effect of including the coverage required by subsection 1, and
44 any provision of the policy or the renewal which is in conflict with
45 subsection 1 is void.



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

3 **Sec. 31.** NRS 689B.500 is hereby amended to read as follows:

4 689B.500 ~~{A carrier that issues a group health plan or coverage~~
5 ~~under blanket accident and health insurance or group health~~
6 ~~insurance shall not deny, exclude or limit a benefit for a preexisting~~
7 ~~condition.}~~

8 1. *An insurer shall offer or issue a policy of group health*
9 *insurance to any person regardless of the health status of the*
10 *person, the spouse of the person or any dependent of the person.*
11 *Such health status includes, without limitation:*

12 (a) *Any preexisting medical condition of the person, including,*
13 *without limitation, any physical or mental illness;*

14 (b) *The claims history of the person, including, without*
15 *limitation, any prior health care services received by the person;*

16 (c) *Genetic information relating to the person; and*

17 (d) *Any increased risk for illness, injury or any other medical*
18 *condition of the person, including, without limitation, any medical*
19 *condition caused by an act of domestic violence.*

20 2. *An insurer that offers or issues a policy of group health*
21 *insurance shall not:*

22 (a) *Deny, limit or exclude a benefit based on the health status*
23 *of an insured; or*

24 (b) *Require an insured, as a condition of enrollment or*
25 *renewal, to pay a premium, deductible, copay or coinsurance*
26 *based on his or her health status which is greater than the*
27 *premium, deductible, copay or coinsurance charged to a similarly*
28 *situated insured or the covered spouse or dependent of such an*
29 *insured who does not have such a health status.*

30 3. *An insurer that offers or issues a policy of group health*
31 *insurance shall not adjust a premium, deductible, copay or*
32 *coinsurance for any insured on the basis of genetic information*
33 *relating to the insured or the covered spouse or dependent of the*
34 *insured.*

35 **Sec. 32.** NRS 689B.520 is hereby amended to read as follows:

36 689B.520 1. *An insurer that offers or issues a policy of*
37 *group health insurance shall include in the policy coverage for*
38 *such health care services relating to maternal and newborn care*
39 *as the Director of the Department of Health and Human Services*
40 *requires.*

41 2. Except as otherwise provided in this subsection, a group
42 health plan or coverage offered under group health insurance issued
43 pursuant to this chapter ~~{that includes coverage for maternity care~~
44 ~~and pediatric care for newborn infants}~~ may not restrict benefits for



1 any length of stay in a hospital in connection with childbirth for a
2 mother or newborn infant covered by the plan or coverage to:

- 3 (a) Less than 48 hours after a normal vaginal delivery; and
- 4 (b) Less than 96 hours after a cesarean section.

5 ➔ If a different length of stay is provided in the guidelines
6 established by the American College of Obstetricians and
7 Gynecologists, or its successor organization, and the American
8 Academy of Pediatrics, or its successor organization, the group
9 health plan or health insurance coverage may follow such guidelines
10 in lieu of following the length of stay set forth above. The
11 provisions of this subsection do not apply to any group health plan
12 or health insurance coverage in any case in which the decision to
13 discharge the mother or newborn infant before the expiration of the
14 minimum length of stay set forth in this subsection is made by the
15 attending physician of the mother or newborn infant.

16 ~~12.1~~ 3. Nothing in this section requires a mother to:

- 17 (a) Deliver her baby in a hospital; or
- 18 (b) Stay in a hospital for a fixed period following the birth of her
19 child.

20 ~~13.1~~ 4. A group health plan or coverage under group health
21 insurance ~~{that offers coverage for maternity care and pediatric care~~
22 ~~of newborn infants}~~ may not:

23 (a) Deny a mother or her newborn infant coverage or continued
24 coverage under the terms of the plan or coverage if the sole purpose
25 of the denial of coverage or continued coverage is to avoid the
26 requirements of this section;

27 (b) Provide monetary payments or rebates to a mother to
28 encourage her to accept less than the minimum protection available
29 pursuant to this section;

30 (c) Penalize, or otherwise reduce or limit, the reimbursement of
31 an attending provider of health care because the attending provider
32 of health care provided care to a mother or newborn infant in
33 accordance with the provisions of this section;

34 (d) Provide incentives of any kind to an attending physician to
35 induce the attending physician to provide care to a mother or
36 newborn infant in a manner that is inconsistent with the provisions
37 of this section; or

38 (e) Except as otherwise provided in subsection ~~14.1~~ 5, restrict
39 benefits for any portion of a hospital stay required pursuant to the
40 provisions of this section in a manner that is less favorable than the
41 benefits provided for any preceding portion of that stay.

42 ~~14.1~~ 5. Nothing in this section:

43 (a) Prohibits a group health plan or carrier from imposing a
44 deductible, coinsurance or other mechanism for sharing costs
45 relating to benefits for hospital stays in connection with childbirth



1 for a mother or newborn child covered by the plan, except that such
2 coinsurance or other mechanism for sharing costs for any portion of
3 a hospital stay required by this section may not be greater than the
4 coinsurance or other mechanism for any preceding portion of that
5 stay.

6 (b) Prohibits an arrangement for payment between a group
7 health plan or carrier and a provider of health care that uses
8 capitation or other financial incentives, if the arrangement is
9 designed to provide services efficiently and consistently in the best
10 interest of the mother and her newborn infant.

11 (c) Prevents a group health plan or carrier from negotiating with
12 a provider of health care concerning the level and type of
13 reimbursement to be provided in accordance with this section.

14 *6. A policy of group health insurance subject to the*
15 *provisions of this chapter that is delivered, issued for delivery or*
16 *renewed on or after January 1, 2018, has the legal effect of*
17 *including the coverage required by subsection 1, and any*
18 *provision of the policy or the renewal which is in conflict with this*
19 *section is void.*

20 *7. The Director of the Department of Health and Human*
21 *Services shall adopt regulations to establish the health care*
22 *services which must be covered by a policy of group health*
23 *insurance pursuant to subsection 1.*

24 *8. As used in this section, "provider of health care" has the*
25 *meaning ascribed to it in NRS 629.031.*

26 **Sec. 33.** Chapter 689C of NRS is hereby amended by adding
27 thereto the provisions set forth as sections 34 to 39, inclusive, of this
28 act.

29 **Sec. 34. 1.** *A carrier that offers or issues a health benefit*
30 *plan which provides coverage for dependent children shall*
31 *continue to make such coverage available for an adult child of an*
32 *insured until such child reaches 26 years of age.*

33 *2. Nothing in this section shall be construed as requiring a*
34 *carrier to make coverage available for a dependent of an adult*
35 *child of an insured.*

36 **Sec. 35. 1.** *A carrier that offers or issues a health benefit*
37 *plan shall include in the plan coverage for such preventive health*
38 *care services relating to women as the Director of the Department*
39 *of Health and Human Services requires.*

40 *2. A carrier that offers or issues a health benefit plan shall*
41 *not:*

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



1 ***(b) Refuse to issue a health benefit plan or cancel a health***
2 ***benefit plan solely because the person applying for or covered by***
3 ***the plan uses or may use a benefit provided in the health benefit***
4 ***plan pursuant to subsection 1;***

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

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

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

15 ***(f) Impose any other restrictions or delays on the access of an***
16 ***insured to any such benefit.***

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

22 ***4. The Director of the Department of Health and Human***
23 ***Services shall adopt regulations to establish the preventive health***
24 ***care services which must be covered by a health benefit plan***
25 ***pursuant to subsection 1, including, without limitation:***

26 ***(a) Such prenatal screenings and tests as recommended by the***
27 ***American College of Obstetricians and Gynecologists or its***
28 ***successor organization;***

29 ***(b) Screening and counseling for interpersonal and domestic***
30 ***violence;***

31 ***(c) Screening, tests and counseling for such other health***
32 ***conditions and diseases as recommended by the Health Resources***
33 ***and Services Administration;***

34 ***(d) Contraceptive drugs, devices and services;***

35 ***(e) Such well-woman preventive visits as recommended by the***
36 ***Health Resources and Services Administration;***

37 ***(f) Any supplements, drugs or devices recommended by the***
38 ***Health Resources and Services Administration; and***

39 ***(g) All vaccinations recommended by the Advisory Committee***
40 ***on Immunization Practices of the Centers for Disease Control and***
41 ***Prevention of the United States Department of Health and Human***
42 ***Services or its successor organization.***

43 ***5. As used in this section, "provider of health care" has the***
44 ***meaning ascribed to it in NRS 629.031.***



1 **Sec. 36. 1. A carrier that offers or issues a health benefit**
2 **plan shall include in the plan coverage for such preventive health**
3 **care services relating to persons 18 years of age or older as the**
4 **Director of the Department of Health and Human Services**
5 **requires.**

6 **2. A carrier that offers or issues a health benefit plan shall**
7 **not:**

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

12 **(b) Refuse to issue a health benefit plan or cancel a health**
13 **benefit plan solely because the person applying for or covered by**
14 **the plan uses or may use a benefit provided in the health benefit**
15 **plan pursuant to subsection 1;**

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

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

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

26 **(f) Impose any other restrictions or delays on the access of an**
27 **insured to any such benefit.**

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

33 **4. The Director of the Department of Health and Human**
34 **Services shall adopt regulations to establish the preventive health**
35 **care services which must be covered by a health benefit plan**
36 **pursuant to subsection 1, including, without limitation:**

37 **(a) Screening, tests and counseling for such other health**
38 **conditions and diseases as recommended by the United States**
39 **Preventive Services Task Force or its successor organization;**

40 **(b) Counseling relating to the dietary needs of certain adults**
41 **who are at high-risk of chronic diseases;**

42 **(c) Smoking cessation programs;**

43 **(d) Any supplements, drugs or devices recommended by the**
44 **United States Preventive Services Task Force or its successor**
45 **organization; and**



1 (e) All vaccinations recommended by the Advisory Committee
2 on Immunization Practices of the Centers for Disease Control and
3 Prevention of the United States Department of Health and Human
4 Services or its successor organization.

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

7 **Sec. 37. 1.** A carrier that offers or issues a health benefit
8 plan shall include in the plan coverage for such preventive health
9 care services relating to persons less than 18 years of age as the
10 Director of the Department of Health and Human Services
11 requires.

12 2. A carrier that offers or issues a health benefit plan shall
13 not:

14 (a) Require an insured to pay a higher deductible, any
15 copayment or coinsurance or require a longer waiting period or
16 other condition to obtain any benefit provided in the health benefit
17 plan pursuant to subsection 1;

18 (b) Refuse to issue a health benefit plan or cancel a health
19 benefit plan solely because the person applying for or covered by
20 the plan uses or may use a benefit provided in the health benefit
21 plan pursuant to subsection 1;

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

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

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

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

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

39 4. The Director of the Department of Health and Human
40 Services shall adopt regulations to establish the preventive health
41 care services which must be covered by a health benefit plan
42 pursuant to subsection 1, including, without limitation:

43 (a) Screening, tests and counseling for such other health
44 conditions and diseases as recommended by the Health Resources
45 and Services Administration;



1 (b) Assessments relating to height, weight, body mass index
2 and medical history;

3 (c) Any supplements, drugs or devices recommended by the
4 Health Resources and Services Administration; and

5 (d) All vaccinations recommended by the Advisory Committee
6 on Immunization Practices of the Centers for Disease Control and
7 Prevention of the United States Department of Health and Human
8 Services or its successor organization.

9 5. As used in this section, "provider of health care" has the
10 meaning ascribed to it in NRS 629.031.

11 **Sec. 38. 1. A health benefit plan must provide coverage for**
12 **benefits payable for expenses incurred for:**

13 (a) Deoxyribonucleic acid testing for high-risk strains of the
14 human papillomavirus; and

15 (b) Administering the human papillomavirus vaccine as
16 recommended for vaccination by a competent authority, including,
17 without limitation, the Centers for Disease Control and Prevention
18 of the United States Department of Health and Human Services,
19 the Food and Drug Administration or the manufacturer of the
20 vaccine.

