

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)

~

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; revising provisions relating to the dispensing of contraceptives; 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 family planning services and supplies and 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.



* A B 4 0 8 R 2 *

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,
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. §
11 300gg-4) **Sections 15, 31, 41, 48, 57, 68, 80, 83 and 94** of this bill align Nevada
12 law with federal law and require all insurers to offer health insurance coverage
13 regardless of the health status of a person and prohibits an insurer from denying,
14 limiting or excluding a benefit or requiring an insured to pay a higher premium,
15 deductible, coinsurance or copay based on the health status of the insured or the
16 covered 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.

26 The Patient Protection and Affordable Care Act (Public Law 111-148, as
27 amended) requires all health insurance plans to include coverage, without any
28 higher deductible or any copay or coinsurance, for certain preventive health care
29 services for women, adults and children, including, without limitation, screenings
30 and tests for certain diseases, counseling, contraceptive and other family planning
31 drugs, devices and services as well as vaccinations. (42 U.S.C. § 300gg-13; 45
32 C.F.R. § 147.130) **Sections 9-10, 16.5-20, 22, 25.5-30, 34.5-39, 49.5-52, 54, 55,**
33 **58.5-61, 63, 64, 69.5-72, 76, 77, 84.5-87, 89 and 90** of this bill align Nevada law
34 with federal law in this manner, and extend these requirements to health insurance
35 purchased by local governments and the Public Employees' Benefits Program.
36 **Sections 1.5-4, 5.5, 6 and 7** of this bill also require the State Plan for Medicaid to
37 include these preventive health care services for women, adults and children.

38 Existing law allows an insurer which is affiliated with a religious organization
39 and which objects on religious grounds to providing coverage for contraceptive
40 drugs and devices to exclude coverage in its policies, plans or contracts for such
41 drugs and devices. (NRS 689A.0415, 689B.0376, 695B.1916, 695C.1694) **Sections**
42 **16.5, 20.3, 20.6, 25.5, 30.3, 30.6, 58.5, 63.3, 63.6, 69.5, 74.3 and 74.6** of this bill
43 move the religious exemption coverage for the contraceptive drugs, devices and
44 services required by this bill to the new provisions relating to coverage of
45 contraception. **Sections 34.5, 49.5 and 84.5** of this bill provide a religious
46 exemption for insurers who are newly required by this bill to provide coverage of
47 drugs and devices for contraception.

48 Existing law authorizes a pharmacist to dispense up to a 90-day supply of a
49 drug pursuant to a valid prescription or order in certain circumstances. (NRS
50 639.2396) **Section 11.3** of this bill requires a pharmacist to dispense up to a
51 12-month supply of a drug for contraception or a therapeutic equivalent pursuant to
52 a valid prescription or order if: (1) the patient has previously received a 3-month
53 supply of the same drug; (2) the patient has previously received a 9-month supply
54 of the same drug or a supply of the same drug for the balance of the plan year in



55 which the 3-month supply was prescribed or ordered, whichever is less; (3) the
56 patient is insured by the same health insurance plan; and (4) a provider of health
57 care has not specified in the prescription or order that a different supply of the drug
58 is necessary.

59 The Patient Protection and Affordable Care Act (Public Law 111-148, as
60 amended) prohibits a provider of health care or state health insurance exchange
61 who receives federal money from discriminating against a person on the basis of
62 race, color, national origin, sex, age, or disability in providing health care services
63 to the person. The Act also prohibits an insurer who receives federal money from
64 discriminating against a person on those same grounds, as well as gender identity or
65 expression. (42 U.S.C. § 18116; 45 C.F.R. § 92.207) The federal regulation that
66 prohibits insurers from discriminating on the basis of gender identity or expression
67 is no longer enforceable, however, because it was recently held to exceed the
68 statutory authority granted by the Act. (*Franciscan Alliance Inc., v. Burwell*, 2016
69 WL 7638311 (N.D. Tex. Dec. 31, 2016)) Federal regulations also require providers
70 of health care, state health insurance exchanges and insurers to provide certain
71 assistive services and notice of these nondiscrimination provisions to all persons
72 who receive health care services. (45 C.F.R. §§ 92.8, 92.201, 92.202) **Sections 11**
73 **and 12** of this bill generally align Nevada law with federal law, and prohibit a
74 provider of health care or an insurer from discriminating against a person on these
75 grounds, including, without limitation, discrimination based on gender identity or
76 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 1.5 to 6, inclusive, of this
21 act.

22 **Sec. 1.5. 1. *The Director shall include in the State Plan for***
23 ***Medicaid a requirement that the State pay the nonfederal share of***
24 ***expenditures for family planning services and supplies, including,***
25 ***without limitation:***



* A B 4 0 8 R 2 *

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

- 3 (1) *Lawfully prescribed or ordered;*
4 (2) *Approved by the Food and Drug Administration; and*
5 (3) *Dispensed in accordance with section 11.3 of this act;*

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

- 7 (1) *Lawfully prescribed or ordered; and*
8 (2) *Approved by the Food and Drug Administration;*

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

10 (d) *Education and counseling relating to the initiation of the*
11 *use of contraception and any necessary follow-up after initiating*
12 *such use;*

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

14 (f) *Voluntary sterilization for women.*

15 2. *Except as otherwise provided in subsections 4 and 5, to*
16 *obtain any benefit included in the Plan pursuant to subsection 1, a*
17 *person enrolled in Medicaid must not be required to:*

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

19 (b) *Be subject to a longer waiting period or any other*
20 *condition.*

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

26 4. *The Plan may require a person enrolled in Medicaid to pay*
27 *a higher deductible, copayment or coinsurance for a drug for*
28 *contraception if the person refuses to accept a therapeutic*
29 *equivalent of the drug.*

30 5. *For each method of contraception which is approved by*
31 *the Food and Drug Administration, the Plan must include at least*
32 *one drug or device for contraception for which no deductible,*
33 *copayment or coinsurance may be charged to the person enrolled*
34 *in Medicaid, but the Plan may charge a deductible, copayment or*
35 *coinsurance for any other drug or device that provides the same*
36 *method of contraception.*

37 6. *As used in this section, "therapeutic equivalent" means a*
38 *drug which:*

39 (a) *Contains an identical amount of the same active*
40 *ingredients in the same dosage and method of administration as*
41 *another drug;*

42 (b) *Is expected to have the same clinical effect when*
43 *administered to a patient pursuant to a prescription or order as*
44 *another drug; and*



1 (c) *Meets any other criteria required by the Food and Drug*
2 *Administration for classification as a therapeutic equivalent.*

3 **Sec. 2. 1.** *The Director shall include in the State Plan for*
4 *Medicaid a requirement that the State pay the nonfederal share of*
5 *expenditures incurred for:*

6 (a) *Counseling and support for breastfeeding;*

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

9 (c) *Counseling for sexually transmitted diseases;*

10 (d) *Screening for blood pressure abnormalities and diabetes,*
11 *including gestational diabetes;*

12 (e) *An annual screening for cervical cancer;*

13 (f) *Screening for depression;*

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

16 (h) *A daily dose of 0.4 to 0.8 milligrams of folic acid for*
17 *women who are capable of becoming pregnant;*

18 (i) *Aspirin for the prevention of preeclampsia for women who*
19 *are determined to be at a high risk of that condition after 12 weeks*
20 *of gestation;*

21 (j) *Medication to prevent breast cancer for women who are at*
22 *a high risk of developing breast cancer and have a low risk of*
23 *adverse side effects from the medication; and*

24 (k) *Prophylactic ocular tubal medication for the prevention of*
25 *gonococcal ophthalmia in newborns.*

26 **2.** *To obtain any benefit provided in the Plan pursuant to*
27 *subsection 1, a recipient of Medicaid must not be required to:*

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

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

31 **Sec. 3. 1.** *The Director shall include in the State Plan for*
32 *Medicaid a requirement that the State pay the nonfederal share of*
33 *expenditures incurred for:*

34 (a) *Counseling relating to the dietary needs of adults who are*
35 *at a high risk of chronic diseases;*

36 (b) *Statin preventive medication for persons between the ages*
37 *of 40 and 75 years who do not have a history of cardiovascular*
38 *disease, but who have:*

39 (1) *One or more risk factors for cardiovascular disease;*
40 *and*

41 (2) *A calculated risk of at least 10 percent of acquiring*
42 *cardiovascular disease within the next 10 years;*

43 (c) *Aspirin for persons between the ages of 50 and 59 years*
44 *who have a calculated risk of at least 10 percent of acquiring*



1 *cardiovascular disease within the next 10 years and a life*
2 *expectancy of at least 10 years;*

3 *(d) Vitamin D supplements for persons who are at least 65*
4 *years of age to prevent the person from falling if the person:*

5 *(1) Does not reside in a medical facility or a facility for the*
6 *dependent; and*

7 *(2) Has an increased risk of falls;*

8 *(e) Tuberculosis screenings for latent tuberculosis infection in*
9 *persons with increased risk of contracting tuberculosis;*

10 *(f) Screening for high blood pressure to confirm a diagnosis*
11 *made outside a clinical setting before treatment is commenced;*

12 *(g) One abdominal aortic screening by ultrasound to detect*
13 *abdominal aortic aneurisms for men between the ages of 65 and*
14 *75 years who have smoked during their lifetimes;*

15 *(h) Screening for hepatitis B infection for persons who are at a*
16 *high risk of contracting hepatitis B;*

17 *(i) Screening for hepatitis C infection for persons who are at a*
18 *high risk of contracting hepatitis C;*

19 *(j) One screening for hepatitis C infection for persons born*
20 *between 1945 and 1965;*

21 *(k) Screening for osteoporosis for women who:*

22 *(1) Are 65 years of age and older; or*

23 *(2) Have a risk of fracturing a bone equal to or greater*
24 *than that of a woman who is 65 years of age without any*
25 *additional risk factors;*

26 *(l) Screening for alcohol misuse for persons 18 years of age or*
27 *older;*

28 *(m) If a person engages in risky or hazardous consumption of*
29 *alcohol, as determined by the screening described in paragraph*
30 *(l), behavioral counseling to reduce such behavior; and*

31 *(n) Screening for lung cancer using low-dose computed*
32 *tomography for persons between the ages of 55 and 80 years who:*

33 *(1) Have a smoking history of 30 pack-years;*

34 *(2) Smoke or have stopped smoking within the immediately*
35 *preceding 15 years; and*

36 *(3) Do not suffer from a health problem that substantially*
37 *limits the life expectancy of the person or the willingness of the*
38 *person to undergo curative surgery.*

39 *2. To obtain any benefit provided in the Plan pursuant to*
40 *subsection 1, a recipient of Medicaid must not be required to:*

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

42 *(b) Be subject to a longer waiting period or any other*
43 *condition.*

44 *3. As used in this section:*



1 (a) "Computed tomography" means the process of producing
2 sectional and three-dimensional images using external ionizing
3 radiation.

4 (b) "Facility for the dependent" has the meaning ascribed to it
5 in NRS 449.0045.

6 (c) "Medical facility" has the meaning ascribed to it in
7 NRS 449.0151.

8 (d) "Pack-year" means the product of the number of packs of
9 cigarettes smoked per day and the number of years that the person
10 has smoked.

11 **Sec. 4. 1. The Director shall include in the State Plan for**
12 **Medicaid a requirement that the State pay the nonfederal share of**
13 **expenditures incurred for:**

14 (a) Screening for depression;

15 (b) Smoking cessation programs, consisting of more than two
16 cessation attempts per year and four counseling sessions of not
17 more than 10 minutes each per year;

18 (c) Screening, tests and counseling for such other health
19 conditions and diseases as recommended by the Health Resources
20 and Services Administration for persons less than 18 years of age;

21 (d) Assessments relating to height, weight, body mass index
22 and medical history of persons less than 18 years of age; and

23 (e) 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 2. To obtain any benefit provided in the Plan pursuant to
28 subsection 1, a recipient of Medicaid must not be required to:

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

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

32 **Sec. 5. (Deleted by amendment.)**

33 **Sec. 5.5. The Director may include in the State Plan for**
34 **Medicaid a requirement that, to the extent money is available, the**
35 **State pay the nonfederal share of expenditures incurred for:**

36 1. Supplies for breastfeeding; and

37 2. Such prenatal screenings and tests as recommended by the
38 American College of Obstetricians and Gynecologists or its
39 successor organization.

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

43 (a) A mammogram not less than once every 2 years, or
44 annually if ordered by a provider of health care, for women 40
45 years of age or older;



- 1 ***(b) Counseling concerning genetic testing for breast cancer for***
2 ***women who are at a high risk of developing breast cancer; and***
3 ***(c) Counseling concerning breast cancer chemoprevention for***
4 ***women who are at risk of developing breast cancer.***

5 ***2. To obtain any benefit provided in the Plan pursuant to***
6 ***subsection 1, a recipient of Medicaid must not be required to:***

- 7 ***(a) Pay a higher deductible, any copayment or coinsurance; or***
8 ***(b) Be subject to a longer waiting period or any other***
9 ***condition.***

10 **Sec. 7.** NRS 422.2718 is hereby amended to read as follows:
11 422.2718 1. The Director shall include in the State Plan for
12 Medicaid a requirement that the State shall pay the nonfederal share
13 of expenses incurred for ~~administering~~ :

14 ***(a) Testing for high-risk strains of the human papillomavirus***
15 ***every 3 years for women 30 years of age or older; and***

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

22 ***2. To obtain any benefit provided in the Plan pursuant to***
23 ***subsection 1, a recipient of Medicaid must not be required to:***

- 24 ***(a) Pay a higher deductible, any copayment or coinsurance; or***
25 ***(b) Be subject to a longer waiting period or any other***
26 ***condition.***

27 **3.** For the purposes of this section, “human papillomavirus
28 vaccine” means the Quadrivalent Human Papillomavirus
29 Recombinant Vaccine or its successor which is approved by the
30 Food and Drug Administration to be used for the prevention of
31 human papillomavirus infection and cervical cancer.

32 **Sec. 7.5.** NRS 422.401 is hereby amended to read as follows:
33 422.401 As used in NRS 422.401 to 422.406, inclusive, ***and***
34 ***section 1.5 of this act,*** unless the context otherwise requires, the
35 words and terms defined in NRS 422.4015 and 422.402 have the
36 meanings ascribed to them in those sections.

37 **Sec. 8.** NRS 422.403 is hereby amended to read as follows:
38 422.403 1. ~~The~~ ***Except as otherwise provided in NRS***
39 ***422.2718, the*** Department shall, by regulation, establish and manage
40 the use by the Medicaid program of step therapy and prior
41 authorization for prescription drugs.

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



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

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

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

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

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

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

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

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

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

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



* A B 4 0 8 R 2 *

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

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

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

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

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

44 (a) Shall be deemed, solely for the purposes of this section, to be
45 officers and employees of the county, school district, municipal



1 corporation, political subdivision, public corporation or other local
2 governmental agency with which the legal services organization has
3 contracted; and

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

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

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

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

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

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

18 **Sec. 9.5.** NRS 287.0272 is hereby amended to read as follows:

19 287.0272 1. If the governing body of any county, school
20 district, municipal corporation, political subdivision, public
21 corporation or other local governmental agency of the State of
22 Nevada provides health insurance through a plan of self-insurance,
23 the plan must provide coverage for benefits payable for expenses
24 incurred for administering the human papillomavirus vaccine ~~to~~
25 ~~women and girls~~ at such ages as recommended for vaccination by a
26 competent authority, including, without limitation, the Centers for
27 Disease Control and Prevention of the United States Department of
28 Health and Human Services, the Food and Drug Administration or
29 the manufacturer of the vaccine.

30 2. The plan of self-insurance must not require an insured to
31 obtain prior authorization for any service provided pursuant to
32 subsection 1.

33 3. A plan of self-insurance described in subsection 1 which is
34 delivered, issued for delivery or renewed on or after July 1, 2007,
35 has the legal effect of including the coverage required by subsection
36 1, and any provision of the plan which is in conflict with subsection
37 1 is void.

38 4. For the purposes of this section, "human papillomavirus
39 vaccine" means the Quadrivalent Human Papillomavirus
40 Recombinant Vaccine or its successor which is approved by the
41 Food and Drug Administration for the prevention of human
42 papillomavirus infection and cervical cancer.



* A B 4 0 8 R 2 *

1 **Sec. 10.** NRS 287.04335 is hereby amended to read as
2 follows:

3 287.04335 If the Board provides health insurance through a
4 plan of self-insurance, it shall comply with the provisions of NRS
5 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645,
6 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177,
7 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive,
8 and 695G.405, *and sections 83 to 89, inclusive, of this act*, in the
9 same manner as an insurer that is licensed pursuant to title 57 of
10 NRS is required to comply with those provisions.

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

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

18 2. *A provider of health care may make distinctions in*
19 *providing health care services based on sex or gender identity or*
20 *expression if the provider has an exceedingly persuasive*
21 *justification for the distinction, which may include, without*
22 *limitation, that the distinction is substantially related to the*
23 *achievement of an important health or scientific objective.*

24 3. *A provider of health care must provide reasonable notice to*
25 *a person who receives health care services relating to the*
26 *provisions of this section.*

27 4. *A provider of health care must take reasonable steps to*
28 *ensure that a person with limited English proficiency or physical*
29 *or mental disabilities who receives health care services from the*
30 *provider has access to any assistance services which may be*
31 *needed for the person to communicate effectively with the*
32 *provider.*

33 5. *As used in this section:*

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

36 (b) *“Health care service” means the care and observation of*
37 *patients, the diagnosis of human diseases, the treatment and*
38 *rehabilitation of patients, or related services.*

39 (c) *“Sexual orientation” has the meaning ascribed to it in*
40 *NRS 118.093.*

41 **Sec. 11.3.** Chapter 639 of NRS is hereby amended by adding
42 thereto a new section to read as follows:

43 1. *Except as otherwise provided in subsections 2 and 3,*
44 *pursuant to a valid prescription or order for a drug to be used for*
45 *contraception or its therapeutic equivalent which has been*



1 approved by the Food and Drug Administration a pharmacist
2 shall:

3 (a) The first time dispensing the drug or therapeutic equivalent
4 to the patient, dispense up to a 3-month supply of the drug or
5 therapeutic equivalent.

6 (b) The second time dispensing the drug or therapeutic
7 equivalent to the patient, dispense up to a 9-month supply of the
8 drug or therapeutic equivalent, or any amount which covers the
9 remainder of the plan year if the patient is covered by a health
10 care plan, whichever is less.

11 (c) For a refill in a plan year following the initial dispensing of
12 a drug or therapeutic equivalent pursuant to paragraphs (a) and
13 (b), dispense up to a 12-month supply of the drug or therapeutic
14 equivalent or any amount which covers the remainder of the plan
15 year if the patient is covered by a health care plan, whichever is
16 less.

17 2. The provisions of paragraphs (b) and (c) of subsection 1
18 only apply if:

19 (a) The drug for contraception or the therapeutic equivalent of
20 such drug is the same drug or therapeutic equivalent which was
21 previously prescribed or ordered pursuant to paragraph (a) of
22 subsection 1; and

23 (b) The patient is covered by the same health care plan.

24 3. If a prescription or order for a drug for contraception or its
25 therapeutic equivalent limits the dispensing of the drug or
26 therapeutic equivalent to a quantity which is less than the amount
27 otherwise authorized to be dispensed pursuant to subsection 1, the
28 pharmacist must dispense the drug or therapeutic equivalent in
29 accordance with the quantity specified in the prescription or order.

30 4. As used in this section:

31 (a) "Health care plan" means a policy, contract, certificate or
32 agreement offered or issued by an insurer, including without
33 limitation, the State Plan for Medicaid, to provide, deliver, arrange
34 for, pay for or reimburse any of the costs of health care services.

35 (b) "Plan year" means the year designated in the evidence of
36 coverage of a health care plan in which a person is covered by
37 such plan.

38 (c) "Therapeutic equivalent" means a drug which:

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

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



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

3 **Sec. 11.6.** NRS 639.2396 is hereby amended to read as
4 follows:

5 639.2396 1. Except as otherwise provided by subsection 2, a
6 prescription which bears specific authorization to refill, given by the
7 prescribing practitioner at the time he or she issued the original
8 prescription, or a prescription which bears authorization permitting
9 the pharmacist to refill the prescription as needed by the patient,
10 may be refilled for the number of times authorized or for the period
11 authorized if it was refilled in accordance with the number of doses
12 ordered and the directions for use.

13 2. ~~1A~~ ***Except as otherwise provided in section 11.3 of this act,***
14 ***a*** pharmacist may, in his or her professional judgment and pursuant
15 to a valid prescription that specifies an initial amount of less than a
16 90-day supply of a drug other than a controlled substance followed
17 by periodic refills of the initial amount of the drug, dispense not
18 more than a 90-day supply of the drug if:

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

22 (b) The total number of dosage units that are dispensed pursuant
23 to the prescription does not exceed the total number of dosage units,
24 including refills, that are authorized on the prescription by the
25 prescribing practitioner; and

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

30 3. Nothing in this section shall be construed to alter the
31 coverage provided under any contract or policy of health insurance,
32 health plan or program or other agreement arrangement that
33 provides health coverage.

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

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

42 ***(a) Cancelling a policy;***

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

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



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

3 *2. An insurer may include distinctions in a policy of health*
4 *insurance based on sex or gender identity or expression if*
5 *the insurer has an exceedingly persuasive justification for the*
6 *distinction, which may include, without limitation, that the*
7 *distinction is substantially related to the achievement of an*
8 *important health or scientific objective.*

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

11 *4. An insurer must take reasonable steps to ensure that an*
12 *insured with limited English proficiency or physical or mental*
13 *disabilities has access to any assistance services which may be*
14 *needed for the insured to communicate effectively with the*
15 *insurer.*

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

21 *6. As used in this section:*

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

24 *(b) "Sexual orientation" has the meaning ascribed to it in*
25 *NRS 118.093.*

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

27 687B.225 1. Except as otherwise provided in NRS
28 689A.0405, 689A.0413, 689A.044, 689A.0445, 689B.031,
29 689B.0313, 689B.0317, 689B.0374, 695B.1912, 695B.1914,
30 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1745,
31 695C.1751, 695G.170, 695G.171 and 695G.177, **and sections 38,**
32 **39, 54, 55 and 89 of this act,** any contract for group, blanket or
33 individual health insurance or any contract by a nonprofit hospital,
34 medical or dental service corporation or organization for dental care
35 which provides for payment of a certain part of medical or dental
36 care may require the insured or member to obtain prior authorization
37 for that care from the insurer or organization. The insurer or
38 organization shall:

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

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

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



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

4 **Sec. 15. 1.** *An insurer shall offer or issue a policy of health
5 insurance to any person regardless of the health status of the
6 person or any dependent of the person. Such health status
7 includes, without limitation:*

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

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

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

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

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

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

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

26 **3.** *An insurer that offers or issues a policy of health
27 insurance shall not adjust a premium, deductible, copay or
28 coinsurance for any insured on the basis of genetic information
29 relating to the insured or the covered dependent of the insured.*

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

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

37 **Sec. 16.5. 1.** *Except as otherwise provided in subsection 7,
38 an insurer that offers or issues a policy of health insurance shall
39 include in the policy coverage for:*

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

42 *(1) Lawfully prescribed or ordered;*

43 *(2) Approved by the Food and Drug Administration;*

44 *(3) Listed in subsection 10; and*

45 *(4) Dispensed in accordance with section 11.3 of this act;*



- 1 **(b) Any type of device for contraception which is:**
2 **(1) Lawfully prescribed or ordered;**
3 **(2) Approved by the Food and Drug Administration; and**
4 **(3) Listed in subsection 10;**
5 **(c) Insertion of a device for contraception or removal of such a**
6 **device if the device was inserted while the insured was covered by**
7 **the same policy of health insurance;**
8 **(d) Education and counseling relating to the initiation of the**
9 **use of contraception and any necessary follow-up after initiating**
10 **such use;**
11 **(e) Management of side effects relating to contraception; and**
12 **(f) Voluntary sterilization for women.**
13 **2. An insurer must ensure that the benefits required by**
14 **subsection 1 are made available to an insured through a provider**
15 **of health care who participates in the network plan of the insurer.**
16 **3. If a covered therapeutic equivalent listed in subsection 1 is**
17 **not available or a provider of health care deems a covered**
18 **therapeutic equivalent to be medically inappropriate, an alternate**
19 **therapeutic equivalent prescribed by a provider of health care**
20 **must be covered by the insurer.**
21 **4. Except as otherwise provided in subsections 8, 9 and 11, an**
22 **insurer that offers or issues a policy of health 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 for coverage to obtain any benefit included in the**
26 **policy 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 any such benefit;**
30 **(c) Offer or pay any type of material inducement or financial**
31 **incentive to an insured to discourage the insured from obtaining**
32 **any such benefit;**
33 **(d) Penalize a provider of health care who provides any such**
34 **benefit to an insured, including, without limitation, reducing the**
35 **reimbursement of the provider of health care;**
36 **(e) Offer or pay any type of material inducement, bonus or**
37 **other financial incentive to a provider of health care to deny,**
38 **reduce, withhold, limit or delay access to any such benefit to an**
39 **insured; or**
40 **(f) Impose any other restrictions or delays on the access of an**
41 **insured to any such benefit.**
42 **5. Coverage pursuant to this section for the covered**
43 **dependent of an insured must be the same as for the insured.**
44 **6. Except as otherwise provided in subsection 7, a policy**
45 **subject to the provisions of this chapter that is delivered, issued for**



1 *delivery or renewed on or after January 1, 2018, has the legal*
2 *effect of including the coverage required by subsection 1, and any*
3 *provision of the policy or the renewal which is in conflict with this*
4 *section is void.*

5 *7. An insurer that offers or issues a policy of health*
6 *insurance and which is affiliated with a religious organization is*
7 *not required to provide the coverage required by subsection 1 if*
8 *the insurer objects on religious grounds. Such an insurer shall,*
9 *before the issuance of a policy of health insurance and before the*
10 *renewal of such a policy, provide to the prospective insured written*
11 *notice of the coverage that the insurer refuses to provide pursuant*
12 *to this subsection.*

13 *8. An insurer may require an insured to pay a higher*
14 *deductible, copayment or coinsurance for a drug for contraception*
15 *if the insured refuses to accept a therapeutic equivalent of the*
16 *drug.*

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

25 *10. The following 18 methods of contraception must be*
26 *covered pursuant to this section:*

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



1 (r) *Antiprogesterin-based drugs for emergency contraception.*

2 11. *Except as otherwise provided in this section and federal*
3 *law, an insurer may use medical management techniques,*
4 *including, without limitation, any available clinical evidence, to*
5 *determine the frequency of or treatment relating to any benefit*
6 *required by this section or the type of provider of health care to*
7 *use for such treatment.*

8 12. *An insurer shall not use medical management techniques*
9 *to require an insured to use a method of contraception other than*
10 *the method prescribed or ordered by a provider of health care.*

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

18 14. *As used in this section:*

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

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

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

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

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

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

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

41 **Sec. 17. 1.** *An insurer that offers or issues a policy of*
42 *health insurance shall include in the policy coverage for:*

43 (a) *Counseling and support for breastfeeding, including*
44 *breastfeeding equipment, counseling and education during the*



1 *antenatal, perinatal and postpartum period for not more than 1*
2 *year;*

3 *(b) Screening and counseling for interpersonal and domestic*
4 *violence for women at least annually, with initial intervention*
5 *services consisting of education, strategies to reduce harm,*
6 *supportive services or a referral for any other appropriate*
7 *services;*

8 *(c) Behavioral counseling concerning sexually transmitted*
9 *diseases from a provider of health care for sexually active women*
10 *who are at increased risk for such diseases;*

11 *(d) Such prenatal screenings and tests as recommended by the*
12 *American College of Obstetricians and Gynecologists or its*
13 *successor organization;*

14 *(e) Screening for blood pressure abnormalities and diabetes,*
15 *including gestational diabetes, after at least 24 weeks of gestation*
16 *or as ordered by a provider of health care;*

17 *(f) Screening for cervical cancer at such intervals as are*
18 *recommended by the American College of Obstetricians and*
19 *Gynecologists or its successor organization;*

20 *(g) Such well-woman preventive visits as recommended by the*
21 *Health Resources and Services Administration, which must*
22 *include at least one such visit per year beginning at 14 years of*
23 *age;*

24 *(h) A daily dose of 0.4 to 0.8 milligrams of folic acid for*
25 *women who are capable of becoming pregnant;*

26 *(i) Aspirin for the prevention of preeclampsia for women who*
27 *are determined to be at a high risk of that condition after 12 weeks*
28 *of gestation;*

29 *(j) Medication to prevent breast cancer for women who are at*
30 *a high risk of developing breast cancer and have a low risk of*
31 *adverse side effects from the medication; and*

32 *(k) Prophylactic ocular tubal medication for the prevention of*
33 *gonococcal ophthalmia in newborns.*

34 *2. An insurer must ensure that the benefits required by*
35 *subsection 1 are made available to an insured through a provider*
36 *of health care who participates in the network plan of the insurer.*

37 *3. Except as otherwise provided in subsection 5, an insurer*
38 *that offers or issues a policy of health 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 *health insurance pursuant to subsection 1;*

43 *(b) Refuse to issue a policy of health insurance or cancel a*
44 *policy of health insurance solely because the person applying for*



1 *or covered by the policy uses or may use a benefit provided in the*
2 *policy of health insurance pursuant 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 *4. A policy of health insurance subject to the provisions of*
16 *this chapter that is delivered, issued for delivery or renewed on or*
17 *after January 1, 2018, has the legal effect of including the*
18 *coverage required by subsection 1, and any provision of the policy*
19 *or the renewal which is in conflict with this section is void.*

20 *5. Except as otherwise provided in this section and federal*
21 *law, an insurer may use medical management techniques,*
22 *including, without limitation, any available clinical evidence, to*
23 *determine the frequency of or treatment relating to any benefit*
24 *required by this section or the type of provider of health care to*
25 *use for such treatment.*

26 *6. As used in this section:*

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

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

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

40 **Sec. 18. 1. An insurer that offers or issues a policy of**
41 **health insurance shall include in the policy coverage for:**

42 *(a) Counseling relating to the dietary needs of adults who are*
43 *at a high risk of chronic diseases;*



1 (b) *Statin preventive medication for persons between the ages*
2 *of 40 and 75 years who do not have a history of cardiovascular*
3 *disease, but who have:*

4 (1) *One or more risk factors for cardiovascular disease;*
5 *and*

6 (2) *A calculated risk of at least 10 percent of acquiring*
7 *cardiovascular disease within the next 10 years;*

8 (c) *Aspirin for persons between the ages of 50 and 59 years*
9 *who have a calculated risk of at least 10 percent of acquiring*
10 *cardiovascular disease within the next 10 years and a life*
11 *expectancy of at least 10 years;*

12 (d) *Vitamin D supplements for persons who are at least 65*
13 *years of age to prevent the person from falling if the person:*

14 (1) *Does not reside in a medical facility or a facility for the*
15 *dependent; and*

16 (2) *Has an increased risk of falls;*

17 (e) *Tuberculosis screenings for latent tuberculosis infection in*
18 *persons with increased risk of contracting tuberculosis;*

19 (f) *Screening for high blood pressure to confirm a diagnosis*
20 *made outside a clinical setting before treatment is commenced;*

21 (g) *One abdominal aortic screening by ultrasound to detect*
22 *abdominal aortic aneurisms for men between the ages of 65 and*
23 *75 years who have smoked during their lifetimes;*

24 (h) *Screening for hepatitis B infection for persons who are at a*
25 *high risk of contracting hepatitis B;*

26 (i) *Screening for hepatitis C infection for persons who are at a*
27 *high risk of contracting hepatitis C;*

28 (j) *One screening for hepatitis C infection for persons born*
29 *between 1945 and 1965;*

30 (k) *Screening for osteoporosis for women who:*

31 (1) *Are 65 years of age and older; or*

32 (2) *Have a risk of fracturing a bone equal to or greater*
33 *than that of a woman who is 65 years of age without any*
34 *additional risk factors;*

35 (l) *Screening for alcohol misuse for persons 18 years of age or*
36 *older;*

37 (m) *If a person engages in risky or hazardous consumption of*
38 *alcohol, as determined by the screening described in paragraph*
39 *(l), behavioral counseling to reduce such behavior; and*

40 (n) *Screening for lung cancer using low-dose computed*
41 *tomography for persons between the ages of 55 and 80 years who:*

42 (1) *Have a smoking history of 30 pack-years;*

43 (2) *Smoke or have stopped smoking within the immediately*
44 *preceding 15 years; and*



1 (3) *Do not suffer from a health problem that substantially*
2 *limits the life expectancy of the person or the willingness of the*
3 *person to undergo curative surgery.*

4 2. *An insurer must ensure that the benefits required by*
5 *subsection 1 are made available to an insured through a provider*
6 *of health care who participates in the network plan of the insurer.*

7 3. *Except as otherwise provided in subsection 5, an insurer*
8 *that offers or issues a policy of health insurance shall not:*

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

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

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

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

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

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

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

34 5. *Except as otherwise provided in this section and federal*
35 *law, an insurer may use medical management techniques,*
36 *including, without limitation, any available clinical evidence, to*
37 *determine the frequency of or treatment relating to any benefit*
38 *required by this section or the type of provider of health care to*
39 *use for such treatment.*

40 6. *As used in this section:*

41 (a) *“Computed tomography” means the process of producing*
42 *sectional and three-dimensional images using external ionizing*
43 *radiation.*

44 (b) *“Facility for the dependent” has the meaning ascribed to it*
45 *in NRS 449.0045.*



1 (c) "Medical facility" has the meaning ascribed to it in
2 NRS 449.0151.

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

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

14 (f) "Pack-year" means the product of the number of packs of
15 cigarettes smoked per day and the number of years that the person
16 has smoked.

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

19 **Sec. 19. 1.** An insurer that offers or issues a policy of
20 health insurance shall include in the policy coverage for:

21 (a) Screening for depression;

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

26 (c) Screening, tests and counseling for such other health
27 conditions and diseases as recommended by the Health Resources
28 and Services Administration for persons less than 18 years of age;
29 and

30 (d) Assessments relating to height, weight, body mass index
31 and medical history for persons less than 18 years of age.

32 2. An insurer must ensure that the benefits required by
33 subsection 1 are made available to an insured through a provider
34 of health care who participates in the network plan of the insurer.

35 3. Except as otherwise provided in subsection 5, an insurer
36 that offers or issues a policy of health insurance shall not:

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

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



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

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

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

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

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

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

24 6. As used in this section:

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

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

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

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

40 689A.0405 1. A policy of health insurance must provide
41 coverage for benefits payable for expenses incurred for:

42 (a) ~~1. An annual cytologic screening test for women 18 years of~~
43 ~~age or older;~~

44 ~~2. A baseline mammogram for women between the ages of 35~~
45 ~~and 40; and~~



1 ~~—(c) An annual~~ A mammogram every 2 years, or annually if
2 ordered by a provider of health care, for women 40 years of age or
3 older ~~†~~;

4 (b) Counseling concerning genetic testing for breast cancer for
5 women who are at a high risk of developing breast cancer; and

6 (c) Counseling concerning breast cancer chemoprevention for
7 women who are at risk of developing breast cancer.