21 2. A health benefit plan must not require an insured to obtain
22 prior authorization for any service provided pursuant to
23 subsection 1.

24 3. A carrier that offers or issues a health benefit plan shall
25 not:

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

30 (b) Refuse to issue a health benefit plan or cancel a health
31 benefit plan solely because the person applying for or covered by
32 the plan uses or may use a benefit provided in the health benefit
33 plan pursuant to subsection 1;

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

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

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

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



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

6 5. As used in this section:

7 (a) "Human papillomavirus vaccine" means the *Quadrivalent*
8 *Human Papillomavirus Recombinant Vaccine* or its successor
9 which is approved by the Food and Drug Administration for the
10 prevention of human papillomavirus infection and cervical
11 cancer.

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

14 **Sec. 39. 1.** A health benefit plan must provide coverage for
15 benefits payable for expenses incurred for:

16 (a) An annual cytologic screening test for women 18 years of
17 age or older;

18 (b) A baseline mammogram for women between the ages of 35
19 and 40 years;

20 (c) An annual mammogram for women 40 years of age or
21 older;

22 (d) Counseling concerning genetic testing for breast cancer;
23 and

24 (e) Counseling concerning breast cancer chemoprevention.

25 2. A health benefit plan must not require an insured to obtain
26 prior authorization for any service provided pursuant to
27 subsection 1.

28 3. A carrier that offers or issues a health benefit plan shall
29 not:

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

34 (b) Refuse to issue a health benefit plan or cancel a health
35 benefit plan solely because the person applying for or covered by
36 the plan uses or may use a benefit provided in the health benefit
37 plan pursuant to subsection 1;

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

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

44 (e) Offer or pay any type of material inducement, bonus or
45 other financial incentive to a provider of health care to deny,



1 *reduce, withhold, limit or delay access to any such benefit to an*
2 *insured; or*

3 *(f) Impose any other restrictions or delays on the access of an*
4 *insured to any such benefit.*

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

10 *5. As used in this section, "provider of health care" has the*
11 *meaning ascribed to it in NRS 629.031.*

12 **Sec. 40.** NRS 689C.159 is hereby amended to read as follows:

13 689C.159 The provisions of NRS 689C.156 ~~and 689C.190~~ do
14 not apply to health benefit plans offered by a carrier if the carrier
15 makes the health benefit plan available in the small employer
16 market only through a bona fide association.

17 **Sec. 41.** NRS 689C.190 is hereby amended to read as follows:

18 689C.190 ~~[A carrier serving small employers that issues a~~
19 ~~health benefit plan shall not deny, exclude or limit a benefit for a~~
20 ~~preexisting condition.]~~

21 *1. A carrier shall offer or issue a health benefit plan to any*
22 *person regardless of the health status of the person, the spouse of*
23 *the person or any dependent of the person. Such health status*
24 *includes, without limitation:*

25 *(a) Any preexisting medical condition of the person, including,*
26 *without limitation, any physical or mental illness;*

27 *(b) The claims history of the person, including, without*
28 *limitation, any prior health care services received by the person;*

29 *(c) Genetic information relating to the person; and*

30 *(d) Any increased risk for illness, injury or any other medical*
31 *condition of the person, including, without limitation, any medical*
32 *condition caused by an act of domestic violence.*

33 *2. A carrier that offers or issues a health benefit plan shall*
34 *not:*

35 *(a) Deny, limit or exclude a benefit based on the health status*
36 *of an insured; or*

37 *(b) Require an insured, as a condition of enrollment or*
38 *renewal, to pay a premium, deductible, copay or coinsurance*
39 *based on his or her health status which is greater than the*
40 *premium, deductible, copay or coinsurance charged to a similarly*
41 *situated insured or the covered spouse or dependent of such an*
42 *insured who does not have such a health status.*

43 *3. A carrier that offers or issues a health benefit plan shall*
44 *not adjust a premium, deductible, copay or coinsurance for any*



1 *insured on the basis of genetic information relating to the insured*
2 *or the covered spouse or dependent of the insured.*

3 **Sec. 42.** NRS 689C.193 is hereby amended to read as follows:

4 689C.193 1. A carrier shall not place any restriction on a
5 small employer or an eligible employee or a dependent of the
6 eligible employee as a condition of being a participant in or a
7 beneficiary of a health benefit plan that is inconsistent with NRS
8 689C.015 to 689C.355, inclusive **H** , *and sections 34 to 39,*
9 *inclusive, of this act.*

10 2. A carrier that offers health insurance coverage to small
11 employers pursuant to this chapter shall not establish rules of
12 eligibility, including, but not limited to, rules which define
13 applicable waiting periods, for the initial or continued enrollment
14 under a health benefit plan offered by the carrier that are based on
15 the following factors relating to the eligible employee or a
16 dependent of the eligible employee:

17 (a) Health status.

18 (b) Medical condition, including physical and mental illnesses,
19 or both.

20 (c) Claims experience.

21 (d) Receipt of health care.

22 (e) Medical history.

23 (f) Genetic information.

24 (g) Evidence of insurability, including conditions which arise
25 out of acts of domestic violence.

26 (h) Disability.

27 3. Except as otherwise provided in NRS 689C.190, the
28 provisions of subsection 1 do not require a carrier to provide
29 particular benefits other than those that would otherwise be provided
30 under the terms of the health benefit plan or coverage.

31 4. As a condition of enrollment or continued enrollment under
32 a health benefit plan, a carrier shall not require any person to pay a
33 premium or contribution that is greater than the premium or
34 contribution for a similarly situated person covered by similar
35 coverage on the basis of any factor described in subsection 2 in
36 relation to the person or a dependent of the person.

37 5. Nothing in this section:

38 (a) Restricts the amount that a small employer may be charged
39 for coverage by a carrier;

40 (b) Prevents a carrier from establishing premium discounts or
41 rebates or from modifying otherwise applicable copayments or
42 deductibles in return for adherence by the insured person to
43 programs of health promotion and disease prevention; or



1 (c) Precludes a carrier from establishing rules relating to
2 employer contribution or group participation when offering health
3 insurance coverage to small employers in this State.

4 6. As used in this section:

5 (a) "Contribution" means the minimum employer contribution
6 toward the premium for enrollment of participants and beneficiaries
7 in a health benefit plan.

8 (b) "Group participation" means the minimum number of
9 participants or beneficiaries that must be enrolled in a health benefit
10 plan in relation to a specified percentage or number of eligible
11 persons or employees of the employer.

12 **Sec. 43.** NRS 689C.194 is hereby amended to read as follows:

13 689C.194 1. *A carrier that offers or issues a health benefit*
14 *plan shall include in the plan coverage for such health care*
15 *services relating to maternal and newborn care as the Director of*
16 *the Department of Health and Human Services requires.*

17 2. Except as otherwise provided in this subsection, a health
18 benefit plan issued pursuant to this chapter ~~that includes coverage~~
19 ~~for maternity care and pediatric care for newborn infants~~ may not
20 restrict benefits for any length of stay in a hospital in connection
21 with childbirth for a mother or newborn infant covered by the plan
22 to:

23 (a) Less than 48 hours after a normal vaginal delivery; and

24 (b) Less than 96 hours after a cesarean section.

25 ➔ If a different length of stay is provided in the guidelines
26 established by the American College of Obstetricians and
27 Gynecologists, or its successor organization, and the American
28 Academy of Pediatrics, or its successor organization, the health
29 benefit plan may follow such guidelines in lieu of following the
30 length of stay set forth above. The provisions of this subsection do
31 not apply to any health benefit plan in any case in which the
32 decision to discharge the mother or newborn infant before the
33 expiration of the minimum length of stay set forth in this subsection
34 is made by the attending physician of the mother or newborn infant.

35 ~~2-~~ 3. Nothing in this section requires a mother to:

36 (a) Deliver her baby in a hospital; or

37 (b) Stay in a hospital for a fixed period following the birth of her
38 child.

39 ~~3-~~ 4. A health benefit plan ~~that offers coverage for maternity~~
40 ~~care and pediatric care of newborn infants~~ may not:

41 (a) Deny a mother or her newborn infant coverage or continued
42 coverage under the terms of the plan if the sole purpose of the denial
43 of coverage or continued coverage is to avoid the requirements of
44 this section;



1 (b) Provide monetary payments or rebates to a mother to
2 encourage her to accept less than the minimum protection available
3 pursuant to this section;

4 (c) Penalize, or otherwise reduce or limit, the reimbursement of
5 an attending provider of health care because the attending provider
6 of health care provided care to a mother or newborn infant in
7 accordance with the provisions of this section;

8 (d) Provide incentives of any kind to an attending physician to
9 induce the attending physician to provide care to a mother or
10 newborn infant in a manner that is inconsistent with the provisions
11 of this section; or

12 (e) Except as otherwise provided in subsection ~~44~~ 5, restrict
13 benefits for any portion of a hospital stay required pursuant to the
14 provisions of this section in a manner that is less favorable than the
15 benefits provided for any preceding portion of that stay.

16 ~~44~~ 5. Nothing in this section:

17 (a) Prohibits a health benefit plan or carrier from imposing a
18 deductible, coinsurance or other mechanism for sharing costs
19 relating to benefits for hospital stays in connection with childbirth
20 for a mother or newborn child covered by the plan, except that such
21 coinsurance or other mechanism for sharing costs for any portion of
22 a hospital stay required by this section may not be greater than the
23 coinsurance or other mechanism for any preceding portion of that
24 stay.

25 (b) Prohibits an arrangement for payment between a health
26 benefit plan or carrier and a provider of health care that uses
27 capitation or other financial incentives, if the arrangement is
28 designed to provide services efficiently and consistently in the best
29 interest of the mother and her newborn infant.

30 (c) Prevents a health benefit plan or carrier from negotiating
31 with a provider of health care concerning the level and type of
32 reimbursement to be provided in accordance with this section.

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

38 *7. The Director of the Department of Health and Human*
39 *Services shall adopt regulations to establish the health care*
40 *services which must be covered by a health benefit plan pursuant*
41 *to subsection 1.*

42 *8. As used in this section, "provider of health care" has the*
43 *meaning ascribed to it in NRS 629.031.*



1 **Sec. 44.** NRS 689C.270 is hereby amended to read as follows:

2 689C.270 1. The Commissioner shall adopt regulations
3 which require a carrier to file with the Commissioner, for approval
4 by the Commissioner, a disclosure offered by the carrier to a small
5 employer. The disclosure must include:

6 (a) Any significant exception, reduction or limitation that
7 applies to the policy;

8 (b) Any restrictions on payments for emergency care, including,
9 without limitation, related definitions of an emergency and medical
10 necessity;

11 (c) The provision of the health benefit plan concerning the
12 carrier's right to change premium rates and the characteristics, other
13 than claim experience, that affect changes in premium rates;

14 (d) The provisions relating to renewability of policies and
15 contracts; *and*

16 (e) ~~The provisions relating to any preexisting condition; and~~
17 ~~—(f)—~~ Any other information that the Commissioner finds
18 necessary to provide for full and fair disclosure of the provisions of
19 a policy or contract of insurance issued pursuant to this chapter.

20 2. The disclosure must be written in language which is easily
21 understood and must include a statement that the disclosure is a
22 summary of the policy only, and that the policy itself should be read
23 to determine the governing contractual provisions.

24 3. The Commissioner shall not approve any proposed
25 disclosure submitted to the Commissioner pursuant to this section
26 which does not comply with the requirements of this section and the
27 applicable regulations.

28 4. The carrier shall make available to a small employer or a
29 producer acting on behalf of a small employer, upon request, a copy
30 of the disclosure approved by the Commissioner pursuant to this
31 section for policies of health insurance for which that employer may
32 be eligible.