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.†~~ An insurer must ensure that the benefits required by
11 subsection 1 are made available to an insured through a provider
12 of health care who participates in the network plan of the insurer.

13 3. Except as otherwise provided in subsection 5, an insurer
14 that offers or issues a policy of health insurance shall not:

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

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

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

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

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

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

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

41 5. Except as otherwise provided in this section and federal
42 law, an insurer may use medical management techniques,
43 including, without limitation, any available clinical evidence, to
44 determine the frequency of or treatment relating to any benefit



1 *required by this section or the type of provider of health care to*
2 *use for such treatment.*

3 **6. As used in this section:**

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

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

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

17 **Sec. 20.3.** NRS 689A.0415 is hereby amended to read as
18 follows:

19 689A.0415 1. ~~{Except as otherwise provided in subsection 5;~~
20 ~~and~~ An insurer that offers or issues a policy of health insurance
21 which provides coverage for prescription drugs or devices shall
22 include in the policy coverage for ~~{~~
23 ~~—(a) Any type of drug or device for contraception; and~~
24 ~~—(b) Any~~ any type of hormone replacement therapy ~~};~~
25 ~~→}~~ which is lawfully prescribed or ordered and which has been
26 approved by the Food and Drug Administration.

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

29 (a) Require an insured to pay a higher deductible, copayment or
30 coinsurance or require a longer waiting period or other condition for
31 coverage for a prescription for ~~{a contraceptive or}~~ hormone
32 replacement therapy than is required for other prescription drugs
33 covered by the policy;

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

38 (c) Offer or pay any type of material inducement or financial
39 incentive to an insured to discourage the insured from accessing
40 ~~{any of the services listed in subsection 1;}~~ hormone replacement
41 therapy;

42 (d) Penalize a provider of health care who provides ~~{any of the~~
43 ~~services listed in subsection 1}~~ hormone replacement therapy to an
44 insured, including, without limitation, reducing the reimbursement
45 of the provider of health care; or



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

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

11 4. The provisions of this section do not:

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

13 (b) Prohibit an insurer from requiring an insured to pay a
14 deductible, copayment or coinsurance for the coverage required by
15 ~~paragraphs (a) and (b) of~~ subsection 1 that is the same as the
16 insured is required to pay for other prescription drugs covered by the
17 policy.

18 5. ~~An insurer which offers or issues a policy of health
19 insurance and which is affiliated with a religious organization is not
20 required to provide the coverage required by paragraph (a) of
21 subsection 1 if the insurer objects on religious grounds. Such an
22 insurer shall, before the issuance of a policy of health insurance and
23 before the renewal of such a policy, provide to the prospective
24 insured, written notice of the coverage that the insurer refuses to
25 provide pursuant to this subsection.~~

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

28 **Sec. 20.6.** NRS 689A.0417 is hereby amended to read as
29 follows:

30 689A.0417 1. ~~Except as otherwise provided in subsection 5,~~
31 ~~an~~ An insurer that offers or issues a policy of health insurance
32 which provides coverage for outpatient care shall include in the
33 policy coverage for any health care service related to ~~contraceptives~~
34 ~~or~~ hormone replacement therapy.

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

37 (a) Require an insured to pay a higher deductible, copayment or
38 coinsurance or require a longer waiting period or other condition for
39 coverage for outpatient care related to ~~contraceptives or~~ hormone
40 replacement therapy than is required for other outpatient care
41 covered by the policy;

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



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

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

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

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

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

24 5. ~~An insurer which offers or issues such a policy of health~~
25 ~~insurance and which is affiliated with a religious organization is not~~
26 ~~required to provide the coverage for health care service related to~~
27 ~~contraceptives required by this section if the insurer objects on~~
28 ~~religious grounds. Such an insurer shall, before the issuance of a~~
29 ~~policy of health insurance and before the renewal of such a policy,~~
30 ~~provide to the prospective insured written notice of the coverage~~
31 ~~that the insurer refuses to provide pursuant to this subsection.~~

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

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

36 689A.0425 1. Except as otherwise provided in this
37 subsection, an individual health benefit plan issued pursuant to this
38 chapter ~~that includes coverage for maternity care and pediatric care~~
39 ~~for newborn infants~~ may not restrict benefits for any length of stay
40 in a hospital in connection with childbirth for a mother or newborn
41 infant covered by the plan to:

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

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

44 ↪ If a different length of stay is provided in the guidelines
45 established by the American College of Obstetricians and



1 Gynecologists, or its successor organization, and the American
2 Academy of Pediatrics, or its successor organization, the individual
3 health benefit plan may follow such guidelines in lieu of following
4 the length of stay set forth above. The provisions of this subsection
5 do not apply to any individual health benefit plan in any case in
6 which the decision to discharge the mother or newborn infant before
7 the expiration of the minimum length of stay set forth in this
8 subsection is made by the attending physician of the mother or
9 newborn infant.

10 2. Nothing in this section requires a mother to:

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

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

14 3. An individual health benefit plan ~~[that offers coverage for~~
15 ~~maternity care and pediatric care of newborn infants]~~ may not:

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

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

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

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

31 (e) Except as otherwise provided in subsection 4, restrict
32 benefits for any portion of a hospital stay required pursuant to the
33 provisions of this section in a manner that is less favorable than the
34 benefits provided for any preceding portion of that stay.

35 4. Nothing in this section:

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

44 (b) Prohibits an arrangement for payment between an individual
45 health benefit plan and a provider of health care that uses capitation



1 or other financial incentives, if the arrangement is designed to
2 provide services efficiently and consistently in the best interest of
3 the mother and her newborn infant.

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

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

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

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

15 689A.044 1. A policy of health insurance must provide
16 coverage for benefits payable for expenses incurred for
17 ~~administering~~ :

18 *(a) Deoxyribonucleic acid testing for high-risk strains of the*
19 *human papillomavirus every 3 years for women 30 years of age or*
20 *older; and*

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

26 2. ~~A policy of health insurance must not require an insured to~~
27 ~~obtain prior authorization for any service provided pursuant to~~
28 ~~subsection 1.~~ *An insurer must ensure that the benefits required by*
29 *subsection 1 are made available to an insured through a provider*
30 *of health care who participates in the network plan of the insurer.*

31 3. *Except as otherwise provided in subsection 5, an insurer*
32 *that offers or issues a policy of health 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 health benefit*
36 *plan 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 4. A policy subject to the provisions of this chapter which is
11 delivered, issued for delivery or renewed on or after ~~July 1, 2007,~~
12 *January 1, 2018*, has the legal effect of including the coverage
13 required by subsection 1, and any provision of the policy or the
14 renewal which is in conflict with ~~subsection 1~~ *this section* is void.

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

16 5. *Except as otherwise provided in this section and federal*
17 *law, an insurer may use medical management techniques,*
18 *including, without limitation, any available clinical evidence, to*
19 *determine the frequency of or treatment relating to any benefit*
20 *required by this section or the type of provider of health care to*
21 *use for such treatment.*

22 6. *As used in this section:*

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

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

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

38 (d) *"Provider of health care"* has the meaning ascribed to it in
39 *NRS 629.031.*

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

41 689A.330 If any policy is issued by a domestic insurer for
42 delivery to a person residing in another state, and if the insurance
43 commissioner or corresponding public officer of that other state has
44 informed the Commissioner that the policy is not subject to approval
45 or disapproval by that officer, the Commissioner may by ruling



1 require that the policy meet the standards set forth in NRS 689A.030
2 to 689A.320, inclusive **H**, *and sections 15 to 19, inclusive, of this*
3 *act.*

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

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

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

14 **Sec. 25.5. 1.** *Except as otherwise provided in subsection 7,*
15 *an insurer that offers or issues a policy of group health insurance*
16 *shall include in the policy coverage for:*

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

- 19 **(1)** *Lawfully prescribed or ordered;*
20 **(2)** *Approved by the Food and Drug Administration;*
21 **(3)** *Listed in subsection 11; and*
22 **(4)** *Dispensed in accordance with section 11.3 of this act;*

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

- 24 **(1)** *Lawfully prescribed or ordered;*
25 **(2)** *Approved by the Food and Drug Administration; and*
26 **(3)** *Listed in subsection 11;*

27 **(c)** *Insertion of a device for contraception or removal of such a*
28 *device if the device was inserted while the insured was covered by*
29 *the same policy of group health insurance;*

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

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

34 **(f)** *Voluntary sterilization for women.*

35 **2.** *An insurer must ensure that the benefits required by*
36 *subsection 1 are made available to an insured through a provider*
37 *of health care who participates in the network plan of the insurer.*

38 **3.** *If a covered therapeutic equivalent listed in subsection 1 is*
39 *not available or a provider of health care deems a covered*
40 *therapeutic equivalent to be medically inappropriate, an alternate*
41 *therapeutic equivalent prescribed by a provider of health care*
42 *must be covered by the insurer.*

43 **4.** *Except as otherwise provided in subsections 9, 10 and 12,*
44 *an insurer that offers or issues a policy of group health insurance*
45 *shall not:*



* A B 4 0 8 R 2 *

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 for coverage to obtain any benefit included in the
4 policy pursuant to subsection 1;

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

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

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

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

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

21 5. Coverage pursuant to this section for the covered
22 dependent of an insured must be the same as for the insured.

23 6. Except as otherwise provided in subsection 7, a policy
24 subject to the provisions of this chapter that is delivered, issued for
25 delivery or renewed on or after January 1, 2018, has the legal
26 effect of including the coverage required by subsection 1, and any
27 provision of the policy or the renewal which is in conflict with this
28 section is void.

29 7. An insurer that offers or issues a policy of group health
30 insurance and which is affiliated with a religious organization is
31 not required to provide the coverage required by subsection 1 if
32 the insurer objects on religious grounds. Such an insurer shall,
33 before the issuance of a policy of group health insurance and
34 before the renewal of such a policy, provide to the prospective
35 insured written notice of the coverage that the insurer refuses to
36 provide pursuant to this subsection.

37 8. If an insurer refuses, pursuant to subsection 7, to provide
38 the coverage required by subsection 1, an employer may otherwise
39 provide for the coverage for the employees of the employer.

40 9. An insurer may require an insured to pay a higher
41 deductible, copayment or coinsurance for a drug for contraception
42 if the insured refuses to accept a therapeutic equivalent of the
43 drug.

44 10. For each of the 18 methods of contraception listed in
45 subsection 11 that have been approved by the Food and Drug



* A B 4 0 8 R 2 *

1 *Administration, a policy of group health insurance must include at*
2 *least one drug or device for contraception within each method for*
3 *which no deductible, copayment or coinsurance may be charged to*
4 *the insured, but the insurer may charge a deductible, copayment*
5 *or coinsurance for any other drug or device that provides the same*
6 *method of contraception.*

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

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

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

35 *13. An insurer shall not use medical management techniques*
36 *to require an insured to use a different method of contraception*
37 *other than the method prescribed or ordered by a provider of*
38 *health care.*

39 *14. An insurer must provide an accessible, transparent and*
40 *expedited process which is not unduly burdensome by which an*
41 *insured, or the authorized representative of the insured, may*
42 *request an exception relating to any medical management*
43 *technique used by the insurer to obtain any benefit required by*
44 *this section without a higher deductible, copayment or*
45 *coinsurance.*



1 15. *As used in this section:*

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

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

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

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

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

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

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

24 **Sec. 26. 1.** *An insurer that offers or issues a policy of*
25 *group health insurance shall include in the policy coverage for:*

26 (a) *Counseling and support for breastfeeding, including*
27 *breastfeeding equipment, counseling and education during the*
28 *antenatal, perinatal and postpartum period for not more than 1*
29 *year;*

30 (b) *Screening and counseling for interpersonal and domestic*
31 *violence for women at least annually, with initial intervention*
32 *services consisting of education, strategies to reduce harm,*
33 *supportive services or a referral for any other appropriate*
34 *services;*

35 (c) *Behavioral counseling concerning sexually transmitted*
36 *diseases from a provider of health care for sexually active women*
37 *who are at increased risk for such diseases;*

38 (d) *Such prenatal screenings and tests as recommended by the*
39 *American College of Obstetricians and Gynecologists or its*
40 *successor organization;*

41 (e) *Screening for blood pressure abnormalities and diabetes,*
42 *including gestational diabetes, after at least 24 weeks of gestation*
43 *or as ordered by a provider of health care;*



1 (f) Screening for cervical cancer at such intervals as are
2 recommended by the American College of Obstetricians and
3 Gynecologists or its successor organization;

4 (g) Such well-woman preventive visits as recommended by the
5 Health Resources and Services Administration, which must
6 include at least one such visit per year beginning at 14 years of
7 age;

8 (h) A daily dose of 0.4 to 0.8 milligrams of folic acid for
9 women who are capable of becoming pregnant;

10 (i) Aspirin for the prevention of preeclampsia for women who
11 are determined to be at a high risk of that condition after 12 weeks
12 of gestation;

13 (j) Medication to prevent breast cancer for women who are at
14 a high risk of developing breast cancer and have a low risk of
15 adverse side effects from the medication; and

16 (k) Prophylactic ocular tubal medication for the prevention of
17 gonococcal ophthalmia in newborns.

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

21 3. Except as otherwise provided in subsection 5, an insurer
22 that offers or issues a policy of group health 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 group health insurance pursuant to subsection 1;

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

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

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

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

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

44 4. A policy of group health insurance subject to the
45 provisions of this chapter that is delivered, issued for delivery or



1 renewed on or after January 1, 2018, has the legal effect of
2 including the coverage required by subsection 1, and any
3 provision of the policy or the renewal which is in conflict with this
4 section is void.

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

11 6. As used in this section:

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

17 (b) "Network plan" means a policy of group health insurance
18 offered by an insurer under which the financing and delivery of
19 medical care, including items and services paid for as medical
20 care, are provided, in whole or in part, through a defined set of
21 providers of health care under contract with the insurer. The term
22 does not include an arrangement for the financing of premiums.

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

25 **Sec. 27. 1.** An insurer that offers or issues a policy of
26 group health insurance shall include in the policy coverage for:

27 (a) Counseling relating to the dietary needs of adults who are
28 at a high risk of chronic diseases;

29 (b) Statin preventive medication for persons between the ages
30 of 40 and 75 years who do not have a history of cardiovascular
31 disease, but who have:

32 (1) One or more risk factors for cardiovascular disease;
33 and

34 (2) A calculated risk of at least 10 percent of acquiring
35 cardiovascular disease within the next 10 years;

36 (c) Aspirin for persons between the ages of 50 and 59 years
37 who have a calculated risk of at least 10 percent of acquiring
38 cardiovascular disease within the next 10 years and a life
39 expectancy of at least 10 years;

40 (d) Vitamin D supplements for persons who are at least 65
41 years of age to prevent the person from falling if the person:

42 (1) Does not reside in a medical facility or a facility for the
43 dependent; and

44 (2) Has an increased risk of falls;



* A B 4 0 8 R 2 *

1 (e) Tuberculosis screenings for latent tuberculosis infection in
2 persons with increased risk of contracting tuberculosis;

3 (f) Screening for high blood pressure to confirm a diagnosis
4 made outside a clinical setting before treatment is commenced;

5 (g) One abdominal aortic screening by ultrasound to detect
6 abdominal aortic aneurisms for men between the ages of 65 and
7 75 years who have smoked during their lifetimes;

8 (h) Screening for hepatitis B infection for persons who are at a
9 high risk of contracting hepatitis B;

10 (i) Screening for hepatitis C infection for persons who are at a
11 high risk of contracting hepatitis C;

12 (j) One screening for hepatitis C infection for persons born
13 between 1945 and 1965;

14 (k) Screening for osteoporosis for women who:

15 (1) Are 65 years of age and older; or

16 (2) Have a risk of fracturing a bone equal to or greater
17 than that of a woman who is 65 years of age without any
18 additional risk factors;

19 (l) Screening for alcohol misuse for persons 18 years of age or
20 older;

21 (m) If a person engages in risky or hazardous consumption of
22 alcohol, as determined by the screening described in paragraph
23 (l), behavioral counseling to reduce such behavior; and

24 (n) Screening for lung cancer using low-dose computed
25 tomography for persons between ages of 55 and 80 years who:

26 (1) Have a smoking history of 30 pack-years;

27 (2) Smoke or have stopped smoking within the immediately
28 preceding 15 years; and

29 (3) Do not suffer from a health problem that substantially
30 limits the life expectancy of the person or the willingness of the
31 person to undergo curative surgery.

32 2. An insurer must ensure that the benefits required by
33 subsection 1 are made available to an insured through a provider
34 of health care who participates in the network plan of the insurer.

35 3. Except as otherwise provided in subsection 5, an insurer
36 that offers or issues a policy of group health insurance shall not:

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

41 (b) Refuse to issue a policy of group health insurance or
42 cancel a policy of group health insurance solely because the
43 person applying for or covered by the policy uses or may use a
44 benefit provided in the policy of group health insurance pursuant
45 to subsection 1;



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

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

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

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

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

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

25 6. As used in this section:

26 (a) "Computed tomography" means the process of producing
27 sectional and three-dimensional images using external ionizing
28 radiation.

29 (b) "Facility for the dependent" has the meaning ascribed to it
30 in NRS 449.0045.

31 (c) "Medical facility" has the meaning ascribed to it in
32 NRS 449.0151.

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

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



1 (f) "Pack-year" means the product of the number of packs of
2 cigarettes smoked per day and the number of years that the person
3 has smoked.

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

6 **Sec. 28. 1. An insurer that offers or issues a policy of**
7 **group health insurance shall include in the policy coverage for:**

8 (a) Screening for depression;

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

13 (c) Screening, tests and counseling for such other health
14 conditions and diseases as recommended by the Health Resources
15 and Services Administration for persons less than 18 years of age;
16 and

17 (d) Assessments relating to height, weight, body mass index
18 and medical history for persons less than 18 years of age.

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

22 3. Except as otherwise provided in subsection 5, an insurer
23 that offers or issues a policy of group health insurance 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 policy of
27 group health insurance pursuant to subsection 1;

28 (b) Refuse to issue a policy of group health insurance or
29 cancel a policy of group health insurance solely because the
30 person applying for or covered by the policy uses or may use a
31 benefit provided in the policy of group health insurance pursuant
32 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 4. A policy of group health insurance 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 policy or the renewal which is in conflict with this
6 section is void.

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

13 6. As used in this section:

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

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

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

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

29 689B.0313 1. A policy of group health insurance must
30 provide coverage for benefits payable for expenses incurred for
31 ~~administering~~:

32 (a) *Deoxyribonucleic acid testing for high-risk strains of the*
33 *human papillomavirus every 3 years for women 30 years of age or*
34 *older; and*

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

40 2. ~~[A policy of group health insurance must not require an~~
41 ~~insured to obtain prior authorization for any service provided~~
42 ~~pursuant to subsection 1.]~~ *An insurer must ensure that the benefits*
43 *required by subsection 1 are made available to an insured through*
44 *a provider of health care who participates in the network plan of*
45 *the insurer.*



1 3. *Except as otherwise provided in subsection 5, an insurer*
2 *that offers or issues a policy of group health 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 policy of*
6 *group health insurance pursuant to subsection 1;*

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

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

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

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

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

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

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

31 5. *Except as otherwise provided in this section and federal*
32 *law, an insurer may use medical management techniques,*
33 *including, without limitation, any available clinical evidence, to*
34 *determine the frequency of or treatment relating to any benefit*
35 *required by this section or the type of provider of health care to*
36 *use for such treatment.*

37 6. *As used in this section:*

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

42 (b) *"Medical management technique"* means a practice which
43 *is used to control the cost or utilization of health care services or*
44 *prescription drug use. The term includes, without limitation, the*



1 *use of step therapy, prior authorization or categorizing drugs and*
2 *devices based on cost, type or method of administration.*

3 (c) *“Network plan” means a policy of group health insurance*
4 *offered by an insurer under which the financing and delivery of*
5 *medical care, including items and services paid for as medical*
6 *care, are provided, in whole or in part, through a defined set of*
7 *providers of health care under contract with the insurer. The term*
8 *does not include an arrangement for the financing of premiums.*

9 (d) *“Provider of health care” has the meaning ascribed to it in*
10 *NRS 629.031.*

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

13 689B.0374 1. A policy of group health insurance must
14 provide coverage for benefits payable for expenses incurred for:

15 (a) ~~IA n annual cytologic screening test for women 18 years of~~
16 ~~age or older;~~

17 ~~—(b) A baseline mammogram for women between the ages of 35~~
18 ~~and 40; and~~

19 ~~—(c) An annual~~ A mammogram *every 2 years, or annually if*
20 *ordered by a provider of health care, for women 40 years of age or*
21 *older* ~~;~~;

22 (b) *Counseling concerning genetic testing for breast cancer for*
23 *women who are at a high risk of developing breast cancer; and*

24 (c) *Counseling concerning breast cancer chemoprevention for*
25 *women who are at risk of developing breast cancer.*

26 2. ~~IA policy of group health insurance must not require an~~
27 ~~insured to obtain prior authorization for any service provided~~
28 ~~pursuant to subsection 1.~~ *An insurer must ensure that the benefits*
29 *required by subsection 1 are made available to an insured through*
30 *a provider of health care who participates in the network plan of*
31 *the insurer.*

32 3. *Except as otherwise provided in subsection 5, an insurer*
33 *that offers or issues a policy of group health insurance 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 policy of*
37 *group health insurance pursuant to subsection 1;*

38 (b) *Refuse to issue a policy of group health insurance or*
39 *cancel a policy of group health insurance solely because the*
40 *person applying for or covered by the policy uses or may use a*
41 *benefit provided in the policy of group health insurance pursuant*
42 *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 4. A policy of group health insurance subject to the
11 provisions of this chapter which is delivered, issued for delivery or
12 renewed on or after ~~{October 1, 1989,}~~ January 1, 2018, has the
13 legal effect of including the coverage required by subsection 1, and
14 any provision of the policy or the renewal which is in conflict with
15 ~~{subsection 1}~~ this section is void.

16 5. Except as otherwise provided in this section and federal
17 law, an insurer may use medical management techniques,
18 including, without limitation, any available clinical evidence, to
19 determine the frequency of or treatment relating to any benefit
20 required by this section or the type of provider of health care to
21 use for such treatment.

22 6. As used in this section:

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

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

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

36 Sec. 30.3. NRS 689B.0376 is hereby amended to read as
37 follows:

38 689B.0376 1. ~~{Except as otherwise provided in subsection 5,~~
39 ~~and}~~ An insurer that offers or issues a policy of group health
40 insurance which provides coverage for prescription drugs or devices
41 shall include in the policy coverage for ~~{~~

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

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

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



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

3 (a) Require an insured to pay a higher deductible, copayment or
4 coinsurance or require a longer waiting period or other condition for
5 coverage for a prescription for ~~{a contraceptive or}~~ hormone
6 replacement therapy than is required for other prescription drugs
7 covered by the policy;

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

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

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

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

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

30 4. The provisions of this section do not:

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

32 (b) Prohibit an insurer from requiring an insured to pay a
33 deductible, copayment or coinsurance for the coverage required by
34 ~~{paragraphs (a) and (b) of}~~ subsection 1 that is the same as the
35 insured is required to pay for other prescription drugs covered by the
36 policy.

37 5. ~~{An insurer which offers or issues a policy of group health~~
38 ~~insurance and which is affiliated with a religious organization is not~~
39 ~~required to provide the coverage required by paragraph (a) of~~
40 ~~subsection 1 if the insurer objects on religious grounds. Such an~~
41 ~~insurer shall, before the issuance of a policy of group health~~
42 ~~insurance and before the renewal of such a policy, provide to the~~
43 ~~group policyholder or prospective insured, as applicable, written~~
44 ~~notice of the coverage that the insurer refuses to provide pursuant to~~
45 ~~this subsection. The insurer shall provide notice to each insured, at~~



1 ~~the time the insured receives his or her certificate of coverage or~~
2 ~~evidence of coverage, that the insurer refused to provide coverage~~
3 ~~pursuant to this subsection.~~

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

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

10 **Sec. 30.6.** NRS 689B.0377 is hereby amended to read as
11 follows:

12 689B.0377 1. ~~{Except as otherwise provided in subsection 5,~~
13 ~~an} An insurer that offers or issues a policy of group health~~
14 insurance which provides coverage for outpatient care shall include
15 in the policy coverage for any health care service related to
16 ~~{contraceptives or}~~ hormone replacement therapy.

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

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

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

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

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

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

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



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

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

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

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

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

25 689B.500 ~~[A carrier that issues a group health plan or coverage
26 under blanket accident and health insurance or group health
27 insurance shall not deny, exclude or limit a benefit for a preexisting
28 condition.]~~

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

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

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

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

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

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

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



1 ***(b) Require an insured, as a condition of enrollment or***
2 ***renewal, to pay a premium, deductible, copay or coinsurance***
3 ***based on his or her health status which is greater than the***
4 ***premium, deductible, copay or coinsurance charged to a similarly***
5 ***situated insured or the covered dependent of such an insured who***
6 ***does not have such a health status.***

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

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

12 689B.520 1. Except as otherwise provided in this subsection,
13 a group health plan or coverage offered under group health
14 insurance issued pursuant to this chapter ~~{that includes coverage for~~
15 ~~maternity care and pediatric care for newborn infants}~~ may not
16 restrict benefits for any length of stay in a hospital in connection
17 with childbirth for a mother or newborn infant covered by the plan
18 or coverage to:

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

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

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

32 2. Nothing in this section requires a mother to:

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

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

36 3. A group health plan or coverage under group health
37 insurance ~~{that offers coverage for maternity care and pediatric care~~
38 ~~of newborn infants}~~ may not:

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

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



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

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

9 (e) Except as otherwise provided in subsection 4, restrict
10 benefits for any portion of a hospital stay required pursuant to the
11 provisions of this section in a manner that is less favorable than the
12 benefits provided for any preceding portion of that stay.

13 4. Nothing in this section:

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

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

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

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

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

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

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



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

4 **Sec. 34.5. 1.** *Except as otherwise provided in subsection 7,*
5 *a carrier that offers or issues a health benefit plan shall include in*
6 *the plan coverage for:*

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

9 (1) *Lawfully prescribed or ordered;*

10 (2) *Approved by the Food and Drug Administration;*

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

12 (4) *Dispensed in accordance with section 11.3 of this act;*

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

14 (1) *Lawfully prescribed or ordered;*

15 (2) *Approved by the Food and Drug Administration; and*

16 (3) *Listed in subsection 10;*

17 (c) *Insertion of a device for contraception or removal of such a*
18 *device if the device was inserted while the insured was covered by*
19 *the same health benefit plan;*

20 (d) *Education and counseling relating to the initiation of the*
21 *use of contraception and any necessary follow-up after initiating*
22 *such use;*

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

24 (f) *Voluntary sterilization for women.*

25 2. *A carrier must ensure that the benefits required by*
26 *subsection 1 are made available to an insured through a provider*
27 *of health care who participates in the network plan of the carrier.*

28 3. *If a covered therapeutic equivalent listed in subsection 1 is*
29 *not available or a provider of health care deems a covered*
30 *therapeutic equivalent to be medically inappropriate, an alternate*
31 *therapeutic equivalent prescribed by a provider of health care*
32 *must be covered by the carrier.*

33 4. *Except as otherwise provided in subsections 8, 9 and 11, a*
34 *carrier that offers or issues a health benefit plan shall not:*

35 (a) *Require an insured to pay a higher deductible, any*
36 *copayment or coinsurance or require a longer waiting period or*
37 *other condition for coverage to obtain any benefit included in the*
38 *plan pursuant to subsection 1;*

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

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;*



* A B 4 0 8 R 2 *

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 5. Coverage pursuant to this section for the covered
11 dependent of an insured must be the same as for the insured.

12 6. Except as otherwise provided in subsection 7, a health
13 benefit plan subject to the provisions of this chapter that is
14 delivered, issued for delivery or renewed on or after January 1,
15 2018, has the legal effect of including the coverage required by
16 subsection 1, and any provision of the plan or the renewal which
17 is in conflict with this section is void.

18 7. A carrier that offers or issues a health benefit plan and
19 which is affiliated with a religious organization is not required to
20 provide the coverage required by subsection 1 if the carrier objects
21 on religious grounds. Such a carrier shall, before the issuance of
22 a health benefit plan and before the renewal of such a plan,
23 provide to the prospective insured written notice of the coverage
24 that the carrier refuses to provide pursuant to this subsection.

25 8. A carrier may require an insured to pay a higher
26 deductible, copayment or coinsurance for a drug for contraception
27 if the insured refuses to accept a therapeutic equivalent of the
28 drug.

29 9. For each of the 18 methods of contraception listed in
30 subsection 10 that have been approved by the Food and Drug
31 Administration, a health benefit plan must include at least one
32 drug or device for contraception within each method for which no
33 deductible, copayment or coinsurance may be charged to the
34 insured, but the carrier may charge a deductible, copayment or
35 coinsurance for any other drug or device that provides the same
36 method of contraception.

37 10. The following 18 methods of contraception must be
38 covered pursuant to this section:

- 39 (a) Voluntary sterilization for women;
40 (b) Surgical sterilization implants for women;
41 (c) Implantable rods;
42 (d) Copper-based intrauterine devices;
43 (e) Progesterone-based intrauterine devices;
44 (f) Injections;
45 (g) Combined estrogen- and progestin-based drugs;



- 1 (h) *Progestin-based drugs;*
- 2 (i) *Extended- or continuous-regimen drugs;*
- 3 (j) *Estrogen- and progestin-based patches;*
- 4 (k) *Vaginal contraceptive rings;*
- 5 (l) *Diaphragms with spermicide;*
- 6 (m) *Sponges with spermicide;*
- 7 (n) *Cervical caps with spermicide;*
- 8 (o) *Female condoms;*
- 9 (p) *Spermicide;*
- 10 (q) *Combined estrogen- and progestin-based drugs for*
- 11 *emergency contraception or progestin-based drugs for emergency*
- 12 *contraception; and*
- 13 (r) *Antiprogesterin-based drugs for emergency contraception.*
- 14 11. *Except as otherwise provided in this section and federal*
- 15 *law, a carrier may use medical management techniques,*
- 16 *including, without limitation, any available clinical evidence, to*
- 17 *determine the frequency of or treatment relating to any benefit*
- 18 *required by this section or the type of provider of health care to*
- 19 *use for such treatment.*
- 20 12. *A carrier shall not use medical management techniques*
- 21 *to require an insured to use a different method of contraception*
- 22 *other than the method prescribed or ordered by a provider of*
- 23 *health care.*
- 24 13. *A carrier must provide an accessible, transparent and*
- 25 *expedited process which is not unduly burdensome by which an*
- 26 *insured, or the authorized representative of the insured, may*
- 27 *request an exception relating to any medical management*
- 28 *technique used by the carrier to obtain any benefit required by this*
- 29 *section without a higher deductible, copayment or coinsurance.*
- 30 14. *As used in this section:*
- 31 (a) *“Medical management technique” means a practice which*
- 32 *is used to control the cost or utilization of health care services or*
- 33 *prescription drug use. The term includes, without limitation, the*
- 34 *use of step therapy, prior authorization or categorizing drugs and*
- 35 *devices based on cost, type or method of administration.*
- 36 (b) *“Network plan” means a health benefit plan offered by a*
- 37 *carrier under which the financing and delivery of medical care,*
- 38 *including items and services paid for as medical care, are*
- 39 *provided, in whole or in part, through a defined set of providers of*
- 40 *health care under contract with the carrier. The term does not*
- 41 *include an arrangement for the financing of premiums.*
- 42 (c) *“Provider of health care” has the meaning ascribed to it in*
- 43 *NRS 629.031.*
- 44 (d) *“Therapeutic equivalent” means a drug which:*



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

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

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

9 **Sec. 35. 1.** *A carrier that offers or issues a health benefit*
10 *plan shall include in the plan coverage for:*

11 (a) *Counseling and support for breastfeeding, including*
12 *breastfeeding equipment, counseling and education during the*
13 *antenatal, perinatal and postpartum period for not more than 1*
14 *year;*

15 (b) *Screening and counseling for interpersonal and domestic*
16 *violence for women at least annually, with initial intervention*
17 *services consisting of education, strategies to reduce harm,*
18 *supportive services or a referral for any other appropriate*
19 *services;*

20 (c) *Behavioral counseling concerning sexually transmitted*
21 *diseases from a provider of health care for sexually active women*
22 *who are at increased risk for such diseases;*

23 (d) *Such prenatal screenings and tests as recommended by the*
24 *American College of Obstetricians and Gynecologists or its*
25 *successor organization;*

26 (e) *Screening for blood pressure abnormalities and diabetes,*
27 *including gestational diabetes, after at least 24 weeks of gestation*
28 *or as ordered by a provider of health care;*

29 (f) *Screening for cervical cancer at such intervals as are*
30 *recommended by the American College of Obstetricians and*
31 *Gynecologists or its successor organization;*

32 (g) *Such well-woman preventive visits as recommended by the*
33 *Health Resources and Services Administration, which must*
34 *include at least one such visit per year beginning at 14 years of*
35 *age;*

36 (h) *A daily dose of 0.4 to 0.8 milligrams of folic acid for*
37 *women who are capable of becoming pregnant;*

38 (i) *Aspirin for the prevention of preeclampsia for women who*
39 *are determined to be at a high risk of that condition after 12 weeks*
40 *of gestation;*

41 (j) *Medication to prevent breast cancer for women who are at*
42 *a high risk of developing breast cancer and have a low risk of*
43 *adverse side effects from the medication; and*

44 (k) *Prophylactic ocular tubal medication for the prevention of*
45 *gonococcal ophthalmia in newborns.*



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

4 3. *Except as otherwise provided in subsection 5, a carrier that*
5 *offers or issues a health benefit plan shall not:*

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

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

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

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

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

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

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

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

37 6. *As used in this section:*

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

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



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

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

6 **Sec. 36. 1.** *A carrier that offers or issues a health benefit*
7 *plan shall include in the plan coverage for:*

8 (a) *Counseling relating to the dietary needs of adults who are*
9 *at a high risk of chronic diseases;*

10 (b) *Statin preventive medication for persons between the ages*
11 *of 40 and 75 years who do not have a history of cardiovascular*
12 *disease, but who have:*

13 (1) *One or more risk factors for cardiovascular disease;*
14 *and*

15 (2) *A calculated risk of at least 10 percent of acquiring*
16 *cardiovascular disease within the next 10 years;*

17 (c) *Aspirin for persons between the ages of 50 and 59 years*
18 *who have a calculated risk of at least 10 percent of acquiring*
19 *cardiovascular disease within the next 10 years and a life*
20 *expectancy of at least 10 years;*

21 (d) *Vitamin D supplements for persons who are at least 65*
22 *years of age to prevent the person from falling if the person:*

23 (1) *Does not reside in a medical facility or a facility for the*
24 *dependent; and*

25 (2) *Has an increased risk of falls;*

26 (e) *Tuberculosis screenings for latent tuberculosis infection in*
27 *persons with increased risk of contracting tuberculosis;*