33 **Sec. 45.** NRS 689C.425 is hereby amended to read as follows:

34 689C.425 A voluntary purchasing group and any contract
35 issued to such a group pursuant to NRS 689C.360 to 689C.600,
36 inclusive, are subject to the provisions of NRS 689C.015 to
37 689C.355, inclusive, *and sections 34 to 39, inclusive, of this act*, to
38 the extent applicable and not in conflict with the express provisions
39 of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

40 **Sec. 46.** NRS 689C.440 is hereby amended to read as follows:

41 689C.440 1. The Commissioner shall adopt regulations
42 which require a carrier to file with the Commissioner, for approval
43 by the Commissioner, a disclosure offered by the carrier to a
44 voluntary purchasing group. The disclosure must include:



1 (a) Any significant exception, prior authorization, reduction or
2 limitation that applies to a contract;

3 (b) Any restrictions on payments for emergency care, including,
4 without limitation, related definitions of an emergency and medical
5 necessity;

6 (c) Any provision of a contract concerning the carrier's right to
7 change premium rates and the characteristics, other than claim
8 experience, that affect changes in premium rates;

9 (d) The provisions relating to renewability of contracts; *and*

10 ~~(e) The provisions relating to any preexisting condition; and~~
11 ~~(f)~~ Any other information that the Commissioner finds
12 necessary to provide for full and fair disclosure of the provisions of
13 a contract.

14 2. The disclosure must be written in a language which is easily
15 understood and must include a statement that the disclosure is a
16 summary of the contract only, and that the contract itself should be
17 read to determine the governing contractual provisions.

18 3. The Commissioner shall not approve any proposed
19 disclosure submitted to the Commissioner pursuant to this section
20 which does not comply with the requirements of this section and the
21 applicable regulations.

22 **Sec. 47.** Chapter 695A of NRS is hereby amended by adding
23 thereto the provisions set forth as sections 48 to 55, inclusive, of this
24 act.

25 **Sec. 48. 1. A society shall offer or issue a benefit contract**
26 ***to any person regardless of the health status of the person, the***
27 ***spouse of the person or any dependent of the person. Such health***
28 ***status includes, without limitation:***

29 ***(a) Any preexisting medical condition of the person, including,***
30 ***without limitation, any physical or mental illness;***

31 ***(b) The claims history of the person, including, without***
32 ***limitation, any prior health care services received by the person;***

33 ***(c) Genetic information relating to the person; and***

34 ***(d) Any increased risk for illness, injury or any other medical***
35 ***condition of the person, including, without limitation, any medical***
36 ***condition caused by an act of domestic violence.***

37 **2. A society that offers or issues a benefit contract shall not:**

38 ***(a) Deny, limit or exclude a benefit based on the health status***
39 ***of an insured; or***

40 ***(b) Require an insured, as a condition of enrollment or***
41 ***renewal, to pay a premium, deductible, copay or coinsurance***
42 ***based on his or her health status which is greater than the***
43 ***premium, deductible, copay or coinsurance charged to a similarly***
44 ***situated insured or the covered spouse or dependent of such an***
45 ***insured who does not have such a health status.***



1 3. *A society that offers or issues a benefit contract shall not*
2 *adjust a premium, deductible, copay or coinsurance for any*
3 *insured on the basis of genetic information relating to the insured*
4 *or the covered spouse or dependent of the insured.*

5 **Sec. 49.** *1. A society that offers or issues a benefit contract*
6 *which provides coverage for dependent children shall continue to*
7 *make such coverage available for an adult child of an insured*
8 *until such child reaches 26 years of age.*

9 *2. Nothing in this section shall be construed as requiring a*
10 *society to make coverage available for a dependent of an adult*
11 *child of an insured.*

12 **Sec. 50.** *1. A society that offers or issues a benefit contract*
13 *shall include in the contract coverage for such preventive health*
14 *care services relating to women as the Director of the Department*
15 *of Health and Human Services requires.*

16 *2. A society that offers or issues a benefit contract shall not:*

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

21 (ii) *Refuse to issue a benefit contract or cancel a benefit*
22 *contract solely because the person applying for or covered by the*
23 *contract uses or may use a benefit provided in the benefit contract*
24 *pursuant to subsection 1;*

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

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

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

35 (vi) *Impose any other restrictions or delays on the access of an*
36 *insured to any such benefit.*

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

42 4. *The Director of the Department of Health and Human*
43 *Services shall adopt regulations to establish the preventive health*
44 *care services which must be covered by a benefit contract pursuant*
45 *to subsection 1, including, without limitation:*



1 (a) Such prenatal screenings and tests as recommended by the
2 American College of Obstetricians and Gynecologists or its
3 successor organization;

4 (b) Screening and counseling for interpersonal and domestic
5 violence;

6 (c) Screening, tests and counseling for such other health
7 conditions and diseases as recommended by the Health Resources
8 and Services Administration;

9 (d) Contraceptive drugs, devices and services;

10 (e) Such well-woman preventive visits as recommended by the
11 Health Resources and Services Administration;

12 (f) Any supplements, drugs or devices recommended by the
13 Health Resources and Services Administration; and

14 (g) All vaccinations recommended by the Advisory Committee
15 on Immunization Practices of the Centers for Disease Control and
16 Prevention of the United States Department of Health and Human
17 Services or its successor organization.

18 5. As used in this section, "provider of health care" has the
19 meaning ascribed to it in NRS 629.031.

20 **Sec. 51.** 1. A society that offers or issues a benefit contract
21 shall include in the contract coverage for such preventive health
22 care services relating to persons 18 years of age or older as the
23 Director of the Department of Health and Human Services
24 requires.

25 2. A society that offers or issues a benefit contract shall not:

26 (a) Require an insured to pay a higher deductible, any
27 copayment or coinsurance or require a longer waiting period or
28 other condition to obtain any benefit provided in the benefit
29 contract pursuant to subsection 1;

30 (b) Refuse to issue a benefit contract or cancel a benefit
31 contract solely because the person applying for or covered by the
32 contract uses or may use a benefit provided in the benefit contract
33 pursuant to subsection 1;

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

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

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

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



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

6 4. *The Director of the Department of Health and Human*
7 *Services shall adopt regulations to establish the preventive health*
8 *care services which must be covered by a benefit contract pursuant*
9 *to subsection 1, including, without limitation:*

10 (a) *Screening, tests and counseling for such other health*
11 *conditions and diseases as recommended by the United States*
12 *Preventive Services Task Force or its successor organization;*

13 (b) *Counseling relating to the dietary needs of certain adults*
14 *who are at high-risk of chronic diseases;*

15 (c) *Smoking cessation programs;*

16 (d) *Any supplements, drugs or devices recommended by the*
17 *United States Preventive Services Task Force or its successor*
18 *organization; and*

19 (e) *All vaccinations recommended by the Advisory Committee*
20 *on Immunization Practices of the Centers for Disease Control and*
21 *Prevention of the United States Department of Health and Human*
22 *Services or its successor organization.*

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

25 **Sec. 52. 1.** *A society that offers or issues a benefit contract*
26 *shall include in the contract coverage for such preventive health*
27 *care services relating to persons less than 18 years of age as the*
28 *Director of the Department of Health and Human Services*
29 *requires.*

30 2. *A society that offers or issues a benefit contract shall not:*

31 (a) *Require an insured to pay a higher deductible, any*
32 *copayment or coinsurance or require a longer waiting period or*
33 *other condition to obtain any benefit provided in the benefit*
34 *contract pursuant to subsection 1;*

35 (b) *Refuse to issue a benefit contract or cancel a benefit*
36 *contract solely because the person applying for or covered by the*
37 *contract uses or may use a benefit provided in the benefit contract*
38 *pursuant to subsection 1;*

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

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



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

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

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

12 4. The Director of the Department of Health and Human
13 Services shall adopt regulations to establish the preventive health
14 care services which must be covered by a benefit contract pursuant
15 to subsection 1, including, without limitation:

16 (a) Screening, tests and counseling for such other health
17 conditions and diseases as recommended by the Health Resources
18 and Services Administration;

19 (b) Assessments relating to height, weight, body mass index
20 and medical history;

21 (c) Any supplements, drugs or devices recommended by the
22 Health Resources and Services Administration; and

23 (d) All vaccinations recommended by the Advisory Committee
24 on Immunization Practices of the Centers for Disease Control and
25 Prevention of the United States Department of Health and Human
26 Services or its successor organization.

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

29 **Sec. 53.** 1. A society that offers or issues a benefit contract
30 shall include in the contract coverage for such health care services
31 relating to maternal and newborn care as the Director of the
32 Department of Health and Human Services requires.

33 2. Except as otherwise provided in this subsection, a benefit
34 contract issued pursuant to this chapter may not restrict benefits
35 for any length of stay in a hospital in connection with childbirth
36 for a mother or newborn infant covered by the contract to:

37 (a) Less than 48 hours after a normal vaginal delivery; and

38 (b) Less than 96 hours after a cesarean section.

39 ↪ If a different length of stay is provided in the guidelines
40 established by the American College of Obstetricians and
41 Gynecologists, or its successor organization, and the American
42 Academy of Pediatrics, or its successor organization, the benefit
43 contract may follow such guidelines in lieu of following the length
44 of stay set forth above. The provisions of this subsection do not
45 apply to any benefit contract in any case in which the decision to



1 *discharge the mother or newborn infant before the expiration of*
2 *the minimum length of stay set forth in this subsection is made by*
3 *the attending physician of the mother or newborn infant.*

4 3. *Nothing in this section requires a mother to:*

5 (a) *Deliver her baby in a hospital; or*

6 (b) *Stay in a hospital for a fixed period following the birth of*
7 *her child.*

8 4. *A benefit contract may not:*

9 (a) *Deny a mother or her newborn infant coverage or*
10 *continued coverage under the terms of the contract or coverage if*
11 *the sole purpose of the denial of coverage or continued coverage is*
12 *to avoid the requirements of this section;*

13 (b) *Provide monetary payments or rebates to a mother to*
14 *encourage her to accept less than the minimum protection*
15 *available pursuant to this section;*

16 (c) *Penalize, or otherwise reduce or limit, the reimbursement*
17 *of an attending provider of health care because the attending*
18 *provider of health care provided care to a mother or newborn*
19 *infant in accordance with the provisions of this section;*

20 (d) *Provide incentives of any kind to an attending physician to*
21 *induce the attending physician to provide care to a mother or*
22 *newborn infant in a manner that is inconsistent with the*
23 *provisions of this section; or*

24 (e) *Except as otherwise provided in subsection 5, restrict*
25 *benefits for any portion of a hospital stay required pursuant to the*
26 *provisions of this section in a manner that is less favorable than*
27 *the benefits provided for any preceding portion of that stay.*

28 5. *Nothing in this section:*

29 (a) *Prohibits a benefit contract from imposing a deductible,*
30 *coinsurance or other mechanism for sharing costs relating to*
31 *benefits for hospital stays in connection with childbirth for a*
32 *mother or newborn child covered by the contract, except that such*
33 *coinsurance or other mechanism for sharing costs for any portion*
34 *of a hospital stay required by this section may not be greater than*
35 *the coinsurance or other mechanism for any preceding portion of*
36 *that stay.*

37 (b) *Prohibits an arrangement for payment between a benefit*
38 *contract or society and a provider of health care that uses*
39 *capitation or other financial incentives, if the arrangement is*
40 *designed to provide services efficiently and consistently in the best*
41 *interest of the mother and her newborn infant.*

42 (c) *Prevents a benefit contract or society from negotiating with*
43 *a provider of health care concerning the level and type of*
44 *reimbursement to be provided in accordance with this section.*



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

6 7. *The Director of the Department of Health and Human*
7 *Services shall adopt regulations to establish the health care*
8 *services which must be covered by a benefit contract pursuant to*
9 *subsection 1.*