28 (f) *Screening for high blood pressure to confirm a diagnosis*
29 *made outside a clinical setting before treatment is commenced;*

30 (g) *One abdominal aortic screening by ultrasound to detect*
31 *abdominal aortic aneurisms for men between ages of 65 and 75*
32 *years who have smoked during their lifetimes;*

33 (h) *Screening for hepatitis B infection for persons who are at a*
34 *high risk of contracting hepatitis B;*

35 (i) *Screening for hepatitis C infection for persons who are at a*
36 *high risk of contracting hepatitis C;*

37 (j) *One screening for hepatitis C infection for persons born*
38 *between 1945 and 1965;*

39 (k) *Screening for osteoporosis for women who:*

40 (1) *Are 65 years of age and older; or*

41 (2) *Have a risk of fracturing a bone equal to or greater*
42 *than that of a woman who is 65 years of age without any*
43 *additional risk factors;*

44 (l) *Screening for alcohol misuse for persons 18 years of age or*
45 *older;*



* A B 4 0 8 R 2 *

1 (m) *If a person engages in risky or hazardous consumption of*
2 *alcohol, as determined by the screening described in paragraph*
3 *(l), behavioral counseling to reduce such behavior; and*

4 (n) *Screening for lung cancer using low-dose computed*
5 *tomography for persons between the ages of 55 and 80 years who:*

6 (1) *Have a smoking history of 30 pack-years;*

7 (2) *Smoke or have stopped smoking within the immediately*
8 *preceding 15 years; and*

9 (3) *Do not suffer from a health problem that substantially*
10 *limits the life expectancy of the person or the willingness of the*
11 *person to undergo curative surgery.*

12 2. *A carrier must ensure that the benefits required by*
13 *subsection 1 are made available to an insured through a provider*
14 *of health care who participates in the network plan of the carrier.*

15 3. *Except as otherwise provided in subsection 5, a carrier that*
16 *offers or issues a health benefit plan shall not:*

17 (a) *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 health benefit*
20 *plan pursuant to subsection 1;*

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

25 (c) *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 (d) *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 (e) *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 (f) *Impose any other restrictions or delays on the access of an*
36 *insured to any such benefit.*

37 4. *A health benefit plan subject to the provisions of this*
38 *chapter 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 plan or the*
41 *renewal which is in conflict with this section is void.*

42 5. *Except as otherwise provided in this section and federal*
43 *law, a carrier may use medical management techniques,*
44 *including, without limitation, any available clinical evidence, to*
45 *determine the frequency of or treatment relating to any benefit*



1 *required by this section or the type of provider of health care to*
2 *use for such treatment.*

3 *6. As used in this section:*

4 *(a) "Computed tomography" means the process of producing*
5 *sectional and three-dimensional images using external ionizing*
6 *radiation.*

7 *(b) "Facility for the dependent" has the meaning ascribed to it*
8 *in NRS 449.0045.*

9 *(c) "Medical facility" has the meaning ascribed to it in*
10 *NRS 449.0151.*

11 *(d) "Medical management technique" means a practice which*
12 *is used to control the cost or utilization of health care services or*
13 *prescription drug use. The term includes, without limitation, the*
14 *use of step therapy, prior authorization or categorizing drugs and*
15 *devices based on cost, type or method of administration.*

16 *(e) "Network plan" means a health benefit plan offered by a*
17 *carrier under which the financing and delivery of medical care,*
18 *including items and services paid for as medical care, are*
19 *provided, in whole or in part, through a defined set of providers of*
20 *health care under contract with the carrier. The term does not*
21 *include an arrangement for the financing of premiums.*

22 *(f) "Pack-year" means the product of the number of packs of*
23 *cigarettes smoked per day and the number of years that the person*
24 *has smoked.*

25 *(g) "Provider of health care" has the meaning ascribed to it in*
26 *NRS 629.031.*

27 **Sec. 37. 1. A carrier that offers or issues a health benefit**
28 **plan shall include in the plan coverage for:**

29 *(a) Screening for depression;*

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

34 *(c) Screening, tests and counseling for such other health*
35 *conditions and diseases as recommended by the Health Resources*
36 *and Services Administration for persons less than 18 years of age;*
37 *and*

38 *(d) Assessments relating to height, weight, body mass index*
39 *and medical history for persons less than 18 years of age.*

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

43 **3. Except as otherwise provided in subsection 5, a carrier that**
44 **offers or issues a health benefit plan 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 health benefit
4 plan pursuant to subsection 1;

5 (b) Refuse to issue a health benefit plan or cancel a health
6 benefit plan solely because the person applying for or covered by
7 the plan uses or may use a benefit provided in the health benefit
8 plan pursuant to subsection 1;

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

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

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

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

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

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

32 6. As used in this section:

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

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

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



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

3 (a) **Deoxyribonucleic acid testing for high-risk strains of the**
4 **human papillomavirus every 3 years for women 30 years of age or**
5 **older; and**

6 (b) **Administering the human papillomavirus vaccine as**
7 **recommended for vaccination by a competent authority, including,**
8 **without limitation, the Centers for Disease Control and Prevention**
9 **of the United States Department of Health and Human Services,**
10 **the Food and Drug Administration or the manufacturer of the**
11 **vaccine.**

12 2. **A carrier must ensure that the benefits required by**
13 **subsection 1 are made available to an insured through a provider**
14 **of health care who participates in the network plan of the carrier.**

15 3. **Except as otherwise provided in subsection 5, a carrier that**
16 **offers or issues a health benefit plan shall not:**

17 (a) **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 health benefit**
20 **plan pursuant to subsection 1;**

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

25 (c) **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 (d) **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 (e) **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 (f) **Impose any other restrictions or delays on the access of an**
36 **insured to any such benefit.**

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

42 5. **Except as otherwise provided in this section and federal**
43 **law, a carrier may use medical management techniques,**
44 **including, without limitation, any available clinical evidence, to**
45 **determine the frequency of or treatment relating to any benefit**



1 required by this section or the type of provider of health care to
2 use for such treatment.

3 6. As used in this section:

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

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

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

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

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

24 (a) A mammogram every 2 years, or annually if ordered by a
25 provider of health care, for women 40 years of age or older;

26 (b) Counseling concerning genetic testing for breast cancer for
27 women who are at a high risk of developing breast cancer; and

28 (c) Counseling concerning breast cancer chemoprevention for
29 women who are at risk of developing breast cancer.

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

33 3. Except as otherwise provided in subsection 5, a carrier that
34 offers or issues a health benefit plan shall not:

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

39 (b) Refuse to issue a health benefit plan or cancel a health
40 benefit plan solely because the person applying for or covered by
41 the plan uses or may use a benefit provided in the health benefit
42 plan 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 4. A health benefit plan subject to the provisions of this
11 chapter which 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 plan
14 or the renewal which is in conflict with this section is void.

15 5. Except as otherwise provided in this section and federal
16 law, a carrier may use medical management techniques,
17 including, without limitation, any available clinical evidence, to
18 determine the frequency of or treatment relating to any benefit
19 required by this section or the type of provider of health care to
20 use for such treatment.

21 6. As used in this section:

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

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

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

35 **Sec. 40.** NRS 689C.159 is hereby amended to read as follows:
36 689C.159 The provisions of NRS 689C.156 ~~and 689C.190~~ do
37 not apply to health benefit plans offered by a carrier if the carrier
38 makes the health benefit plan available in the small employer
39 market only through a bona fide association.

40 **Sec. 41.** NRS 689C.190 is hereby amended to read as follows:
41 689C.190 ~~[A carrier serving small employers that issues a~~
42 ~~health benefit plan shall not deny, exclude or limit a benefit for a~~
43 ~~preexisting condition.]~~

44 1. A carrier shall offer or issue a health benefit plan to any
45 person regardless of the health status of the person or any



1 *dependent of the person. Such health status includes, without*
2 *limitation:*

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

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

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

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

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

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

15 *(b) Require an insured, as a condition of enrollment or*
16 *renewal, to pay a premium, deductible, copay or coinsurance*
17 *based on his or her health status which is greater than the*
18 *premium, deductible, copay or coinsurance charged to a similarly*
19 *situated insured or the covered dependent of such an insured who*
20 *does not have such a health status.*

21 *3. A carrier that offers or issues a health benefit plan shall*
22 *not adjust a premium, deductible, copay or coinsurance for any*
23 *insured on the basis of genetic information relating to the insured*
24 *or the covered dependent of the insured.*

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

26 689C.193 1. A carrier shall not place any restriction on a
27 small employer or an eligible employee or a dependent of the
28 eligible employee as a condition of being a participant in or a
29 beneficiary of a health benefit plan that is inconsistent with NRS
30 689C.015 to 689C.355, inclusive **H**, *and sections 34 to 39,*
31 *inclusive, of this act.*

32 2. A carrier that offers health insurance coverage to small
33 employers pursuant to this chapter shall not establish rules of
34 eligibility, including, but not limited to, rules which define
35 applicable waiting periods, for the initial or continued enrollment
36 under a health benefit plan offered by the carrier that are based on
37 the following factors relating to the eligible employee or a
38 dependent of the eligible employee:

39 (a) Health status.

40 (b) Medical condition, including physical and mental illnesses,
41 or both.

42 (c) Claims experience.

43 (d) Receipt of health care.

44 (e) Medical history.

45 (f) Genetic information.



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

3 (h) Disability.

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

8 4. As a condition of enrollment or continued enrollment under
9 a health benefit plan, a carrier shall not require any person to pay a
10 premium or contribution that is greater than the premium or
11 contribution for a similarly situated person covered by similar
12 coverage on the basis of any factor described in subsection 2 in
13 relation to the person or a dependent of the person.

14 5. Nothing in this section:

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

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

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

24 6. As used in this section:

25 (a) "Contribution" means the minimum employer contribution
26 toward the premium for enrollment of participants and beneficiaries
27 in a health benefit plan.

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

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

33 689C.194 1. Except as otherwise provided in this subsection,
34 a health benefit plan issued pursuant to this chapter ~~{that includes~~
35 ~~coverage for maternity care and pediatric care for newborn infants}~~
36 may not restrict benefits for any length of stay in a hospital in
37 connection with childbirth for a mother or newborn infant covered
38 by the plan to:

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

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

41 ➔ If a different length of stay is provided in the guidelines
42 established by the American College of Obstetricians and
43 Gynecologists, or its successor organization, and the American
44 Academy of Pediatrics, or its successor organization, the health
45 benefit plan may follow such guidelines in lieu of following the



1 length of stay set forth above. The provisions of this subsection do
2 not apply to any health benefit plan in any case in which the
3 decision to discharge the mother or newborn infant before the
4 expiration of the minimum length of stay set forth in this subsection
5 is made by the attending physician of the mother or newborn infant.

6 2. Nothing in this section requires a mother to:

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

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

10 3. A health benefit plan ~~{that offers coverage for maternity care~~
11 ~~and pediatric care of newborn infants}~~ may not:

12 (a) Deny a mother or her newborn infant coverage or continued
13 coverage under the terms of the plan if the sole purpose of the denial
14 of coverage or continued coverage is to avoid the requirements of
15 this section;

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

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

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

27 (e) Except as otherwise provided in subsection 4, restrict
28 benefits for any portion of a hospital stay required pursuant to the
29 provisions of this section in a manner that is less favorable than the
30 benefits provided for any preceding portion of that stay.

31 4. Nothing in this section:

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

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



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

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

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

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

12 689C.270 1. The Commissioner shall adopt regulations
13 which require a carrier to file with the Commissioner, for approval
14 by the Commissioner, a disclosure offered by the carrier to a small
15 employer. The disclosure must include:

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

18 (b) Any restrictions on payments for emergency care, including,
19 without limitation, related definitions of an emergency and medical
20 necessity;

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

24 (d) The provisions relating to renewability of policies and
25 contracts; **and**

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

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

34 3. The Commissioner shall not approve any proposed
35 disclosure submitted to the Commissioner pursuant to this section
36 which does not comply with the requirements of this section and the
37 applicable regulations.

38 4. The carrier shall make available to a small employer or a
39 producer acting on behalf of a small employer, upon request, a copy
40 of the disclosure approved by the Commissioner pursuant to this
41 section for policies of health insurance for which that employer may
42 be eligible.

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

44 689C.425 A voluntary purchasing group and any contract
45 issued to such a group pursuant to NRS 689C.360 to 689C.600,



1 inclusive, are subject to the provisions of NRS 689C.015 to
2 689C.355, inclusive, *and sections 34 to 39, inclusive, of this act*, to
3 the extent applicable and not in conflict with the express provisions
4 of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

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

6 689C.440 1. The Commissioner shall adopt regulations
7 which require a carrier to file with the Commissioner, for approval
8 by the Commissioner, a disclosure offered by the carrier to a
9 voluntary purchasing group. The disclosure must include:

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

12 (b) Any restrictions on payments for emergency care, including,
13 without limitation, related definitions of an emergency and medical
14 necessity;

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

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

19 (e) ~~The provisions relating to any preexisting condition; and~~
20 ~~(f)~~ Any other information that the Commissioner finds
21 necessary to provide for full and fair disclosure of the provisions of a
22 contract.

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

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

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

34 **Sec. 48. 1. *A society shall offer or issue a benefit contract***
35 ***to any person regardless of the health status 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 society that offers or issues a benefit contract shall not:*
2 (a) *Deny, limit or exclude a benefit based on the health status*
3 *of an insured; or*

4 (b) *Require an insured, as a condition of enrollment or*
5 *renewal, to pay a premium, deductible, copay or coinsurance*
6 *based on his or her health status which is greater than the*
7 *premium, deductible, copay or coinsurance charged to a similarly*
8 *situated insured or the covered dependent of such an insured who*
9 *does not have such a health status.*

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

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

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

21 **Sec. 49.5. 1.** *Except as otherwise provided in subsection 7,*
22 *a society that offers or issues a benefit contract shall include in the*
23 *plan coverage for:*

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

- 26 (1) *Lawfully prescribed or ordered;*
- 27 (2) *Approved by the Food and Drug Administration;*
- 28 (3) *Listed in subsection 10; and*
- 29 (4) *Dispensed in accordance with section 11.3 of this act;*

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

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

34 (c) *Insertion of a device for contraception or removal of such a*
35 *device if the device was inserted while the insured was covered by*
36 *the same benefit contract;*

37 (d) *Education and counseling relating to the initiation of the*
38 *use of contraception and any necessary follow-up after initiating*
39 *such use;*

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

41 (f) *Voluntary sterilization for women.*

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



* A B 4 0 8 R 2 *

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

6 4. *Except as otherwise provided in subsections 8, 9 and 11, a*
7 *society that offers or issues a benefit contract shall not:*

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

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

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

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

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

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

27 5. *Coverage pursuant to this section for the covered*
28 *dependent of an insured must be the same as for the insured.*

29 6. *Except as otherwise provided in subsection 7, a benefit*
30 *contract subject to the provisions of this chapter that is delivered,*
31 *issued for delivery or renewed on or after January 1, 2018, has the*
32 *legal effect of including the coverage required by subsection 1,*
33 *and any provision of the plan or the renewal which is in conflict*
34 *with this section is void.*

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

42 8. *A society may require an insured to pay a higher*
43 *deductible, copayment or coinsurance for a drug for contraception*
44 *if the insured refuses to accept a therapeutic equivalent of the*
45 *drug.*



1 9. For each of the 18 methods of contraception listed in
2 subsection 10 that have been approved by the Food and Drug
3 Administration, a benefit contract must include at least one drug
4 or device for contraception within each method for which no
5 deductible, copayment or coinsurance may be charged to the
6 insured, but the society may charge a deductible, copayment or
7 coinsurance for any other drug or device that provides the same
8 method of contraception.

9 10. The following 18 methods of contraception must be
10 covered pursuant to this section:

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

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

37 12. A society shall not use medical management techniques to
38 require an insured to use a different method of contraception
39 other than the method prescribed or ordered by a provider of
40 health care.

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



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

3 *14. As used in this section:*

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

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

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

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

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

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

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

26 **Sec. 50. 1. A society that offers or issues a benefit contract**
27 **shall include in the contract coverage for:**

28 *(a) Counseling and support for breastfeeding, including*
29 *breastfeeding equipment, counseling and education during the*
30 *antenatal, perinatal and postpartum period for not more than 1*
31 *year;*

32 *(b) Screening and counseling for interpersonal and domestic*
33 *violence for women at least annually, with initial intervention*
34 *services consisting of education, strategies to reduce harm,*
35 *supportive services or a referral for any other appropriate*
36 *services;*

37 *(c) Behavioral counseling concerning sexually transmitted*
38 *diseases from a provider of health care for sexually active women*
39 *who are at increased risk for such diseases;*

40 *(d) Such prenatal screenings and tests as recommended by the*
41 *American College of Obstetricians and Gynecologists or its*
42 *successor organization;*

43 *(e) Screening for blood pressure abnormalities and diabetes,*
44 *including gestational diabetes, after at least 24 weeks of gestation*
45 *or as ordered by a provider of health care;*



1 (f) Screening for cervical cancer at such intervals as are
2 recommended by the American College of Obstetricians and
3 Gynecologists or its successor organization;

4 (g) Such well-woman preventive visits as recommended by the
5 Health Resources and Services Administration, which must
6 include at least one such visit per year beginning at 14 years of
7 age;

8 (h) A daily dose of 0.4 to 0.8 milligrams of folic acid for
9 women who are capable of becoming pregnant;

10 (i) Aspirin for the prevention of preeclampsia for women who
11 are determined to be at a high risk of that condition after 12 weeks
12 of gestation;

13 (j) Medication to prevent breast cancer for women who are at
14 a high risk of developing breast cancer and have a low risk of
15 adverse side effects from the medication; and

16 (k) Prophylactic ocular tubal medication for the prevention of
17 gonococcal ophthalmia in newborns.