10 8. *As used in this section, "provider of health care" has the*
11 *meaning ascribed to it in NRS 629.031.*

12 **Sec. 54. 1.** *A benefit contract must provide coverage for*
13 *benefits payable for expenses incurred for:*

14 (a) *Deoxyribonucleic acid testing for high-risk strains of the*
15 *human papillomavirus; and*

16 (b) *Administering the human papillomavirus vaccine as*
17 *recommended for vaccination by a competent authority, including,*
18 *without limitation, the Centers for Disease Control and Prevention*
19 *of the United States Department of Health and Human Services,*
20 *the Food and Drug Administration or the manufacturer of the*
21 *vaccine.*

22 2. *A benefit contract must not require an insured to obtain*
23 *prior authorization for any service provided pursuant to*
24 *subsection 1.*

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

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

30 (b) *Refuse to issue a benefit contract or cancel a benefit*
31 *contract solely because the person applying for or covered by the*
32 *contract uses or may use a benefit provided in the benefit contract*
33 *pursuant to subsection 1;*

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

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

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

44 (f) *Impose any other restrictions or delays on the access of an*
45 *insured to any such benefit.*



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

6 5. *As used in this section:*

7 (a) *“Human papillomavirus vaccine” means the Quadrivalent*
8 *Human Papillomavirus Recombinant Vaccine or its successor*
9 *which is approved by the Food and Drug Administration for the*
10 *prevention of human papillomavirus infection and cervical*
11 *cancer.*

12 (b) *“Provider of health care” has the meaning ascribed to it in*
13 *NRS 629.031.*

14 **Sec. 55. 1.** *A benefit contract must provide coverage for*
15 *benefits payable for expenses incurred for:*

16 (a) *An annual cytologic screening test for women 18 years of*
17 *age or older;*

18 (b) *A baseline mammogram for women between the ages of 35*
19 *and 40 years;*

20 (c) *An annual mammogram for women 40 years of age or*
21 *older;*

22 (d) *Counseling concerning genetic testing for breast cancer;*
23 *and*

24 (e) *Counseling concerning breast cancer chemoprevention.*

25 2. *A benefit contract must not require an insured to obtain*
26 *prior authorization for any service provided pursuant to*
27 *subsection 1.*

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

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

33 (b) *Refuse to issue a benefit contract or cancel a benefit*
34 *contract solely because the person applying for or covered by the*
35 *contract uses or may use a benefit provided in the benefit contract*
36 *pursuant to subsection 1;*

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

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

43 (e) *Offer or pay any type of material inducement, bonus or*
44 *other financial incentive to a provider of health care to deny,*



1 *reduce, withhold, limit or delay access to any such benefit to an*
2 *insured; or*

3 *(f) Impose any other restrictions or delays on the access of an*
4 *insured to any such benefit.*

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

10 *5. As used in this section, "provider of health care" has the*
11 *meaning ascribed to it in NRS 629.031.*

12 **Sec. 56.** Chapter 695B of NRS is hereby amended by adding
13 thereto the provisions set forth as sections 57 to 62, inclusive, of this
14 act.

15 **Sec. 57. 1.** *An insurer shall offer or issue a contract for*
16 *hospital or medical service to any person regardless of the health*
17 *status of the person, the spouse of the person or any dependent of*
18 *the person. Such health status includes, without limitation:*

19 *(a) Any preexisting medical condition of the person, including,*
20 *without limitation, any physical or mental illness;*

21 *(b) The claims history of the person, including, without*
22 *limitation, any prior health care services received by the person;*

23 *(c) Genetic information relating to the person; and*

24 *(d) Any increased risk for illness, injury or any other medical*
25 *condition of the person, including, without limitation, any medical*
26 *condition caused by an act of domestic violence.*

27 *2. An insurer that offers or issues a contract for hospital or*
28 *medical service shall not:*

29 *(a) Deny, limit or exclude a benefit based on the health status*
30 *of an insured; or*

31 *(b) Require an insured, as a condition of enrollment or*
32 *renewal, to pay a premium, deductible, copay or coinsurance*
33 *based on his or her health status which is greater than the*
34 *premium, deductible, copay or coinsurance charged to a similarly*
35 *situated insured or the covered spouse or dependent of such an*
36 *insured who does not have such a health status.*

37 *3. An insurer that offers or issues a contract for hospital or*
38 *medical service shall not adjust a premium, deductible, copay or*
39 *coinsurance for any insured on the basis of genetic information*
40 *relating to the insured or the covered spouse or dependent of the*
41 *insured.*

42 **Sec. 58. 1.** *An insurer that offers or issues a contract for*
43 *hospital or medical service which provides coverage for dependent*
44 *children shall continue to make such coverage available for an*
45 *adult child of an insured until such child reaches 26 years of age.*



1 2. *Nothing in this section shall be construed as requiring a*
2 *hospital or medical service corporation to make coverage available*
3 *for a dependent of an adult child of an insured.*

4 **Sec. 59. 1.** *An insurer that offers or issues a contract for*
5 *hospital or medical service shall include in the contract coverage*
6 *for such preventive health care services relating to women as the*
7 *Director of the Department of Health and Human Services*
8 *requires.*

9 2. *An insurer that offers or issues a contract for hospital or*
10 *medical service shall not:*

11 (a) *Require an insured to pay a higher deductible, any*
12 *copayment or coinsurance or require a longer waiting period or*
13 *other condition to obtain any benefit provided in the contract for*
14 *hospital or medical service pursuant to subsection 1;*

15 (b) *Refuse to issue a contract for hospital or medical service or*
16 *cancel a contract for hospital or medical service solely because the*
17 *person applying for or covered by the contract uses or may use a*
18 *benefit provided in the contract for hospital or medical service*
19 *pursuant to subsection 1;*

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

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

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

30 (f) *Impose any other restrictions or delays on the access of an*
31 *insured to any such benefit.*

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

38 4. *The Director of the Department of Health and Human*
39 *Services shall adopt regulations to establish the preventive health*
40 *care services which must be covered by a contract for hospital or*
41 *medical service pursuant to subsection 1, including, without*
42 *limitation:*

43 (a) *Such prenatal screenings and tests as recommended by the*
44 *American College of Obstetricians and Gynecologists or its*
45 *successor organization;*



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1 (b) *Screening and counseling for interpersonal and domestic*
2 *violence;*

3 (c) *Screening, tests and counseling for such other health*
4 *conditions and diseases as recommended by the Health Resources*
5 *and Services Administration;*

6 (d) *Contraceptive drugs, devices and services;*

7 (e) *Such well-woman preventive visits as recommended by the*
8 *Health Resources and Services Administration;*

9 (f) *Any supplements, drugs or devices recommended by the*
10 *Health Resources and Services Administration; and*

11 (g) *All vaccinations recommended by the Advisory Committee*
12 *on Immunization Practices of the Centers for Disease Control and*
13 *Prevention of the United States Department of Health and Human*
14 *Services or its successor organization.*

15 5. *As used in this section, "provider of health care" has the*
16 *meaning ascribed to it in NRS 629.031.*

17 **Sec. 60. 1.** *An insurer that offers or issues a contract for*
18 *hospital or medical service shall include in the contract coverage*
19 *for such preventive health care services relating to persons 18*
20 *years of age or older as the Director of the Department of Health*
21 *and Human Services requires.*

22 2. *An insurer that offers or issues a contract for hospital or*
23 *medical service shall not:*

24 (a) *Require an insured to pay a higher deductible, any*
25 *copayment or coinsurance or require a longer waiting period or*
26 *other condition to obtain any benefit provided in the contract for*
27 *hospital or medical service pursuant to subsection 1;*

28 (b) *Refuse to issue a contract for hospital or medical service or*
29 *cancel a contract for hospital or medical service solely because the*
30 *person applying for or covered by the contract uses or may use a*
31 *benefit provided in the contract for hospital or medical service*
32 *pursuant to subsection 1;*

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

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

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

43 (f) *Impose any other restrictions or delays on the access of an*
44 *insured to any such benefit.*



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

7 4. *The Director of the Department of Health and Human*
8 *Services shall adopt regulations to establish the preventive health*
9 *care services which must be covered by a contract for hospital or*
10 *medical service pursuant to subsection 1, including, without*
11 *limitation:*

12 (a) *Screening, tests and counseling for such other health*
13 *conditions and diseases as recommended by the United States*
14 *Preventive Services Task Force or its successor organization;*

15 (b) *Counseling relating to the dietary needs of certain adults*
16 *who are at high-risk of chronic diseases;*

17 (c) *Smoking cessation programs;*

18 (d) *Any supplements, drugs or devices recommended by the*
19 *United States Preventive Services Task Force or its successor*
20 *organization; and*

21 (e) *All vaccinations recommended by the Advisory Committee*
22 *on Immunization Practices of the Centers for Disease Control and*
23 *Prevention of the United States Department of Health and Human*
24 *Services or its successor organization.*

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

27 **Sec. 61. 1.** *An insurer that offers or issues a contract for*
28 *hospital or medical service shall include in the contract coverage*
29 *for such preventive health care services relating to persons less*
30 *than 18 years of age as the Director of the Department of Health*
31 *and Human Services requires.*

32 2. *An insurer that offers or issues a contract for hospital or*
33 *medical service shall not:*

34 (a) *Require an insured to pay a higher deductible, any*
35 *copayment or coinsurance or require a longer waiting period or*
36 *other condition to obtain any benefit provided in the contract for*
37 *hospital or medical service pursuant to subsection 1;*

38 (b) *Refuse to issue a contract for hospital or medical service or*
39 *cancel a contract for hospital or medical service solely because the*
40 *person applying for or covered by the contract uses or may use a*
41 *benefit provided in the contract for hospital or medical service*
42 *pursuant to subsection 1;*

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



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

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

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

10 3. A contract for hospital or medical service subject to the
11 provisions of this chapter that is delivered, issued for delivery or
12 renewed on or after January 1, 2018, has the legal effect of
13 including the coverage required by subsection 1, and any
14 provision of the contract or the renewal which is in conflict with
15 this section is void.

16 4. The Director of the Department of Health and Human
17 Services shall adopt regulations to establish the preventive health
18 care services which must be covered by a contract for hospital or
19 medical service pursuant to subsection 1, including, without
20 limitation:

21 (a) Screening, tests and counseling for such other health
22 conditions and diseases as recommended by the Health Resources
23 and Services Administration;

24 (b) Assessments relating to height, weight, body mass index
25 and medical history;

26 (c) Any supplements, drugs or devices recommended by the
27 Health Resources and Services Administration; and

28 (d) All vaccinations recommended by the Advisory Committee
29 on Immunization Practices of the Centers for Disease Control and
30 Prevention of the United States Department of Health and Human
31 Services or its successor organization.

32 5. As used in this section, "provider of health care" has the
33 meaning ascribed to it in NRS 629.031.

34 **Sec. 62. 1.** An insurer that offers or issues a contract for
35 hospital or medical service shall include in the contract coverage
36 for such health care services relating to maternal and newborn
37 care as the Director of the Department of Health and Human
38 Services requires.

39 2. Except as otherwise provided in this subsection, a contract
40 for hospital or medical service issued pursuant to this chapter may
41 not restrict benefits for any length of stay in a hospital in
42 connection with childbirth for a mother or newborn infant covered
43 by the contract to:

44 (a) Less than 48 hours after a normal vaginal delivery; and

45 (b) Less than 96 hours after a cesarean section.