18 2. A society must ensure that the benefits required by
19 subsection 1 are made available to an insured through a provider
20 of health care who participates in the network plan of the society.

21 3. Except as otherwise provided in subsection 5, a society that
22 offers or issues a benefit contract 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 benefit
26 contract pursuant to subsection 1;

27 (b) Refuse to issue a benefit contract or cancel a benefit
28 contract solely because the person applying for or covered by the
29 contract uses or may use a benefit provided in the benefit contract
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 4. A benefit contract subject to the provisions of this chapter
44 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 contract or the*
2 *renewal which is in conflict with this section is void.*

3 5. *Except as otherwise provided in this section and federal*
4 *law, a society may use medical management techniques,*
5 *including, without limitation, any available clinical evidence, to*
6 *determine the frequency of or treatment relating to any benefit*
7 *required by this section or the type of provider of health care to*
8 *use for such treatment.*

9 6. *As used in this section:*

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

15 (b) *“Network plan” means a benefit contract offered by a*
16 *society under which the financing and delivery of medical care,*
17 *including items and services paid for as medical care, are*
18 *provided, in whole or in part, through a defined set of providers of*
19 *health care under contract with the society. The term does not*
20 *include an arrangement for the financing of premiums.*

21 (c) *“Provider of health care” has the meaning ascribed to it in*
22 *NRS 629.031.*

23 **Sec. 51. 1.** *A society that offers or issues a benefit contract*
24 *shall include in the contract coverage for:*

25 (a) *Counseling relating to the dietary needs of adults who are*
26 *at a high risk of chronic diseases;*

27 (b) *Statin preventive medication for persons between the ages*
28 *of 40 and 75 years who do not have a history of cardiovascular*
29 *disease, but who have:*

30 (1) *One or more risk factors for cardiovascular disease;*
31 *and*

32 (2) *A calculated risk of at least 10 percent of acquiring*
33 *cardiovascular disease within the next 10 years;*

34 (c) *Aspirin for persons between the ages of 50 and 59 years*
35 *who have a calculated risk of at least 10 percent of acquiring*
36 *cardiovascular disease within the next 10 years and a life*
37 *expectancy of at least 10 years;*

38 (d) *Vitamin D supplements for persons who are at least 65*
39 *years of age to prevent the person from falling if the person:*

40 (1) *Does not reside in a medical facility or a facility for the*
41 *dependent; and*

42 (2) *Has an increased risk of falls;*

43 (e) *Tuberculosis screenings for latent tuberculosis infection in*
44 *persons with increased risk of contracting tuberculosis;*



* A B 4 0 8 R 2 *

1 (f) Screening for high blood pressure to confirm a diagnosis
2 made outside a clinical setting before treatment is commenced;

3 (g) One abdominal aortic screening by ultrasound to detect
4 abdominal aortic aneurisms for men between the ages of 65 and
5 75 years who have smoked during their lifetimes;

6 (h) Screening for hepatitis B infection for persons who are at a
7 high risk of contracting hepatitis B;

8 (i) Screening for hepatitis C infection for persons who are at a
9 high risk of contracting hepatitis C;

10 (j) One screening for hepatitis C infection for persons born
11 between 1945 and 1965;

12 (k) Screening for osteoporosis for women who:

13 (1) Are 65 years of age and older; or

14 (2) Have a risk of fracturing a bone equal to or greater
15 than that of a woman who is 65 years of age without any
16 additional risk factors;

17 (l) Screening for alcohol misuse for persons 18 years of age or
18 older;

19 (m) If a person engages in risky or hazardous consumption of
20 alcohol, as determined by the screening described in paragraph
21 (l), behavioral counseling to reduce such behavior; and

22 (n) Screening for lung cancer using low-dose computed
23 tomography for persons between the ages of 55 and 80 years who:

24 (1) Have a smoking history of 30 pack-years;

25 (2) Smoke or have stopped smoking within the immediately
26 preceding 15 years; and

27 (3) Do not suffer from a health problem that substantially
28 limits the life expectancy of the person or the willingness of the
29 person to undergo curative surgery.

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

33 3. Except as otherwise provided in subsection 5, a society that
34 offers or issues a benefit contract shall not:

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

39 (b) Refuse to issue a benefit contract or cancel a benefit
40 contract solely because the person applying for or covered by the
41 contract uses or may use a benefit provided in the benefit contract
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 4. A benefit contract subject to the provisions of this chapter
11 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 contract or the
14 renewal which is in conflict with this section is void.

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

21 6. As used in this section:

22 (a) "Computed tomography" means the process of producing
23 sectional and three-dimensional images using external ionizing
24 radiation.

25 (b) "Facility for the dependent" has the meaning ascribed to it
26 in NRS 449.0045.

27 (c) "Medical facility" has the meaning ascribed to it in
28 NRS 449.0151.

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

34 (e) "Network plan" means a benefit contract offered by a
35 society under which the financing and delivery of medical care,
36 including items and services paid for as medical care, are
37 provided, in whole or in part, through a defined set of providers of
38 health care under contract with the society. The term does not
39 include an arrangement for the financing of premiums.

40 (f) "Pack-year" means the product of the number of packs of
41 cigarettes smoked per day and the number of years that the person
42 has smoked.

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



1 **Sec. 52. 1. A society that offers or issues a benefit contract**
2 **shall include in the contract coverage for:**

3 (a) **Screening for depression;**

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

8 (c) **Screening, tests and counseling for such other health**
9 **conditions and diseases as recommended by the Health Resources**
10 **and Services Administration for persons less than 18 years of age;**
11 **and**

12 (d) **Assessments relating to height, weight, body mass index**
13 **and medical history for persons less than 18 years of age.**

14 2. **A society must ensure that the benefits required by**
15 **subsection 1 are made available to an insured through a provider**
16 **of health care who participates in the network plan of the society.**

17 3. **Except as otherwise provided in subsection 5, a society that**
18 **offers or issues a benefit contract 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 benefit**
22 **contract pursuant to subsection 1;**

23 (b) **Refuse to issue a benefit contract or cancel a benefit**
24 **contract solely because the person applying for or covered by the**
25 **contract uses or may use a benefit provided in the benefit contract**
26 **pursuant 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 4. **A benefit contract subject to the provisions of this chapter**
40 **that is delivered, issued for delivery or renewed on or after**
41 **January 1, 2018, has the legal effect of including the coverage**
42 **required by subsection 1, and any provision of the contract or the**
43 **renewal which is in conflict with this section is void.**

44 5. **Except as otherwise provided in this section and federal**
45 **law, a society may use medical management techniques,**



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

5 6. *As used in this section:*

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

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

17 (c) *“Provider of health care” has the meaning ascribed to it in*
18 *NRS 629.031.*

19 **Sec. 53. 1.** *Except as otherwise provided in this subsection,*
20 *a benefit contract issued pursuant to this chapter may not restrict*
21 *benefits for any length of stay in a hospital in connection with*
22 *childbirth for a mother or newborn infant covered by the contract*
23 *to:*

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

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

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

36 2. *Nothing in this section requires a mother to:*

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

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

40 3. *A benefit contract may not:*

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



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

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

12 (e) Except as otherwise provided in subsection 4, 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
15 the benefits provided for any preceding portion of that stay.

16 4. Nothing in this section:

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

25 (b) Prohibits an arrangement for payment between a benefit
26 contract or society 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 benefit contract or society from negotiating with
31 a provider of health care concerning the level and type of
32 reimbursement to be provided in accordance with this section.

33 5. A benefit contract subject to the provisions of this chapter
34 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 contract or the
37 renewal which is in conflict with this section is void.

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

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

42 (a) Deoxyribonucleic acid testing for high-risk strains of the
43 human papillomavirus every 3 years for women 30 years of age or
44 older; and



* A B 4 0 8 R 2 *

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,***
5 ***the Food and Drug Administration or the manufacturer of the***
6 ***vaccine.***

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

10 ***3. Except as otherwise provided in subsection 5, a society that***
11 ***offers or issues a benefit contract shall not:***

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

16 ***(b) Refuse to issue a benefit contract or cancel a benefit***
17 ***contract solely because the person applying for or covered by the***
18 ***contract uses or may use a benefit provided in the benefit contract***
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 ***4. A benefit contract subject to the provisions of this chapter***
33 ***which is delivered, issued for delivery or renewed on or after***
34 ***January 1, 2018, has the legal effect of including the coverage***
35 ***required by subsection 1, and any provision of the contract or the***
36 ***renewal which is in conflict with this section is void.***

37 ***5. Except as otherwise provided in this section and federal***
38 ***law, a society may use medical management techniques,***
39 ***including, without limitation, any available clinical evidence, to***
40 ***determine the frequency of or treatment relating to any benefit***
41 ***required by this section or the type of provider of health care to***
42 ***use for such treatment.***

43 ***6. As used in this section:***

44 ***(a) "Human papillomavirus vaccine" means the Quadrivalent***
45 ***Human Papillomavirus Recombinant Vaccine or its successor***



1 *which is approved by the Food and Drug Administration for the*
2 *prevention of human papillomavirus infection and cervical*
3 *cancer.*

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

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

15 (d) *“Provider of health care” has the meaning ascribed to it in*
16 *NRS 629.031.*

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

19 (a) *A mammogram every 2 years, or annually if ordered by a*
20 *provider of health care, for women 40 years of age or older;*

21 (b) *Counseling concerning genetic testing for breast cancer for*
22 *women who are at a high risk of developing breast cancer; and*

23 (c) *Counseling concerning breast cancer chemoprevention for*
24 *women who are at risk of developing breast cancer.*

25 2. *A society must ensure that the benefits required by*
26 *subsection 1 are made available to an insured through a provider*
27 *of health care who participates in the network plan of the society.*

28 3. *Except as otherwise provided in subsection 5, a society that*
29 *offers or issues a benefit contract shall not:*

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

34 (b) *Refuse to issue a benefit contract or cancel a benefit*
35 *contract solely because the person applying for or covered by the*
36 *contract uses or may use a benefit provided in the benefit contract*
37 *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 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 this section is void.*

10 *5. Except as otherwise provided in this section and federal*
11 *law, a society may use medical management techniques,*
12 *including, without limitation, any available clinical evidence,*
13 *to determine the frequency of or treatment relating to any benefit*
14 *required by this section or the type of provider of health care to*
15 *use for such treatment.*

16 *6. As used in this section:*

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

22 *(b) "Network plan" means a benefit contract offered by a*
23 *society under which the financing and delivery of medical care,*
24 *including items and services paid for as medical care, are*
25 *provided, in whole or in part, through a defined set of providers of*
26 *health care under contract with the society. The term does not*
27 *include an arrangement for the financing of premiums.*

28 *(c) "Provider of health care" has the meaning ascribed to it in*
29 *NRS 629.031.*

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

33 **Sec. 57. 1.** *An insurer shall offer or issue a contract for*
34 *hospital or medical service to any person regardless of the health*
35 *status of the person or any dependent of the person. Such health*
36 *status includes, without limitation:*

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

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

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

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



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

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

5 (b) *Require an insured, 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 insured or the covered dependent of such an insured who*
10 *does not have such a health status.*

11 3. *An insurer that offers or issues a contract for hospital or*
12 *medical service shall not adjust a premium, deductible, copay or*
13 *coinsurance for any insured on the basis of genetic information*
14 *relating to the insured or the covered dependent of the insured.*

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

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

22 **Sec. 58.5.** 1. *Except as otherwise provided in subsection 7,*
23 *an insurer that offers or issues a contract for hospital or medical*
24 *service shall include in the contract coverage for:*

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

- 27 (1) *Lawfully prescribed or ordered;*
28 (2) *Approved by the Food and Drug Administration;*
29 (3) *Listed in subsection 11; and*
30 (4) *Dispensed in accordance with section 11.3 of this act;*

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

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

35 (c) *Insertion of a device for contraception or removal of such a*
36 *device if the device was inserted while the insured was covered by*
37 *the same contract for hospital or medical service;*

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

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

42 (f) *Voluntary sterilization for women.*

43 2. *An insurer must ensure that the benefits required by*
44 *subsection 1 are made available to an insured through a provider*
45 *of health care who participates in the network plan of the insurer.*



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

6 4. *Except as otherwise provided in subsections 9, 10 and 12,*
7 *an insurer that offers or issues a contract for hospital or medical*
8 *service shall not:*

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

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

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

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

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

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

29 5. *Coverage pursuant to this section for the covered*
30 *dependent of an insured must be the same as for the insured.*

31 6. *Except as otherwise provided in subsection 7, a contract*
32 *for hospital or medical service subject to the provisions of this*
33 *chapter that is delivered, issued for delivery or renewed on or after*
34 *January 1, 2018, has the legal effect of including the coverage*
35 *required by subsection 1, and any provision of the contract or the*
36 *renewal which is in conflict with this section is void.*

37 7. *An insurer that offers or issues a contract for hospital or*
38 *medical service and which is affiliated with a religious*
39 *organization is not required to provide the coverage required by*
40 *subsection 1 if the insurer objects on religious grounds. Such an*
41 *insurer shall, before the issuance of a contract for hospital or*
42 *medical service and before the renewal of such a contract, provide*
43 *to the prospective insured written notice of the coverage that the*
44 *insurer refuses to provide pursuant to this subsection.*



1 8. *If an insurer refuses, pursuant to subsection 7, to provide*
2 *the coverage required by subsection 1, an employer may otherwise*
3 *provide for the coverage for the employees of the employer.*

4 9. *An insurer may require an insured to pay a higher*
5 *deductible, copayment or coinsurance for a drug for contraception*
6 *if the insured refuses to accept a therapeutic equivalent of the*
7 *drug.*

8 10. *For each of the 18 methods of contraception listed in*
9 *subsection 11 that have been approved by the Food and Drug*
10 *Administration, a contract for hospital or medical service must*
11 *include at least one drug or device for contraception within each*
12 *method for which no deductible, copayment or coinsurance may*
13 *be charged to the insured, but the insurer may charge a*
14 *deductible, copayment or coinsurance for any other drug or device*
15 *that provides the same method of contraception.*

16 11. *The following 18 methods of contraception must be*
17 *covered pursuant to this section:*

- 18 (a) *Voluntary sterilization for women;*
- 19 (b) *Surgical sterilization implants for women;*
- 20 (c) *Implantable rods;*
- 21 (d) *Copper-based intrauterine devices;*
- 22 (e) *Progesterone-based intrauterine devices;*
- 23 (f) *Injections;*
- 24 (g) *Combined estrogen- and progestin-based drugs;*
- 25 (h) *Progestin-based drugs;*
- 26 (i) *Extended- or continuous-regimen drugs;*
- 27 (j) *Estrogen- and progestin-based patches;*
- 28 (k) *Vaginal contraceptive rings;*
- 29 (l) *Diaphragms with spermicide;*
- 30 (m) *Sponges with spermicide;*
- 31 (n) *Cervical caps with spermicide;*
- 32 (o) *Female condoms;*
- 33 (p) *Spermicide;*
- 34 (q) *Combined estrogen- and progestin-based drugs for*
35 *emergency contraception or progestin-based drugs for emergency*
36 *contraception; and*
- 37 (r) *Antiprogestin-based drugs for emergency contraception.*

38 12. *Except as otherwise provided in this section and federal*
39 *law, an insurer may use medical management techniques,*
40 *including, without limitation, any available clinical evidence, to*
41 *determine the frequency of or treatment relating to any benefit*
42 *required by this section or the type of provider of health care to*
43 *use for such treatment.*

44 13. *An insurer shall not use medical management techniques*
45 *to require an insured to use a different method of contraception*



1 *other than the method prescribed or ordered by a provider of*
2 *health care.*

3 *14. An insurer must provide an accessible, transparent and*
4 *expedited process which is not unduly burdensome by which an*
5 *insured, or the authorized representative of the insured, may*
6 *request an exception relating to any medical management*
7 *technique used by the insurer to obtain any benefit required by*
8 *this section without a higher deductible, copayment or*
9 *coinsurance.*

10 *15. As used in this section:*

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

16 *(b) "Network plan" means a contract for hospital or medical*
17 *service offered by an insurer under which the financing and*
18 *delivery of medical care, including items and services paid for as*
19 *medical care, are provided, in whole or in part, through a defined*
20 *set of providers of health care under contract with the insurer. The*
21 *term does not include an arrangement for the financing of*
22 *premiums.*

23 *(c) "Provider of health care" has the meaning ascribed to it in*
24 *NRS 629.031.*

25 *(d) "Therapeutic equivalent" means a drug which:*

26 *(1) Contains an identical amount of the same active*
27 *ingredients in the same dosage and method of administration as*
28 *another drug;*

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

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

34 **Sec. 59. 1.** *An insurer that offers or issues a contract for*
35 *hospital or medical service shall include in the contract coverage*
36 *for:*

37 *(a) Counseling and support for breastfeeding, including*
38 *breastfeeding equipment, counseling and education during the*
39 *antenatal, perinatal and postpartum period for not more than 1*
40 *year;*

41 *(b) Screening and counseling for interpersonal and domestic*
42 *violence for women at least annually, with initial intervention*
43 *services consisting of education, strategies to reduce harm,*
44 *supportive services or a referral for any other appropriate*
45 *services;*



* A B 4 0 8 R 2 *

1 (c) Behavioral counseling concerning sexually transmitted
2 diseases from a provider of health care for sexually active women
3 who are at increased risk for such diseases;

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

7 (e) Screening for blood pressure abnormalities and diabetes,
8 including gestational diabetes, after at least 24 weeks of gestation
9 or as ordered by a provider of health care;

10 (f) Screening for cervical cancer at such intervals as are
11 recommended by the American College of Obstetricians and
12 Gynecologists or its successor organization;

13 (g) Such well-woman preventive visits as recommended by the
14 Health Resources and Services Administration, which must
15 include at least one such visit per year beginning at 14 years of
16 age;

17 (h) A daily dose of 0.4 to 0.8 milligrams of folic acid for
18 women who are capable of becoming pregnant;

19 (i) Aspirin for the prevention of preeclampsia for women who
20 are determined to be at a high risk of that condition after 12 weeks
21 of gestation;

22 (j) Medication to prevent breast cancer for women who are at
23 a high risk of developing breast cancer and have a low risk of
24 adverse side effects from the medication; and

25 (k) Prophylactic ocular tubal medication for the prevention of
26 gonococcal ophthalmia in newborns.

27 2. An insurer must ensure that the benefits required by
28 subsection 1 are made available to an insured through a provider
29 of health care who participates in the network plan of the insurer.

30 3. Except as otherwise provided in subsection 5, an insurer
31 that offers or issues a contract for hospital or medical service shall
32 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 contract for
36 hospital or medical service pursuant to subsection 1;

37 (b) Refuse to issue a contract for hospital or medical service or
38 cancel a contract for hospital or medical service solely because the
39 person applying for or covered by the contract uses or may use a
40 benefit provided in the contract for hospital or medical service
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 4. 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 5. Except as otherwise provided in this section and federal
17 law, an insurer may use medical management techniques,
18 including, without limitation, any available clinical evidence, to
19 determine the frequency of or treatment relating to any benefit
20 required by this section or the type of provider of health care to
21 use for such treatment.

22 6. As used in this section:

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

28 (b) "Network plan" means a contract for hospital or medical
29 service offered by an insurer under which the financing and
30 delivery of medical care, including items and services paid for as
31 medical care, are provided, in whole or in part, through a defined
32 set of providers of health care under contract with the insurer. The
33 term does not include an arrangement for the financing of
34 premiums.

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

37 **Sec. 60. 1.** An insurer that offers or issues a contract for
38 hospital or medical service shall include in the contract coverage
39 for:

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

42 (b) Statin preventive medication for persons between the ages
43 of 40 and 75 years who do not have a history of cardiovascular
44 disease, but who have:



- 1 (1) *One or more risk factors for cardiovascular disease;*
2 *and*
3 (2) *A calculated risk of at least 10 percent of acquiring*
4 *cardiovascular disease within the next 10 years;*
5 (c) *Aspirin for persons between the ages of 50 and 59 years*
6 *who have a calculated risk of at least 10 percent of acquiring*
7 *cardiovascular disease within the next 10 years and a life*
8 *expectancy of at least 10 years;*
9 (d) *Vitamin D supplements for persons who are at least 65*
10 *years of age to prevent the person from falling if the person:*
11 (1) *Does not reside in a medical facility or a facility for the*
12 *dependent; and*
13 (2) *Has an increased risk of falls;*
14 (e) *Tuberculosis screenings for latent tuberculosis infection in*
15 *persons with increased risk of contracting tuberculosis;*
16 (f) *Screening for high blood pressure to confirm a diagnosis*
17 *made outside a clinical setting before treatment is commenced;*
18 (g) *One abdominal aortic screening by ultrasound to detect*
19 *abdominal aortic aneurisms for men between the ages of 65 and*
20 *75 years who have smoked during their lifetimes;*
21 (h) *Screening for hepatitis B infection for persons who are at a*
22 *high risk of contracting hepatitis B;*
23 (i) *Screening for hepatitis C infection for persons who are at a*
24 *high risk of contracting hepatitis C;*
25 (j) *One screening for hepatitis C infection for persons born*
26 *between 1945 and 1965;*
27 (k) *Screening for osteoporosis for women who:*
28 (1) *Are 65 years of age and older; or*
29 (2) *Have a risk of fracturing a bone equal to or greater*
30 *than that of a woman who is 65 years of age without any*
31 *additional risk factors;*
32 (l) *Screening for alcohol misuse for persons 18 years of age or*
33 *older;*
34 (m) *If a person engages in risky or hazardous consumption of*
35 *alcohol, as determined by the screening described in paragraph*
36 *(l), behavioral counseling to reduce such behavior; and*
37 (n) *Screening for lung cancer using low-dose computed*
38 *tomography for persons between the ages of 55 and 80 years who:*
39 (1) *Have a smoking history of 30 pack-years;*
40 (2) *Smoke or have stopped smoking within the immediately*
41 *preceding 15 years; and*
42 (3) *Do not suffer from a health problem that substantially*
43 *limits the life expectancy of the person or the willingness of the*
44 *person to undergo curative surgery.*



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

4 3. *Except as otherwise provided in subsection 5, an insurer*
5 *that offers or issues a contract for hospital or medical service shall*
6 *not:*

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

11 (b) *Refuse to issue a contract for hospital or medical service or*
12 *cancel a contract for hospital or medical service solely because the*
13 *person applying for or covered by the contract uses or may use a*
14 *benefit provided in the contract for hospital or medical service*
15 *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 4. *A contract for hospital or medical service subject to the*
29 *provisions of this chapter that is delivered, issued for delivery or*
30 *renewed on or after January 1, 2018, has the legal effect of*
31 *including the coverage required by subsection 1, and any*
32 *provision of the contract or the renewal which is in conflict with*
33 *this section is void.*

34 5. *Except as otherwise provided in this section and federal*
35 *law, an insurer may use medical management techniques,*
36 *including, without limitation, any available clinical evidence, to*
37 *determine the frequency of or treatment relating to any benefit*
38 *required by this section or the type of provider of health care to*
39 *use for such treatment.*

40 6. *As used in this section:*

41 (a) *“Computed tomography” means the process of producing*
42 *sectional and three-dimensional images using external ionizing*
43 *radiation.*

44 (b) *“Facility for the dependent” has the meaning ascribed to it*
45 *in NRS 449.0045.*



* A B 4 0 8 R 2 *

1 (c) "Medical facility" has the meaning ascribed to it in
2 NRS 449.0151.

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

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

15 (f) "Pack-year" means the product of the number of packs of
16 cigarettes smoked per day and the number of years that the person
17 has smoked.

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

20 **Sec. 61. 1.** An insurer that offers or issues a contract for
21 hospital or medical service shall include in the contract coverage
22 for:

23 (a) Screening for depression;

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

28 (c) Screening, tests and counseling for such other health
29 conditions and diseases as recommended by the Health Resources
30 and Services Administration for persons less than 18 years of age;
31 and

32 (d) Assessments relating to height, weight, body mass index
33 and medical history for persons less than 18 years of age.

34 2. An insurer must ensure that the benefits required by
35 subsection 1 are made available to an insured through a provider
36 of health care who participates in the network plan of the insurer.

37 3. Except as otherwise provided in subsection 5, an insurer
38 that offers or issues a contract for hospital or medical service shall
39 not:

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

44 (b) Refuse to issue a contract for hospital or medical service or
45 cancel a contract for hospital or medical service solely because the



1 *person applying for or covered by the contract uses or may use a*
2 *benefit provided in the contract for hospital or medical service*
3 *pursuant to subsection 1;*

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

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

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

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

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

22 5. *Except as otherwise provided in this section and federal*
23 *law, an insurer may use medical management techniques,*
24 *including, without limitation, any available clinical evidence, to*
25 *determine the frequency of or treatment relating to any benefit*
26 *required by this section or the type of provider of health care to*
27 *use for such treatment.*

28 6. *As used in this section:*

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

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

41 (c) *“Provider of health care” has the meaning ascribed to it in*
42 *NRS 629.031.*

43 **Sec. 62. 1.** *Except as otherwise provided in this subsection,*
44 *a contract for hospital or medical service issued pursuant to this*
45 *chapter may not restrict benefits for any length of stay in a*



1 *hospital in connection with childbirth for a mother or newborn*
2 *infant covered by the contract 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 contract*
9 *for hospital or medical service may follow such guidelines in lieu*
10 *of following the length of stay set forth above. The provisions of*
11 *this subsection do not apply to any contract for hospital or medical*
12 *service in any case in which the decision to discharge the mother*
13 *or newborn infant before the expiration of the minimum length of*
14 *stay set forth in this subsection is made by the attending physician*
15 *of the mother or newborn infant.*

16 2. *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*
19 *her child.*

20 3. *A contract for hospital or medical service may not:*

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

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

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

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

36 (e) *Except as otherwise provided in subsection 4, restrict*
37 *benefits for any portion of a hospital stay required pursuant to the*
38 *provisions of this section in a manner that is less favorable than*
39 *the benefits provided for any preceding portion of that stay.*

40 4. *Nothing in this section:*

41 (a) *Prohibits a contract for hospital or medical service from*
42 *imposing a deductible, coinsurance or other mechanism for*
43 *sharing costs relating to benefits for hospital stays in connection*
44 *with childbirth for a mother or newborn child covered by the*
45 *contract, except that such coinsurance or other mechanism for*



1 *sharing costs for any portion of a hospital stay required by this*
2 *section may not be greater than the coinsurance or other*
3 *mechanism for any preceding portion of that stay.*

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

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

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

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

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

22 695B.1912 1. A ~~{policy of health insurance}~~ *contract for*
23 *hospital or medical service* issued by a hospital or medical service
24 corporation must provide coverage for benefits payable for expenses
25 incurred for:

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

28 ~~—(b) A baseline mammogram for women between the ages of 35~~
29 ~~and 40; and~~

30 ~~—(c) An annual~~ *A mammogram every 2 years, or annually if*
31 *ordered by a provider of health care, for women 40 years of age or*
32 *older* ~~{~~;

33 *(b) Counseling concerning genetic testing for breast cancer for*
34 *women who are at a high risk of developing breast cancer; and*

35 *(c) Counseling concerning breast cancer chemoprevention for*
36 *women who are at risk of developing breast cancer.*

37 2. ~~{A policy of health insurance issued by a hospital or medical~~
38 ~~service corporation must not require an insured to obtain prior~~
39 ~~authorization for any service provided pursuant to subsection 1.} *An*~~
40 *insurer must ensure that the benefits required by subsection 1 are*
41 *made available to an insured through a provider of health care*
42 *who participates in the network plan of the insurer.*

43 3. *Except as otherwise provided in subsection 5, an insurer*
44 *that offers or issues a contract for hospital or medical service shall*
45 *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 ~~October 1, 1989,~~ January 1, 2018,
25 has the legal effect of including the coverage required by subsection
26 1, and any provision of the ~~policy~~ contract or the renewal which is
27 in conflict with ~~subsection 1~~ this section is void.

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

34 6. As used in this section:

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

40 (b) "Network plan" means a contract for hospital or medical
41 service offered by an insurer under which the financing and
42 delivery of medical care, including items and services paid for as
43 medical care, are provided, in whole or in part, through a defined
44 set of providers of health care under contract with the insurer. The



1 *term does not include an arrangement for the financing of*
2 *premiums.*

3 (c) *“Provider of health care” has the meaning ascribed to it in*
4 *NRS 629.031.*

5 **Sec. 63.3.** NRS 695B.1916 is hereby amended to read as
6 follows:

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

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

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

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

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

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

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

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

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

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

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



1 4. The provisions of this section do not:

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

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

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

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

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

26 **Sec. 63.6.** NRS 695B.1918 is hereby amended to read as
27 follows:

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

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

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

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



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

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

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

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

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

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

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

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

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

44 695B.1925 1. A ~~policy of health insurance~~ *contract for*
45 *hospital or medical service* issued by a hospital or medical service



1 corporation must provide coverage for benefits payable for expenses
2 incurred for ~~administering~~ :

3 *(a) Deoxyribonucleic acid testing for high-risk strains of the*
4 *human papillomavirus every 3 years for women 30 years of age or*
5 *older; and*

6 *(b) Administering* the human papillomavirus vaccine ~~to women~~
7 ~~and girls~~ at such ages as recommended for vaccination by a
8 competent authority, including, without limitation, the Centers for
9 Disease Control and Prevention of the United States Department of
10 Health and Human Services, the Food and Drug Administration or
11 the manufacturer of the vaccine.

12 2. ~~[A policy of health insurance issued by a hospital or medical~~
13 ~~service corporation must not require an insured to obtain prior~~
14 ~~authorization for any service provided pursuant to subsection 1.]~~ *An*
15 *insurer must ensure that the benefits required by subsection 1 are*
16 *made available to an insured through a provider of health care*
17 *who participates in the network plan of the insurer.*

18 3. *Except as otherwise provided in subsection 5, an insurer*
19 *that offers or issues a contract for hospital or medical service shall*
20 *not:*

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

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

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

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

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

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

42 4. A ~~policy~~ *contract for hospital or medical service* subject
43 to the provisions of this chapter which is delivered, issued for
44 delivery or renewed on or after ~~July 1, 2007,~~ *January 1, 2018,* has
45 the legal effect of including the coverage required by subsection 1,



* A B 4 0 8 R 2 *

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

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

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

10 **6. As used in this section:**

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

15 **(b) "Medical management technique"** means a practice which
16 is used to control the cost or utilization of health care services or
17 prescription drug use. The term includes, without limitation, the
18 use of step therapy, prior authorization or categorizing drugs and
19 devices based on cost, type or method of administration.

20 **(c) "Network plan"** means a contract for hospital or medical
21 service offered by an insurer under which the financing and
22 delivery of medical care, including items and services paid for as
23 medical care, are provided, in whole or in part, through a defined
24 set of providers of health care under contract with the insurer. The
25 term does not include an arrangement for the financing of
26 premiums.

27 **(d) "Provider of health care"** has the meaning ascribed to it in
28 **NRS 629.031.**

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

30 695B.193 1. All individual and group service or indemnity-
31 type contracts issued by a nonprofit corporation which provide
32 coverage for a family member of the subscriber must as to such
33 coverage provide that the health benefits applicable for children are
34 payable with respect to:

35 (a) A newly born child of the subscriber from the moment of
36 birth;

37 (b) An adopted child from the date the adoption becomes
38 effective, if the child was not placed in the home before adoption;
39 and

40 (c) A child placed with the subscriber for the purpose of
41 adoption from the moment of placement as certified by the public or
42 private agency making the placement. The coverage of such a child
43 ceases if the adoption proceedings are terminated as certified by the
44 public or private agency making the placement.



* A B 4 0 8 R 2 *

1 ↳ The contracts must provide the coverage specified in subsection
2 3, and must not exclude premature births.

3 2. The contract may require that notification of:

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

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

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

7 ↳ and payments of the required fees, if any, must be furnished to
8 the nonprofit service corporation within 31 days after the date of
9 birth, adoption or placement for adoption in order to have the
10 coverage continue beyond the 31-day period.

11 3. The coverage for newly born and adopted children and
12 children placed for adoption consists of coverage of injury or
13 sickness, including the necessary care and treatment of medically
14 diagnosed congenital defects and birth abnormalities and, within the
15 limits of the policy, necessary transportation costs from place of
16 birth to the nearest specialized treatment center under major medical
17 policies, and with respect to basic policies to the extent such costs
18 are charged by the treatment center.

19 4. ~~¶A corporation shall not restrict the coverage of a dependent~~
20 ~~child adopted or placed for adoption solely because of a preexisting~~
21 ~~condition the child has at the time the child would otherwise become~~
22 ~~eligible for coverage pursuant to that contract. Any provision~~
23 ~~relating to an exclusion for a preexisting condition must comply~~
24 ~~with NRS 689C.190.~~

25 ~~—5.†~~ For covered services provided to the child, the corporation
26 shall reimburse noncontracted providers of health care to an amount
27 equal to the average amount of payment for which the organization
28 has agreements, contracts or arrangements for those covered
29 services.

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

32 695B.2555 A ~~¶converted contract must not exclude a~~
33 ~~preexisting condition not excluded by the group contract, but a~~
34 converted contract may provide that any hospital, surgical or
35 medical benefits payable under it may be reduced by the amount of
36 any benefits payable under the group contract after his or her
37 termination. A converted contract may provide that during the first
38 contract year the benefits payable under it, together with the benefits
39 payable under the group contract, must not exceed those that would
40 have been payable if the subscriber's coverage under the group
41 contract had remained in effect.