1 ↪ *If a different length of stay is provided in the guidelines*
2 *established by the American College of Obstetricians and*
3 *Gynecologists, or its successor organization, and the American*
4 *Academy of Pediatrics, or its successor organization, the contract*
5 *for hospital or medical service may follow such guidelines in lieu*
6 *of following the length of stay set forth above. The provisions of*
7 *this subsection do not apply to any contract for hospital or medical*
8 *service in any case in which the decision to discharge the mother*
9 *or newborn infant before the expiration of the minimum length of*
10 *stay set forth in this subsection is made by the attending physician*
11 *of the mother or newborn infant.*

12 3. *Nothing in this section requires a mother to:*

13 (a) *Deliver her baby in a hospital; or*

14 (b) *Stay in a hospital for a fixed period following the birth of*
15 *her child.*

16 4. *A contract for hospital or medical service may not:*

17 (a) *Deny a mother or her newborn infant coverage or*
18 *continued coverage under the terms of the contract or coverage if*
19 *the sole purpose of the denial of coverage or continued coverage is*
20 *to avoid the requirements of this section;*

21 (b) *Provide monetary payments or rebates to a mother to*
22 *encourage her to accept less than the minimum protection*
23 *available pursuant to this section;*

24 (c) *Penalize, or otherwise reduce or limit, the reimbursement*
25 *of an attending provider of health care because the attending*
26 *provider of health care provided care to a mother or newborn*
27 *infant in accordance with the provisions of this section;*

28 (d) *Provide incentives of any kind to an attending physician to*
29 *induce the attending physician to provide care to a mother or*
30 *newborn infant in a manner that is inconsistent with the*
31 *provisions of this section; or*

32 (e) *Except as otherwise provided in subsection 5, restrict*
33 *benefits for any portion of a hospital stay required pursuant to the*
34 *provisions of this section in a manner that is less favorable than*
35 *the benefits provided for any preceding portion of that stay.*

36 5. *Nothing in this section:*

37 (a) *Prohibits a contract for hospital or medical service from*
38 *imposing a deductible, coinsurance or other mechanism for*
39 *sharing costs relating to benefits for hospital stays in connection*
40 *with childbirth for a mother or newborn child covered by the*
41 *contract, except that such coinsurance or other mechanism for*
42 *sharing costs for any portion of a hospital stay required by this*
43 *section may not be greater than the coinsurance or other*
44 *mechanism for any preceding portion of that stay.*



1 (b) Prohibits an arrangement for payment between an insurer
2 and a provider of health care that uses capitation or other
3 financial incentives, if the arrangement is designed to provide
4 services efficiently and consistently in the best interest of the
5 mother and her newborn infant.

6 (c) Prevents an insurer from negotiating with a provider of
7 health care concerning the level and type of reimbursement to be
8 provided in accordance with this section.

9 6. A contract for hospital or medical service subject to the
10 provisions of this chapter that is delivered, issued for delivery or
11 renewed on or after January 1, 2018, has the legal effect of
12 including the coverage required by subsection 1, and any
13 provision of the contract or the renewal which is in conflict with
14 this section is void.

15 7. The Director of the Department of Health and Human
16 Services shall adopt regulations to establish the health care
17 services which must be covered by a contract for hospital or
18 medical service pursuant to subsection 1.

19 8. As used in this section, "provider of health care" has the
20 meaning ascribed to it in NRS 629.031.

21 **Sec. 63.** NRS 695B.1912 is hereby amended to read as
22 follows:

23 695B.1912 1. A ~~{policy of health insurance}~~ contract for
24 hospital or medical service issued by a hospital or medical service
25 corporation must provide coverage for benefits payable for expenses
26 incurred for:

27 (a) An annual cytologic screening test for women 18 years of
28 age or older;

29 (b) A baseline mammogram for women between the ages of 35
30 and 40; ~~{and}~~

31 (c) An annual mammogram for women 40 years of age or
32 older ~~{;}~~;

33 (d) Counseling concerning genetic testing for breast cancer;
34 and

35 (e) Counseling concerning breast cancer chemoprevention.

36 2. A ~~{policy of health insurance}~~ contract for hospital or
37 medical service issued by a hospital or medical service corporation
38 must not require an insured to obtain prior authorization for any
39 service provided pursuant to subsection 1.

40 3. An insurer that offers or issues a contract for hospital or
41 medical service shall not:

42 (a) Require an insured to pay a higher deductible, any
43 copayment or coinsurance or require a longer waiting period or
44 other condition to obtain any benefit provided in the contract for
45 hospital or medical service pursuant to subsection 1;



1 ***(b) Refuse to issue a contract for hospital or medical service or***
2 ***cancel a contract for hospital or medical service solely because the***
3 ***person applying for or covered by the contract uses or may use a***
4 ***benefit provided in the contract for hospital or medical service***
5 ***pursuant to subsection 1;***

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

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

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

16 ***(f) Impose any other restrictions or delays on the access of an***
17 ***insured to any such benefit.***

18 **4. A ~~{policy}~~ contract for hospital or medical service** subject
19 to the provisions of this chapter which is delivered, issued for
20 delivery or renewed on or after ~~{October 1, 1989,}~~ **January 1, 2018,**
21 has the legal effect of including the coverage required by subsection
22 1, and any provision of the ~~{policy}~~ contract or the renewal which is
23 in conflict with subsection 1 is void.

24 ***5. As used in this section, “provider of health care” has the***
25 ***meaning ascribed to it in NRS 629.031.***

26 **Sec. 64.** NRS 695B.1925 is hereby amended to read as
27 follows:

28 695B.1925 1. A ~~{policy of health insurance}~~ **contract for**
29 **hospital or medical service** issued by a hospital or medical service
30 corporation must provide coverage for benefits payable for expenses
31 incurred for ~~{administering}~~ :

32 ***(a) Deoxyribonucleic acid testing for high-risk strains of the***
33 ***human papillomavirus; and***

34 ***(b) Administering*** the human papillomavirus vaccine to women
35 and girls at such ages as recommended for vaccination by a
36 competent authority, including, without limitation, the Centers for
37 Disease Control and Prevention of the United States Department of
38 Health and Human Services, the Food and Drug Administration or
39 the manufacturer of the vaccine.

40 2. A ~~{policy of health insurance}~~ **contract for hospital or**
41 **medical service** issued by a hospital or medical service corporation
42 must not require an insured to obtain prior authorization for any
43 service provided pursuant to subsection 1.

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



1 (a) *Require an insured to pay a higher deductible, any*
2 *copayment or coinsurance or require a longer waiting period or*
3 *other condition to obtain any benefit provided in the contract for*
4 *hospital or medical service pursuant to subsection 1;*

5 (b) *Refuse to issue a contract for hospital or medical service or*
6 *cancel a contract for hospital or medical service solely because the*
7 *person applying for or covered by the contract uses or may use a*
8 *benefit provided in the contract for hospital or medical service*
9 *pursuant to subsection 1;*

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

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

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

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

22 4. A ~~{policy}~~ *contract for hospital or medical service* subject
23 to the provisions of this chapter which is delivered, issued for
24 delivery or renewed on or after ~~{July 1, 2007,}~~ *January 1, 2018*, has
25 the legal effect of including the coverage required by subsection 1,
26 and any provision of the policy or the renewal which is in conflict
27 with subsection 1 is void.

28 ~~{4. For the purposes of this section, "human}~~

29 5. *As used in this section:*

30 (a) *"Human papillomavirus vaccine"* means the Quadrivalent
31 Human Papillomavirus Recombinant Vaccine or its successor which
32 is approved by the Food and Drug Administration for the prevention
33 of human papillomavirus infection and cervical cancer.

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

36 **Sec. 65.** NRS 695B.193 is hereby amended to read as follows:

37 695B.193 1. All individual and group service or indemnity-
38 type contracts issued by a nonprofit corporation which provide
39 coverage for a family member of the subscriber must as to such
40 coverage provide that the health benefits applicable for children are
41 payable with respect to:

42 (a) A newly born child of the subscriber from the moment of
43 birth;



1 (b) An adopted child from the date the adoption becomes
2 effective, if the child was not placed in the home before adoption;
3 and

4 (c) A child placed with the subscriber for the purpose of
5 adoption from the moment of placement as certified by the public or
6 private agency making the placement. The coverage of such a child
7 ceases if the adoption proceedings are terminated as certified by the
8 public or private agency making the placement.

9 ↪ The contracts must provide the coverage specified in subsection
10 3, and must not exclude premature births.

11 2. The contract may require that notification of:

12 (a) The birth of a newly born child;

13 (b) The effective date of adoption of a child; or

14 (c) The date of placement of a child for adoption,

15 ↪ and payments of the required fees, if any, must be furnished to
16 the nonprofit service corporation within 31 days after the date of
17 birth, adoption or placement for adoption in order to have the
18 coverage continue beyond the 31-day period.

19 3. The coverage for newly born and adopted children and
20 children placed for adoption consists of coverage of injury or
21 sickness, including the necessary care and treatment of medically
22 diagnosed congenital defects and birth abnormalities and, within the
23 limits of the policy, necessary transportation costs from place of
24 birth to the nearest specialized treatment center under major medical
25 policies, and with respect to basic policies to the extent such costs
26 are charged by the treatment center.

27 4. ~~[A corporation shall not restrict the coverage of a dependent~~
28 ~~child adopted or placed for adoption solely because of a preexisting~~
29 ~~condition the child has at the time the child would otherwise become~~
30 ~~eligible for coverage pursuant to that contract. Any provision~~
31 ~~relating to an exclusion for a preexisting condition must comply~~
32 ~~with NRS 689C.190.~~

33 ~~—5.]~~ For covered services provided to the child, the corporation
34 shall reimburse noncontracted providers of health care to an amount
35 equal to the average amount of payment for which the organization
36 has agreements, contracts or arrangements for those covered
37 services.

38 **Sec. 66.** NRS 695B.2555 is hereby amended to read as
39 follows:

40 695B.2555 A ~~[converted contract must not exclude a~~
41 ~~preexisting condition not excluded by the group contract, but a]~~
42 converted contract may provide that any hospital, surgical or
43 medical benefits payable under it may be reduced by the amount of
44 any benefits payable under the group contract after his or her
45 termination. A converted contract may provide that during the first



1 contract year the benefits payable under it, together with the benefits
2 payable under the group contract, must not exceed those that would
3 have been payable if the subscriber's coverage under the group
4 contract had remained in effect.

5 **Sec. 67.** Chapter 695C of NRS is hereby amended by adding
6 thereto the provisions set forth as sections 68 to 73, inclusive, of this
7 act.

8 **Sec. 68. 1.** *A health maintenance organization shall offer
9 or issue a health care plan to any person regardless of the health
10 status of the person, the spouse of the person or any dependent of
11 the person. Such health status includes, without limitation:*

12 *(a) Any preexisting medical condition of the person, including,
13 without limitation, any physical or mental illness;*

14 *(b) The claims history of the person, including, without
15 limitation, any prior health care services received by the person;*

16 *(c) Genetic information relating to the person; and*

17 *(d) Any increased risk for illness, injury or any other medical
18 condition of the person, including, without limitation, any medical
19 condition caused by an act of domestic violence.*

20 **2.** *A health maintenance organization that offers or issues a
21 health care plan shall not:*

22 *(a) Deny, limit or exclude a benefit based on the health status
23 of an enrollee; or*

24 *(b) Require an enrollee, as a condition of enrollment or
25 renewal, to pay a premium, deductible, copay or coinsurance
26 based on his or her health status which is greater than the
27 premium, deductible, copay or coinsurance charged to a similarly
28 situated enrollee or the covered spouse or dependent of such an
29 enrollee who does not have such a health status.*

30 **3.** *A health maintenance organization that offers or issues a
31 health care plan shall not adjust a premium, deductible, copay or
32 coinsurance for any enrollee on the basis of genetic information
33 relating to the enrollee or the covered spouse or dependent of the
34 enrollee.*

35 **Sec. 69. 1.** *A health maintenance organization that offers
36 or issues a health care plan which provides coverage for
37 dependent children shall continue to make such coverage
38 available for an adult child of an enrollee until such child reaches
39 26 years of age.*

40 **2.** *Nothing in this section shall be construed as requiring a
41 health maintenance organization to make coverage available for a
42 dependent of an adult child of an enrollee.*

43 **Sec. 70. 1.** *A health maintenance organization that offers
44 or issues a health care plan shall include in the plan coverage for
45 such preventive health care services relating to women as the*



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1 *Director of the Department of Health and Human Services*
2 *requires.*

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

5 (a) *Require an enrollee to pay a higher deductible, any*
6 *copayment or coinsurance or require a longer waiting period or*
7 *other condition to obtain any benefit provided in the health care*
8 *plan pursuant to subsection 1;*

9 (b) *Refuse to issue a health care plan or cancel a health care*
10 *plan solely because the person applying for or covered by the plan*
11 *uses or may use a benefit provided in the health care plan*
12 *pursuant to subsection 1;*

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

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

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

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

25 3. *An evidence of coverage subject to the provisions of this*
26 *chapter that is delivered, issued for delivery or renewed on or after*
27 *January 1, 2018, has the legal effect of including the coverage*
28 *required by subsection 1, and any provision of the evidence of*
29 *coverage or the renewal which is in conflict with this section is*
30 *void.*

31 4. *The Director of the Department of Health and Human*
32 *Services shall adopt regulations to establish the preventive health*
33 *care services which must be covered by a health care plan*
34 *pursuant to subsection 1, including, without limitation:*

35 (a) *Such prenatal screenings and tests as recommended by the*
36 *American College of Obstetricians and Gynecologists or its*
37 *successor organization;*

38 (b) *Screening and counseling for interpersonal and domestic*
39 *violence;*

40 (c) *Screening, tests and counseling for such other health*
41 *conditions and diseases as recommended by the Health Resources*
42 *and Services Administration;*

43 (d) *Contraceptive drugs, devices and services;*

44 (e) *Such well-woman preventive visits as recommended by the*
45 *Health Resources and Services Administration;*



1 (f) Any supplements, drugs or devices recommended by the
2 Health Resources and Services Administration; and

3 (g) All vaccinations recommended by the Advisory Committee
4 on Immunization Practices of the Centers for Disease Control and
5 Prevention of the United States Department of Health and Human
6 Services or its successor organization.

7 5. As used in this section, "provider of health care" has the
8 meaning ascribed to it in NRS 629.031.

9 **Sec. 71. 1.** A health maintenance organization that offers
10 or issues a health care plan shall include in the plan coverage for
11 such preventive health care services relating to persons 18 years of
12 age or older as the Director of the Department of Health and
13 Human Services requires.

14 2. A health maintenance organization that offers or issues a
15 health care plan shall not:

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

20 (b) Refuse to issue a health care plan or cancel a health care
21 plan solely because the person applying for or covered by the plan
22 uses or may use a benefit provided in the health care plan
23 pursuant to subsection 1;

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

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

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

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

36 3. An evidence of coverage subject to the provisions of this
37 chapter that is delivered, issued for delivery or renewed on or after
38 January 1, 2018, has the legal effect of including the coverage
39 required by subsection 1, and any provision of the evidence of
40 coverage or the renewal which is in conflict with this section is
41 void.

42 4. The Director of the Department of Health and Human
43 Services shall adopt regulations to establish the preventive health
44 care services which must be covered by a health care plan
45 pursuant to subsection 1, including, without limitation:



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1 (a) Screening, tests and counseling for such other health
2 conditions and diseases as recommended by the United States
3 Preventive Services Task Force or its successor organization;

4 (b) Counseling relating to the dietary needs of certain adults
5 who are at high-risk of chronic diseases;

6 (c) Smoking cessation programs;

7 (d) Any supplements, drugs or devices recommended by the
8 United States Preventive Services Task Force or its successor
9 organization; and

10 (e) All vaccinations recommended by the Advisory Committee
11 on Immunization Practices of the Centers for Disease Control and
12 Prevention of the United States Department of Health and Human
13 Services or its successor organization.

14 5. As used in this section, "provider of health care" has the
15 meaning ascribed to it in NRS 629.031.

16 **Sec. 72. 1.** A health maintenance organization that offers
17 or issues a health care plan shall include in the plan coverage for
18 such preventive health care services relating to persons less than
19 18 years of age as the Director of the Department of Health and
20 Human Services requires.

21 2. A health maintenance organization that offers or issues a
22 health care plan shall not:

23 (a) Require an enrollee to pay a higher deductible, any
24 copayment or coinsurance or require a longer waiting period or
25 other condition to obtain any benefit provided in the health care
26 plan pursuant to subsection 1;

27 (b) Refuse to issue a health care plan or cancel a health care
28 plan solely because the person applying for or covered by the plan
29 uses or may use a benefit provided in the health care plan
30 pursuant to subsection 1;

31 (c) Offer or pay any type of material inducement or financial
32 incentive to an enrollee to discourage the enrollee from obtaining
33 any such benefit;

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

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

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

43 3. An evidence of coverage subject to the provisions of this
44 chapter that is delivered, issued for delivery or renewed on or after
45 January 1, 2018, has the legal effect of including the coverage



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

4 4. The Director of the Department of Health and Human
5 Services shall adopt regulations to establish the preventive health
6 care services which must be covered by a health care plan
7 pursuant to subsection 1, including, without limitation:

8 (a) Screening, tests and counseling for such other health
9 conditions and diseases as recommended by the Health Resources
10 and Services Administration;

11 (b) Assessments relating to height, weight, body mass index
12 and medical history;

13 (c) Any supplements, drugs or devices recommended by the
14 Health Resources and Services Administration; and

15 (d) All vaccinations recommended by the Advisory Committee
16 on Immunization Practices of the Centers for Disease Control and
17 Prevention of the United States Department of Health and Human
18 Services or its successor organization.

19 5. As used in this section, "provider of health care" has the
20 meaning ascribed to it in NRS 629.031.

21 **Sec. 73. 1.** A health maintenance organization that offers
22 or issues a health care plan shall include in the plan coverage for
23 such health care services relating to maternal and newborn care
24 as the Director of the Department of Health and Human Services
25 requires.

26 2. Except as otherwise provided in this subsection, an
27 evidence of coverage issued pursuant to this chapter may not
28 restrict benefits for any length of stay in a hospital in connection
29 with childbirth for a mother or newborn infant covered by the
30 health care plan to:

31 (a) Less than 48 hours after a normal vaginal delivery; and

32 (b) Less than 96 hours after a cesarean section.

33 ↪ If a different length of stay is provided in the guidelines
34 established by the American College of Obstetricians and
35 Gynecologists, or its successor organization, and the American
36 Academy of Pediatrics, or its successor organization, the health
37 care plan may follow such guidelines in lieu of following the
38 length of stay set forth above. The provisions of this subsection do
39 not apply to any health care plan in any case in which the decision
40 to discharge the mother or newborn infant before the expiration of
41 the minimum length of stay set forth in this subsection is made by
42 the attending physician of the mother or newborn infant.

43 3. Nothing in this section requires a mother to:

44 (a) Deliver her baby in a hospital; or



1 (b) *Stay in a hospital for a fixed period following the birth of*
2 *her child.*

3 4. *A health care plan may not:*

4 (a) *Deny a mother or her newborn infant coverage or*
5 *continued coverage under the terms of the plan or coverage if the*
6 *sole purpose of the denial of coverage or continued coverage is to*
7 *avoid the requirements of this section;*

8 (b) *Provide monetary payments or rebates to a mother to*
9 *encourage her to accept less than the minimum protection*
10 *available pursuant to this section;*

11 (c) *Penalize, or otherwise reduce or limit, the reimbursement*
12 *of an attending provider of health care because the attending*
13 *provider of health care provided care to a mother or newborn*
14 *infant in accordance with the provisions of this section;*

15 (d) *Provide incentives of any kind to an attending physician to*
16 *induce the attending physician to provide care to a mother or*
17 *newborn infant in a manner that is inconsistent with the*
18 *provisions of this section; or*

19 (e) *Except as otherwise provided in subsection 5, restrict*
20 *benefits for any portion of a hospital stay required pursuant to the*
21 *provisions of this section in a manner that is less favorable than*
22 *the benefits provided for any preceding portion of that stay.*

23 5. *Nothing in this section:*

24 (a) *Prohibits a health care plan from imposing a deductible,*
25 *coinsurance or other mechanism for sharing costs relating to*
26 *benefits for hospital stays in connection with childbirth for a*
27 *mother or newborn child covered by the plan, except that such*
28 *coinsurance or other mechanism for sharing costs for any portion*
29 *of a hospital stay required by this section may not be greater than*
30 *the coinsurance or other mechanism for any preceding portion of*
31 *that stay.*

32 (b) *Prohibits an arrangement for payment between a health*
33 *maintenance organization and a provider of health care that uses*
34 *capitation or other financial incentives, if the arrangement is*
35 *designed to provide services efficiently and consistently in the best*
36 *interest of the mother and her newborn infant.*

37 (c) *Prevents a health maintenance organization from*
38 *negotiating with a provider of health care concerning the level and*
39 *type of reimbursement to be provided in accordance with this*
40 *section.*

41 6. *An evidence of coverage subject to the provisions of this*
42 *chapter that is delivered, issued for delivery or renewed on or after*
43 *January 1, 2018, has the legal effect of including the coverage*
44 *required by subsection 1, and any provision of the evidence of*



1 *coverage or the renewal which is in conflict with this section is*
2 *void.*

3 *7. The Director of the Department of Health and Human*
4 *Services shall adopt regulations to establish the health care*
5 *services which must be covered by a health care plan pursuant to*
6 *subsection 1.*

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

9 **Sec. 74.** NRS 695C.050 is hereby amended to read as follows:

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

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

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

24 4. The provisions of NRS 695C.110, 695C.125, 695C.1691,
25 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to
26 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734,
27 ~~695C.1735 to~~ *695C.1751*, 695C.1755, ~~inclusive.~~ 695C.176 to
28 695C.200, inclusive, and 695C.265 do not apply to a health
29 maintenance organization that provides health care services through
30 managed care to recipients of Medicaid under the State Plan for
31 Medicaid or insurance pursuant to the Children's Health Insurance
32 Program pursuant to a contract with the Division of Health Care
33 Financing and Policy of the Department of Health and Human
34 Services. This subsection does not exempt a health maintenance
35 organization from any provision of this chapter for services
36 provided pursuant to any other contract.

37 5. The provisions of NRS 695C.1694, 695C.1695, 695C.1708,
38 695C.1731, 695C.17345 ~~and~~ , *695C.1735, 695C.1745 and*
39 *695C.1757 and sections 68 to 73, inclusive, of this act* apply to a
40 health maintenance organization that provides health care services
41 through managed care to recipients of Medicaid under the State Plan
42 for Medicaid.

43 **Sec. 75.** NRS 695C.173 is hereby amended to read as follows:

44 695C.173 1. All individual and group health care plans which
45 provide coverage for a family member of the enrollee must as to



1 such coverage provide that the health care services applicable for
2 children are payable with respect to:

3 (a) A newly born child of the enrollee from the moment of birth;
4 (b) An adopted child from the date the adoption becomes
5 effective, if the child was not placed in the home before adoption;
6 and

7 (c) A child placed with the enrollee for the purpose of adoption
8 from the moment of placement as certified by the public or private
9 agency making the placement. The coverage of such a child ceases
10 if the adoption proceedings are terminated as certified by the public
11 or private agency making the placement.

12 ➤ The plans must provide the coverage specified in subsection 3,
13 and must not exclude premature births.

14 2. The evidence of coverage may require that notification of:

15 (a) The birth of a newly born child;
16 (b) The effective date of adoption of a child; or
17 (c) The date of placement of a child for adoption,

18 ➤ and payments of the required charge, if any, must be furnished to
19 the health maintenance organization within 31 days after the date of
20 birth, adoption or placement for adoption in order to have the
21 coverage continue beyond the 31-day period.

22 3. The coverage for newly born and adopted children and
23 children placed for adoption consists of preventive health care
24 services as well as coverage of injury or sickness, including the
25 necessary care and treatment of medically diagnosed congenital
26 defects and birth abnormalities and, within the limits of the policy,
27 necessary transportation costs from place of birth to the nearest
28 specialized treatment center under major medical policies, and with
29 respect to basic policies to the extent such costs are charged by the
30 treatment center.

31 4. ~~†A health maintenance organization shall not restrict the
32 coverage of a dependent child adopted or placed for adoption solely
33 because of a preexisting condition the child has at the time the child
34 would otherwise become eligible for coverage pursuant to that plan.
35 Any provision relating to an exclusion for a preexisting condition
36 must comply with NRS 689B.500 or 689C.190, as appropriate.~~

37 ~~5.†~~ For covered services provided to the child, the health
38 maintenance organization shall reimburse noncontracted providers
39 of health care to an amount equal to the average amount of payment
40 for which the organization has agreements, contracts or
41 arrangements for those covered services.



1 **Sec. 76.** NRS 695C.1735 is hereby amended to read as
2 follows:

3 695C.1735 1. A health maintenance *organization which*
4 *offers or issues a health care* plan must provide coverage for
5 benefits payable for expenses incurred for:

6 (a) An annual cytologic screening test for women 18 years of
7 age or older;

8 (b) A baseline mammogram for women between the ages of 35
9 and 40; ~~and~~

10 (c) An annual mammogram for women 40 years of age or
11 older ~~+~~;

12 (d) *Counseling concerning genetic testing for breast cancer;*
13 *and*

14 (e) *Counseling concerning breast cancer chemoprevention.*

15 2. A health ~~maintenance~~ care plan must not require an
16 insured to obtain prior authorization for any service provided
17 pursuant to subsection 1.

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

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

24 (b) *Refuse to issue a health care plan or cancel a health care*
25 *plan solely because the person applying for or covered by the plan*
26 *uses or may use a benefit provided in the health care plan*
27 *pursuant to subsection 1;*

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

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

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

38 (f) *Impose any other restrictions or delays on the access of an*
39 *enrollee to any such benefit.*

40 4. ~~A policy~~ *An evidence of coverage* subject to the provisions
41 of this chapter which is delivered, issued for delivery or renewed on
42 or after ~~October 1, 1989,~~ *January 1, 2018*, has the legal effect of
43 including the coverage required by subsection 1, and any provision
44 of the ~~policy~~ *evidence of coverage* or the renewal which is in
45 conflict with subsection 1 is void.



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

3 **Sec. 77.** NRS 695C.1745 is hereby amended to read as
4 follows:

5 695C.1745 1. A health care plan of a health maintenance
6 organization must provide coverage for benefits payable for
7 expenses incurred for ~~administering~~:

8 **(a) Deoxyribonucleic acid testing for high-risk strains of the**
9 **human papillomavirus; and**

10 **(b) Administering** the human papillomavirus vaccine as
11 recommended for vaccination by a competent authority, including,
12 without limitation, the Centers for Disease Control and Prevention
13 of the United States Department of Health and Human Services, the
14 Food and Drug Administration or the manufacturer of the vaccine.

15 2. A health care plan of a health maintenance organization
16 must not require an insured to obtain prior authorization for any
17 service provided pursuant to subsection 1.

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

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

24 **(b) Refuse to issue a health care plan or cancel a health care**
25 **plan solely because the person applying for or covered by the plan**
26 **uses or may use a benefit provided in the health care plan**
27 **pursuant to subsection 1;**

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

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

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

38 **(f) Impose any other restrictions or delays on the access of an**
39 **enrollee to any such benefit.**

40 4. Any evidence of coverage subject to the provisions of this
41 chapter which is delivered, issued for delivery or renewed on or
42 after ~~July 1, 2007,~~ **January 1, 2018**, has the legal effect of
43 including the coverage required by subsection 1, and any provision
44 of the evidence of coverage or the renewal which is in conflict with
45 subsection 1 is void.



~~14. For the purposes of this section, "human"~~

5. As used in this section:

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

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

Sec. 78. NRS 695C.330 is hereby amended to read as follows:

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

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

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, **and sections 68 to 73, inclusive, of this act** or 695C.207;

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

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

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

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

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

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

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

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



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

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

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

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

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

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

15 3. If the certificate of authority of a health maintenance
16 organization is suspended, the health maintenance organization shall
17 not, during the period of that suspension, enroll any additional
18 groups or new individual contracts, unless those groups or persons
19 were contracted for before the date of suspension.

20 4. If the certificate of authority of a health maintenance
21 organization is revoked, the organization shall proceed, immediately
22 following the effective date of the order of revocation, to wind up its
23 affairs and shall conduct no further business except as may be
24 essential to the orderly conclusion of the affairs of the organization.
25 It shall engage in no further advertising or solicitation of any kind.
26 The Commissioner may, by written order, permit such further
27 operation of the organization as the Commissioner may find to be in
28 the best interest of enrollees to the end that enrollees are afforded
29 the greatest practical opportunity to obtain continuing coverage for
30 health care.

31 **Sec. 79.** Chapter 695F of NRS is hereby amended by adding
32 thereto the provisions set forth as sections 80 and 81 of this act.

33 **Sec. 80. 1. *A prepaid limited health service organization***
34 ***shall offer or issue evidence of coverage to any person regardless***
35 ***of the health status of the person, the spouse of the person or any***
36 ***dependent of the person. Such health status includes, without***
37 ***limitation:***

38 ***(a) Any preexisting medical condition of the person, including,***
39 ***without limitation, any physical or mental illness;***

40 ***(b) The claims history of the person, including, without***
41 ***limitation, any prior health care services received by the person;***

42 ***(c) Genetic information relating to the person; and***

43 ***(d) Any increased risk for illness, injury or any other medical***
44 ***condition of the person, including, without limitation, any medical***
45 ***condition caused by an act of domestic violence.***



1 2. *A prepaid limited health service organization that offers or*
2 *issues evidence of coverage shall not:*

3 (a) *Deny, limit or exclude a benefit based on the health status*
4 *of an enrollee; or*

5 (b) *Require an enrollee, as a condition of enrollment or*
6 *renewal, to pay a premium, deductible, copay or coinsurance*
7 *based on his or her health status which is greater than the*
8 *premium, deductible, copay or coinsurance charged to a similarly*
9 *situated enrollee or the covered spouse or dependent of such an*
10 *enrollee who does not have such a health status.*

11 3. *A prepaid limited health service organization that offers or*
12 *issues evidence of coverage shall not adjust a premium,*
13 *deductible, copay or coinsurance for any enrollee on the basis of*
14 *genetic information relating to the enrollee or the covered spouse*
15 *or dependent of the enrollee.*

16 **Sec. 81. 1.** *A prepaid limited health service organization*
17 *that offers or issues evidence of coverage which provides coverage*
18 *for dependent children shall continue to make such coverage*
19 *available for an adult child of an enrollee until such child reaches*
20 *26 years of age.*

21 2. *Nothing in this section shall be construed as requiring a*
22 *prepaid limited health service organization to make coverage*
23 *available for a dependent of an adult child of an enrollee.*

24 **Sec. 82.** Chapter 695G of NRS is hereby amended by adding
25 thereto the provisions set forth as sections 83 to 89, inclusive, of this
26 act.

27 **Sec. 83. 1.** *A managed care organization shall offer or*
28 *issue a health care plan to any person regardless of the health*
29 *status of the person, the spouse of the person or any dependent of*
30 *the person. Such health status includes, without limitation:*

31 (a) *Any preexisting medical condition of the person, including,*
32 *without limitation, any physical or mental illness;*

33 (b) *The claims history of the person, including, without*
34 *limitation, any prior health care services received by the person;*

35 (c) *Genetic information relating to the person; and*

36 (d) *Any increased risk for illness, injury or any other medical*
37 *condition of the person, including, without limitation, any medical*
38 *condition caused by an act of domestic violence.*

39 2. *A managed care organization that offers or issues a health*
40 *care plan shall not:*

41 (a) *Deny, limit or exclude a benefit based on the health status*
42 *of an insured; or*

43 (b) *Require an insured, as a condition of enrollment or*
44 *renewal, to pay a premium, deductible, copay or coinsurance*
45 *based on his or her health status which is greater than the*



1 *premium, deductible, copay or coinsurance charged to a similarly*
2 *situated insured or the covered spouse or dependent of such an*
3 *insured who does not have such a health status.*

4 3. *A managed care organization that offers or issues a health*
5 *care plan shall not adjust a premium, deductible, copay or*
6 *coinsurance for any insured on the basis of genetic information*
7 *relating to the insured or the covered spouse or dependent of the*
8 *insured.*

9 **Sec. 84. 1.** *A managed care organization that offers or*
10 *issues a health care plan which provides coverage for dependent*
11 *children shall continue to make such coverage available for an*
12 *adult child of an insured until such child reaches 26 years of age.*

13 2. *Nothing in this section shall be construed as requiring a*
14 *managed care organization to make coverage available for a*
15 *dependent of an adult child of an insured.*

16 **Sec. 85. 1.** *A managed care organization that offers or*
17 *issues a health care plan shall include in the plan coverage for*
18 *such preventive health care services relating to women as the*
19 *Director of the Department of Health and Human Services*
20 *requires.*

21 2. *A managed care organization that offers or issues a health*
22 *care plan shall not:*

23 (a) *Require an insured to pay a higher deductible, any*
24 *copayment or coinsurance or require a longer waiting period or*
25 *other condition to obtain any benefit provided in the health care*
26 *plan pursuant to subsection 1;*

27 (b) *Refuse to issue a health care plan or cancel a health care*
28 *plan solely because the person applying for or covered by the plan*
29 *uses or may use a benefit provided in the health care plan*
30 *pursuant to subsection 1;*

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

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

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

41 (f) *Impose any other restrictions or delays on the access of an*
42 *insured to any such benefit.*

43 3. *An evidence of coverage subject to the provisions of this*
44 *chapter that is delivered, issued for delivery or renewed on or after*
45 *January 1, 2018, has the legal effect of including the coverage*



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

4 4. The Director of the Department of Health and Human
5 Services shall adopt regulations to establish the preventive health
6 care services which must be covered by a health care plan
7 pursuant to subsection 1, including, without limitation:

8 (a) Such prenatal screenings and tests as recommended by the
9 American College of Obstetricians and Gynecologists or its
10 successor organization;

11 (b) Screening and counseling for interpersonal and domestic
12 violence;

13 (c) Screening, tests and counseling for such other health
14 conditions and diseases as recommended by the Health Resources
15 and Services Administration;

16 (d) Contraceptive drugs, devices and services;

17 (e) Such well-woman preventive visits as recommended by the
18 Health Resources and Services Administration;

19 (f) Any supplements, drugs or devices recommended by the
20 Health Resources and Services Administration; and

21 (g) All vaccinations recommended by the Advisory Committee
22 on Immunization Practices of the Centers for Disease Control and
23 Prevention of the United States Department of Health and Human
24 Services or its successor organization.

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

27 **Sec. 86. 1.** A managed care organization that offers or
28 issues a health care plan shall include in the plan coverage for
29 such preventive health care services relating to persons 18 years of
30 age or older as the Director of the Department of Health and
31 Human Services requires.

32 2. A managed care organization that offers or issues a health
33 care plan shall not:

34 (a) Require an insured to pay a higher deductible, any
35 copayment or coinsurance or require a longer waiting period or
36 other condition to obtain any benefit provided in the health care
37 plan pursuant to subsection 1;

38 (b) Refuse to issue a health care plan or cancel a health care
39 plan solely because the person applying for or covered by the plan
40 uses or may use a benefit provided in the health care plan
41 pursuant to subsection 1;

42 (c) Offer or pay any type of material inducement or financial
43 incentive to an insured to discourage the insured from obtaining
44 any such benefit;



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

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

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

10 3. An evidence of coverage subject to the provisions of this
11 chapter that is delivered, issued for delivery or renewed on or after
12 January 1, 2018, has the legal effect of including the coverage
13 required by subsection 1, and any provision of the evidence of
14 coverage or the renewal which is in conflict with this section is
15 void.

16 4. The Director of the Department of Health and Human
17 Services shall adopt regulations to establish the preventive health
18 care services which must be covered by a health care plan
19 pursuant to subsection 1, including, without limitation:

20 (a) Screening, tests and counseling for such other health
21 conditions and diseases as recommended by the United States
22 Preventive Services Task Force or its successor organization;

23 (b) Counseling relating to the dietary needs of certain adults
24 who are at high-risk of chronic diseases;

25 (c) Smoking cessation programs;

26 (d) Any supplements, drugs or devices recommended by the
27 United States Preventive Services Task Force or its successor
28 organization; and

29 (e) All vaccinations recommended by the Advisory Committee
30 on Immunization Practices of the Centers for Disease Control and
31 Prevention of the United States Department of Health and Human
32 Services or its successor organization.

33 5. As used in this section, "provider of health care" has the
34 meaning ascribed to it in NRS 629.031.

35 **Sec. 87. 1.** A managed care organization that offers or
36 issues a health care plan shall include in the plan coverage for
37 such preventive health care services relating to persons less than
38 18 years of age as the Director of the Department of Health and
39 Human Services requires.

40 2. A managed care organization that offers or issues a health
41 care plan shall not:

42 (a) Require an insured to pay a higher deductible, any
43 copayment or coinsurance or require a longer waiting period or
44 other condition to obtain any benefit provided in the health care
45 plan pursuant to subsection 1;



1 (b) Refuse to issue a health care plan or cancel a health care
2 plan solely because the person applying for or covered by the plan
3 uses or may use a benefit provided in the health care plan
4 pursuant to subsection 1;

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

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

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

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

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

23 4. The Director of the Department of Health and Human
24 Services shall adopt regulations to establish the preventive health
25 care services which must be covered by a health care plan
26 pursuant to subsection 1, including, without limitation:

27 (a) Screening, tests and counseling for such other health
28 conditions and diseases as recommended by the Health Resources
29 and Services Administration;

30 (b) Assessments relating to height, weight, body mass index
31 and medical history;

32 (c) Any supplements, drugs or devices recommended by the
33 Health Resources and Services Administration; and

34 (d) All vaccinations recommended by the Advisory Committee
35 on Immunization Practices of the Centers for Disease Control and
36 Prevention of the United States Department of Health and Human
37 Services or its successor organization.

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

40 **Sec. 88. 1.** A managed care organization that offers or
41 issues a health care plan shall include in the plan coverage for
42 such health care services relating to maternal and newborn care
43 as the Director of the Department of Health and Human Services
44 requires.



1 2. Except as otherwise provided in this subsection, an
2 evidence of coverage issued pursuant to this chapter may not
3 restrict benefits for any length of stay in a hospital in connection
4 with childbirth for a mother or newborn infant covered by the
5 health care plan to:

6 (a) Less than 48 hours after a normal vaginal delivery; and

7 (b) Less than 96 hours after a cesarean section.

8 ↪ If a different length of stay is provided in the guidelines
9 established by the American College of Obstetricians and
10 Gynecologists, or its successor organization, and the American
11 Academy of Pediatrics, or its successor organization, the health
12 care plan may follow such guidelines in lieu of following the
13 length of stay set forth above. The provisions of this subsection do
14 not apply to any health care plan in any case in which the decision
15 to discharge the mother or newborn infant before the expiration of
16 the minimum length of stay set forth in this subsection is made by
17 the attending physician of the mother or newborn infant.

18 3. Nothing in this section requires a mother to:

19 (a) Deliver her baby in a hospital; or

20 (b) Stay in a hospital for a fixed period following the birth of
21 her child.

22 4. A health care plan may not:

23 (a) Deny a mother or her newborn infant coverage or
24 continued coverage under the terms of the plan or coverage if the
25 sole purpose of the denial of coverage or continued coverage is to
26 avoid the requirements of this section;

27 (b) Provide monetary payments or rebates to a mother to
28 encourage her to accept less than the minimum protection
29 available pursuant to this section;

30 (c) Penalize, or otherwise reduce or limit, the reimbursement
31 of an attending provider of health care because the attending
32 provider of health care provided care to a mother or newborn
33 infant in accordance with the provisions of this section;

34 (d) Provide incentives of any kind to an attending physician to
35 induce the attending physician to provide care to a mother or
36 newborn infant in a manner that is inconsistent with the
37 provisions of this section; or

38 (e) Except as otherwise provided in subsection 5, restrict
39 benefits for any portion of a hospital stay required pursuant to the
40 provisions of this section in a manner that is less favorable than
41 the benefits provided for any preceding portion of that stay.

42 5. Nothing in this section:

43 (a) Prohibits a health care plan from imposing a deductible,
44 coinsurance or other mechanism for sharing costs relating to
45 benefits for hospital stays in connection with childbirth for a



1 *mother or newborn child covered by the plan, except that such*
2 *coinsurance or other mechanism for sharing costs for any portion*
3 *of a hospital stay required by this section may not be greater than*
4 *the coinsurance or other mechanism for any preceding portion of*
5 *that stay.*

6 *(b) Prohibits an arrangement for payment between a managed*
7 *care organization and a provider of health care that uses*
8 *capitation or other financial incentives, if the arrangement is*
9 *designed to provide services efficiently and consistently in the best*
10 *interest of the mother and her newborn infant.*

11 *(c) Prevents a managed care organization from negotiating*
12 *with a provider of health care concerning the level and type of*
13 *reimbursement to be provided in accordance with this section.*

14 *6. An evidence of coverage subject to the provisions of this*
15 *chapter that is delivered, issued for delivery or renewed on or after*
16 *January 1, 2018, has the legal effect of including the coverage*
17 *required by subsection 1, and any provision of the evidence of*
18 *coverage or the renewal which is in conflict with this section is*
19 *void.*

20 *7. The Director of the Department of Health and Human*
21 *Services shall adopt regulations to establish the health care*
22 *services which must be covered by a health care plan pursuant to*
23 *subsection 1.*

24 *8. As used in this section, "provider of health care" has the*
25 *meaning ascribed to it in NRS 629.031.*

26 **Sec. 89. 1. A managed care organization which offers or**
27 **issues a health care plan must provide coverage for benefits**
28 **payable for expenses incurred for:**

29 *(a) An annual cytologic screening test for women 18 years of*
30 *age or older;*

31 *(b) A baseline mammogram for women between the ages of 35*
32 *and 40 years;*

33 *(c) An annual mammogram for women 40 years of age or*
34 *older;*

35 *(d) Counseling concerning genetic testing for breast cancer;*
36 *and*

37 *(e) Counseling concerning breast cancer chemoprevention.*

38 *2. A health care plan must not require an insured to obtain*
39 *prior authorization for any service provided pursuant to*
40 *subsection 1.*

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

43 *(a) Require an insured to pay a higher deductible, any*
44 *copayment or coinsurance or require a longer waiting period or*



1 *other condition to obtain any benefit provided in the health care*
2 *plan pursuant to subsection 1;*

3 *(b) Refuse to issue a health care plan or cancel a health care*
4 *plan solely because the person applying for or covered by the plan*
5 *uses or may use a benefit provided in the health care plan*
6 *pursuant to subsection 1;*

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

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

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

17 *(f) Impose any other restrictions or delays on the access of an*
18 *insured to any such benefit.*

19 *4. An evidence of coverage subject to the provisions of this*
20 *chapter which is delivered, issued for delivery or renewed on or*
21 *after January 1, 2018, has the legal effect of including the*
22 *coverage required by subsection 1, and any provision of the*
23 *evidence of coverage or the renewal which is in conflict with*
24 *subsection 1 is void.*

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

27 **Sec. 90.** NRS 695G.171 is hereby amended to read as follows:

28 695G.171 1. A health care plan issued by a managed care
29 organization must provide coverage for benefits payable for
30 expenses incurred for ~~administering~~ :

31 *(a) Deoxyribonucleic acid testing for high-risk strains of the*
32 *human papillomavirus; and*

33 *(b) Administering* the human papillomavirus vaccine as
34 recommended for vaccination by a competent authority, including,
35 without limitation, the Centers for Disease Control and Prevention
36 of the United States Department of Health and Human Services, the
37 Food and Drug Administration or the manufacturer of the vaccine.

38 2. A health care plan must not require an insured to
39 obtain prior authorization for any service provided pursuant to
40 subsection 1.

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

43 *(a) Require an insured to pay a higher deductible, any*
44 *copayment or coinsurance or require a longer waiting period or*



1 *other condition to obtain any benefit provided in the health care*
2 *plan pursuant to subsection 1;*

3 (b) *Refuse to issue a health care plan or cancel a health care*
4 *plan solely because the person applying for or covered by the plan*
5 *uses or may use a benefit provided in the health care plan*
6 *pursuant to subsection 1;*

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

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

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

17 (f) *Impose any other restrictions or delays on the access of an*
18 *insured to any such benefit.*

19 4. An evidence of coverage for a health care plan subject to the
20 provisions of this chapter which is delivered, issued for delivery or
21 renewed on or after ~~July 1, 2007,~~ **January 1, 2018**, has the legal
22 effect of including the coverage required by subsection 1, and any
23 provision of the evidence of coverage or the renewal thereof which
24 is in conflict with subsection 1 is void.

25 ~~{4. For the purposes of this section, "human}~~

26 5. *As used in this section:*

27 (a) *"Human papillomavirus vaccine"* means the Quadrivalent
28 Human Papillomavirus Recombinant Vaccine or its successor which
29 is approved by the Food and Drug Administration for the prevention
30 of human papillomavirus infection and cervical cancer.

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

33 **Sec. 91.** (Deleted by amendment.)

34 **Sec. 92.** The provisions of NRS 354.599 do not apply to any
35 additional expenses of a local government that are related to the
36 provisions of this act.

37 **Sec. 93.** 1. The Director of the Department of Health and
38 Human Services shall adopt regulations as soon as possible after the
39 effective date of this act which establish the health care services
40 which must be covered by a policy of health insurance, policy of
41 group health insurance, health benefit plan, benefit contract, contract
42 for hospital or medical service or health care plan pursuant to
43 sections 2 to 5, inclusive, 17, 18, 19, 21, 26, 27, 28, 32, 35, 36, 37,
44 43, 50 to 53, inclusive, 59 to 62, inclusive, 70 to 73, inclusive, and
45 85 to 88, inclusive, of this act.



1 2. The regulations adopted pursuant to subsection 1 must
2 include, without limitation, the health care services which are
3 required to be covered pursuant to 45 C.F.R. § 147.130 and the
4 Patient Protection and Affordable Care Act, Pub. L. 111-148, as
5 amended.

6 **Sec. 94.** NRS 689A.523, 689A.585, 689B.450, 689C.082,
7 695A.159 and 695F.480 are hereby repealed.

8 **Sec. 95.** This act becomes effective:

9 1. Upon passage and approval for the purposes of adopting any
10 regulations and performing any other preparatory administrative
11 tasks that are necessary to carry out the provisions of this act; and

12 2. On January 1, 2018, for all other purposes.

LEADLINES OF REPEALED SECTIONS

689A.523 “Exclusion for a preexisting condition” defined.

689A.585 “Preexisting condition” defined.

689B.450 “Preexisting condition” defined.

689C.082 “Preexisting condition” defined.

**695A.159 Society prohibited from restricting coverage of
child based on preexisting condition when person who is eligible
for group coverage adopts or assumes legal obligation for child.**

**695F.480 Organization prohibited from restricting
coverage of child based on preexisting condition if person who is
eligible for group coverage adopts or assumes legal obligation
for child.**