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

4 **Sec. 68. 1.** *A health maintenance organization shall offer
5 or issue a health care plan to any person regardless of the health
6 status of the person or any dependent of the person. Such health
7 status includes, without limitation:*

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

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

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

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

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

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

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

26 **3.** *A health maintenance organization that offers or issues a
27 health care plan shall not adjust a premium, deductible, copay or
28 coinsurance for any enrollee on the basis of genetic information
29 relating to the enrollee or the covered dependent of the enrollee.*

30 **Sec. 69. 1.** *A health maintenance organization that offers
31 or issues a health care plan which provides coverage for
32 dependent children shall continue to make such coverage
33 available for an adult child of an enrollee until such child reaches
34 26 years of age.*

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

38 **Sec. 69.5. 1.** *Except as otherwise provided in subsection 7,
39 a health maintenance organization that offers or issues a health
40 care plan shall include in the plan coverage for:*

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

43 *(1) Lawfully prescribed or ordered;*

44 *(2) Approved by the Food and Drug Administration;*

45 *(3) Listed in subsection 11; and*



* A B 4 0 8 R 2 *

- 1 ***(4) Dispensed in accordance with section 11.3 of this act;***
2 ***(b) Any type of device for contraception which is:***
3 ***(1) Lawfully prescribed or ordered;***
4 ***(2) Approved by the Food and Drug Administration; and***
5 ***(3) Listed in subsection 11;***
6 ***(c) Insertion of a device for contraception or removal of such a***
7 ***device if the device was inserted while the enrollee was covered by***
8 ***the same health care plan;***
9 ***(d) Education and counseling relating to the initiation of the***
10 ***use of contraception and any necessary follow-up after initiating***
11 ***such use;***
12 ***(e) Management of side effects relating to contraception; and***
13 ***(f) Voluntary sterilization for women.***
14 ***2. A health maintenance organization must ensure that the***
15 ***benefits required by subsection 1 are made available to an enrollee***
16 ***through a provider of health care who participates in the network***
17 ***plan of the health maintenance organization.***
18 ***3. If a covered therapeutic equivalent listed in subsection 1 is***
19 ***not available or a provider of health care deems a covered***
20 ***therapeutic equivalent to be medically inappropriate, an alternate***
21 ***therapeutic equivalent prescribed by a provider of health care***
22 ***must be covered by the health maintenance organization.***
23 ***4. Except as otherwise provided in subsections 9, 10 and 12, a***
24 ***health maintenance organization that offers or issues a health***
25 ***care plan shall not:***
26 ***(a) Require an enrollee to pay a higher deductible, any***
27 ***copayment or coinsurance or require a longer waiting period or***
28 ***other condition for coverage to obtain any benefit included in the***
29 ***plan pursuant to subsection 1;***
30 ***(b) Refuse to issue a health care plan or cancel a health care***
31 ***plan solely because the person applying for or covered by the plan***
32 ***uses or may use any such benefit;***
33 ***(c) Offer or pay any type of material inducement or financial***
34 ***incentive to an enrollee to discourage the enrollee from obtaining***
35 ***any such benefit;***
36 ***(d) Penalize a provider of health care who provides any such***
37 ***benefit to an enrollee, 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 ***enrollee; or***
43 ***(f) Impose any other restrictions or delays on the access of an***
44 ***enrollee to any such benefit.***



* A B 4 0 8 R 2 *

1 5. Coverage pursuant to this section for the covered
2 dependent of an enrollee must be the same as for the enrollee.

3 6. Except as otherwise provided in subsection 7, a health care
4 plan subject to the provisions of this chapter that is delivered,
5 issued for delivery or renewed on or after January 1, 2018, has the
6 legal effect of including the coverage required by subsection 1,
7 and any provision of the plan or the renewal which is in conflict
8 with this section is void.

9 7. A health maintenance organization that offers or issues a
10 health care plan and which is affiliated with a religious
11 organization is not required to provide the coverage required by
12 subsection 1 if the health maintenance organization objects on
13 religious grounds. Such a health maintenance organization shall,
14 before the issuance of a health care plan and before the renewal
15 of such a plan, provide to the prospective enrollee written notice of
16 the coverage that the health maintenance organization refuses to
17 provide pursuant to this subsection.

18 8. If a health maintenance organization refuses, pursuant to
19 subsection 7, to provide the coverage required by subsection 1, an
20 employer may otherwise provide for the coverage for the
21 employees of the employer.

22 9. A health maintenance organization may require an
23 enrollee to pay a higher deductible, copayment or coinsurance for
24 a drug for contraception if the enrollee refuses to accept a
25 therapeutic equivalent of the drug.

26 10. For each of the 18 methods of contraception listed in
27 subsection 11 that have been approved by the Food and Drug
28 Administration, a health care plan must include at least one drug
29 or device for contraception within each method for which no
30 deductible, copayment or coinsurance may be charged to the
31 enrollee, but the health maintenance organization may charge a
32 deductible, copayment or coinsurance for any other drug or device
33 that provides the same method of contraception.

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

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



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

11 12. *Except as otherwise provided in this section and federal*
12 *law, a health maintenance organization may use medical*
13 *management techniques, including, without limitation, any*
14 *available clinical evidence, to determine the frequency of or*
15 *treatment relating to any benefit required by this section or the*
16 *type of provider of health care to use for such treatment.*

17 13. *A health maintenance organization shall not use medical*
18 *management techniques to require an enrollee to use a different*
19 *method of contraception other than the method prescribed or*
20 *ordered by a provider of health care.*

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

28 15. *As used in this section:*

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

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

41 (c) *“Provider of health care” has the meaning ascribed to it in*
42 *NRS 629.031.*

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



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

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

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

9 **Sec. 70. 1.** *A health maintenance organization that offers*
10 *or issues a health care plan shall include in the plan coverage for:*

11 (a) *Counseling and support for breastfeeding, including*
12 *breastfeeding equipment, counseling and education during the*
13 *antenatal, perinatal and postpartum period for not more than 1*
14 *year;*

15 (b) *Screening and counseling for interpersonal and domestic*
16 *violence for women at least annually, with initial intervention*
17 *services consisting of education, strategies to reduce harm,*
18 *supportive services or a referral for any other appropriate*
19 *services;*

20 (c) *Behavioral counseling concerning sexually transmitted*
21 *diseases from a provider of health care for sexually active women*
22 *who are at increased risk for such diseases;*

23 (d) *Such prenatal screenings and tests as recommended by the*
24 *American College of Obstetricians and Gynecologists or its*
25 *successor organization;*

26 (e) *Screening for blood pressure abnormalities and diabetes,*
27 *including gestational diabetes, after at least 24 weeks of gestation*
28 *or as ordered by a provider of health care;*

29 (f) *Screening for cervical cancer at such intervals as are*
30 *recommended by the American College of Obstetricians and*
31 *Gynecologists or its successor organization;*

32 (g) *Such well-woman preventive visits as recommended by the*
33 *Health Resources and Services Administration, which must*
34 *include at least one such visit per year beginning at 14 years of*
35 *age;*

36 (h) *A daily dose of 0.4 to 0.8 milligrams of folic acid for*
37 *women who are capable of becoming pregnant;*

38 (i) *Aspirin for the prevention of preeclampsia for women who*
39 *are determined to be at a high risk of that condition after 12 weeks*
40 *of gestation;*

41 (j) *Medication to prevent breast cancer for women who are at*
42 *a high risk of developing breast cancer and have a low risk of*
43 *adverse side effects from the medication; and*

44 (k) *Prophylactic ocular tubal medication for the prevention of*
45 *gonococcal ophthalmia in newborns.*



* A B 4 0 8 R 2 *

1 2. *A health maintenance organization must ensure that the*
2 *benefits required by subsection 1 are made available to an enrollee*
3 *through a provider of health care who participates in the network*
4 *plan of the health maintenance organization.*

5 3. *Except as otherwise provided in subsection 5, a health*
6 *maintenance organization that offers or issues a health care plan*
7 *shall not:*

8 (a) *Require an enrollee 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 care*
11 *plan pursuant to subsection 1;*

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

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

19 (d) *Penalize a provider of health care who provides any such*
20 *benefit to an enrollee, 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 *enrollee; or*

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

28 4. *An evidence of coverage 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 evidence of*
32 *coverage or the renewal which is in conflict with this section is*
33 *void.*

34 5. *Except as otherwise provided in this section and federal*
35 *law, a health maintenance organization may use medical*
36 *management techniques, including, without limitation, any*
37 *available clinical evidence, to determine the frequency of or*
38 *treatment relating to any benefit required by this section or the*
39 *type of provider of health care to use for such treatment.*

40 6. *As used in this section:*

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



* A B 4 0 8 R 2 *

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

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

10 **Sec. 71. 1.** A health maintenance organization that offers
11 or issues a health care plan shall include in the plan coverage for:

12 (a) Counseling relating to the dietary needs of adults who are
13 at a high risk of chronic diseases;

14 (b) Statin preventive medication for persons between the ages
15 of 40 and 75 years who do not have a history of cardiovascular
16 disease, but who have:

17 (1) One or more risk factors for cardiovascular disease;
18 and

19 (2) A calculated risk of at least 10 percent of acquiring
20 cardiovascular disease within the next 10 years;

21 (c) Aspirin for persons between the ages of 50 and 59 years
22 who have a calculated risk of at least 10 percent of acquiring
23 cardiovascular disease within the next 10 years and a life
24 expectancy of at least 10 years;

25 (d) Vitamin D supplements for persons who are at least 65
26 years of age to prevent the person from falling if the person:

27 (1) Does not reside in a medical facility or a facility for the
28 dependent; and

29 (2) Has an increased risk of falls;

30 (e) Tuberculosis screenings for latent tuberculosis infection in
31 persons with increased risk of contracting tuberculosis;

32 (f) Screening for high blood pressure to confirm a diagnosis
33 made outside a clinical setting before treatment is commenced;

34 (g) One abdominal aortic screening by ultrasound to detect
35 abdominal aortic aneurisms for men between the ages of 65 and
36 75 years who have smoked during their lifetimes;

37 (h) Screening for hepatitis B infection for persons who are at a
38 high risk of contracting hepatitis B;

39 (i) Screening for hepatitis C infection for persons who are at a
40 high risk of contracting hepatitis C;

41 (j) One screening for hepatitis C infection for persons born
42 between 1945 and 1965;

43 (k) Screening for osteoporosis for women who:

44 (1) Are 65 years of age and older; or



1 (2) *Have a risk of fracturing a bone equal to or greater*
2 *than that of a woman who is 65 years of age without any*
3 *additional risk factors;*

4 (l) *Screening for alcohol misuse for persons 18 years of age or*
5 *older;*

6 (m) *If a person engages in risky or hazardous consumption of*
7 *alcohol, as determined by the screening described in paragraph*
8 *(l), behavioral counseling to reduce such behavior; and*

9 (n) *Screening for lung cancer using low-dose computed*
10 *tomography for persons between the ages of 55 and 80 years who:*

11 (1) *Have a smoking history of 30 pack-years;*

12 (2) *Smoke or have stopped smoking within the immediately*
13 *preceding 15 years; and*

14 (3) *Do not suffer from a health problem that substantially*
15 *limits the life expectancy of the person or the willingness of the*
16 *person to undergo curative surgery.*

17 2. *A health maintenance organization must ensure that the*
18 *benefits required by subsection 1 are made available to an enrollee*
19 *through a provider of health care who participates in the network*
20 *plan of the health maintenance organization.*

21 3. *Except as otherwise provided in subsection 5, a health*
22 *maintenance organization that offers or issues a health care plan*
23 *shall not:*

24 (a) *Require an enrollee 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 health care*
27 *plan pursuant to subsection 1;*

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

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

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

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

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

44 4. *An evidence of coverage subject to the provisions of this*
45 *chapter that is delivered, issued for delivery or renewed on or after*



1 *January 1, 2018, has the legal effect of including the coverage*
2 *required by subsection 1, and any provision of the evidence of*
3 *coverage or the renewal which is in conflict with this section is*
4 *void.*

5 *5. Except as otherwise provided in this section and federal*
6 *law, a health maintenance organization may use medical*
7 *management techniques, including, without limitation, any*
8 *available clinical evidence, to determine the frequency of or*
9 *treatment relating to any benefit required by this section or the*
10 *type of provider of health care to use for such treatment.*

11 *6. As used in this section:*

12 *(a) "Computed tomography" means the process of producing*
13 *sectional and three-dimensional images using external ionizing*
14 *radiation.*

15 *(b) "Facility for the dependent" has the meaning ascribed to it*
16 *in NRS 449.0045.*

17 *(c) "Medical facility" has the meaning ascribed to it in*
18 *NRS 449.0151.*

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

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

31 *(f) "Pack-year" means the product of the number of packs of*
32 *cigarettes smoked per day and the number of years that the person*
33 *has smoked.*

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

36 *Sec. 72. 1. A health maintenance organization that offers*
37 *or issues a health care plan shall include in the plan coverage for:*

38 *(a) Screening for depression;*

39 *(b) 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 *(c) Screening, tests and counseling for such other health*
44 *conditions and diseases as recommended by the Health Resources*



1 *and Services Administration for persons less than 18 years of age;*
2 *and*

3 *(d) Assessments relating to height, weight, body mass index*
4 *and medical history for persons less than 18 years of age.*

5 *2. A health maintenance organization must ensure that the*
6 *benefits required by subsection 1 are made available to an enrollee*
7 *through a provider of health care who participates in the network*
8 *plan of the health maintenance organization.*

9 *3. Except as otherwise provided in subsection 5, a health*
10 *maintenance organization that offers or issues a health care plan*
11 *shall not:*

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

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

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

23 *(d) Penalize a provider of health care who provides any such*
24 *benefit to an enrollee, 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 *enrollee; or*

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

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

38 *5. Except as otherwise provided in this section and federal*
39 *law, a health maintenance organization may use medical*
40 *management techniques, including, without limitation, any*
41 *available clinical evidence, to determine the frequency of or*
42 *treatment relating to any benefit required by this section or the*
43 *type of provider of health care to use for such treatment.*

44 *6. As used in this section:*



* A B 4 0 8 R 2 *

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

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

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

15 **Sec. 73. 1.** Except as otherwise provided in this subsection,
16 an evidence of coverage issued pursuant to this chapter may not
17 restrict benefits for any length of stay in a hospital in connection
18 with childbirth for a mother or newborn infant covered by the
19 health care plan to:

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

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

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

32 2. Nothing in this section requires a mother to:

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

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

36 3. A health care plan may not:

37 (a) Deny a mother or her newborn infant coverage or
38 continued coverage under the terms of the plan or coverage if the
39 sole purpose of the denial of coverage or continued coverage is to
40 avoid the requirements of this section;

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

44 (c) Penalize, or otherwise reduce or limit, the reimbursement
45 of an attending provider of health care because the attending



1 *provider of health care provided care to a mother or newborn*
2 *infant in accordance with the provisions of this section;*

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

7 *(e) Except as otherwise provided in subsection 4, restrict*
8 *benefits for any portion of a hospital stay required pursuant to the*
9 *provisions of this section in a manner that is less favorable than*
10 *the benefits provided for any preceding portion of that stay.*

11 *4. Nothing in this section:*

12 *(a) Prohibits a health care plan from imposing a deductible,*
13 *coinsurance or other mechanism for sharing costs relating to*
14 *benefits for hospital stays in connection with childbirth for a*
15 *mother or newborn child covered by the plan, except that such*
16 *coinsurance or other mechanism for sharing costs for any portion*
17 *of a hospital stay required by this section may not be greater than*
18 *the coinsurance or other mechanism for any preceding portion of*
19 *that stay.*

20 *(b) Prohibits an arrangement for payment between a health*
21 *maintenance organization and a provider of health care that uses*
22 *capitation or other financial incentives, if the arrangement is*
23 *designed to provide services efficiently and consistently in the best*
24 *interest of the mother and her newborn infant.*

25 *(c) Prevents a health maintenance organization from*
26 *negotiating with a provider of health care concerning the level and*
27 *type of reimbursement to be provided in accordance with this*
28 *section.*

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

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

37 **Sec. 74.** NRS 695C.050 is hereby amended to read as follows:

38 695C.050 1. Except as otherwise provided in this chapter or
39 in specific provisions of this title, the provisions of this title are not
40 applicable to any health maintenance organization granted a
41 certificate of authority under this chapter. This provision does not
42 apply to an insurer licensed and regulated pursuant to this title
43 except with respect to its activities as a health maintenance
44 organization authorized and regulated pursuant to this chapter.



* A B 4 0 8 R 2 *

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

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

8 4. The provisions of NRS 695C.110, 695C.125, 695C.1691,
9 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to
10 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734,
11 ~~695C.1735 to~~ 695C.1751, 695C.1755, ~~inclusive,~~ 695C.176 to
12 695C.200, inclusive, and 695C.265 do not apply to a health
13 maintenance organization that provides health care services through
14 managed care to recipients of Medicaid under the State Plan for
15 Medicaid or insurance pursuant to the Children's Health Insurance
16 Program pursuant to a contract with the Division of Health Care
17 Financing and Policy of the Department of Health and Human
18 Services. This subsection does not exempt a health maintenance
19 organization from any provision of this chapter for services
20 provided pursuant to any other contract.

21 5. The provisions of NRS 695C.1694, 695C.1695, 695C.1708,
22 695C.1731, 695C.17345 ~~and~~ , 695C.1735, 695C.1745 and
23 695C.1757 *and sections 68 to 73, inclusive, of this act* apply to a
24 health maintenance organization that provides health care services
25 through managed care to recipients of Medicaid under the State Plan
26 for Medicaid.

27 **Sec. 74.3.** NRS 695C.1694 is hereby amended to read as
28 follows:

29 695C.1694 1. ~~Except as otherwise provided in subsection 5,~~
30 ~~a~~ A health maintenance organization which offers or issues a health
31 care plan that provides coverage for prescription drugs or devices
32 shall include in the plan coverage for ~~f~~:

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

34 ~~(b) Any~~ any type of hormone replacement therapy ~~f~~:

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

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

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



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

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

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

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

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

23 4. The provisions of this section do not:

24 (a) Require a health maintenance organization to provide
25 coverage for fertility drugs.

26 (b) Prohibit a health maintenance organization from requiring an
27 enrollee to pay a deductible, copayment or coinsurance for the
28 coverage required by ~~paragraphs (a) and (b) of~~ subsection 1 that is
29 the same as the enrollee is required to pay for other prescription
30 drugs covered by the plan.

31 5. ~~A health maintenance organization which offers or issues a~~
32 ~~health care plan and which is affiliated with a religious organization~~
33 ~~is not required to provide the coverage required by paragraph (a) of~~
34 ~~subsection 1 if the health maintenance organization objects on~~
35 ~~religious grounds. The health maintenance organization shall, before~~
36 ~~the issuance of a health care plan and before renewal of enrollment~~
37 ~~in such a plan, provide to the group policyholder or prospective~~
38 ~~enrollee, as applicable, written notice of the coverage that the health~~
39 ~~maintenance organization refuses to provide pursuant to this~~
40 ~~subsection. The health maintenance organization shall provide~~
41 ~~notice to each enrollee, at the time the enrollee receives his or her~~
42 ~~evidence of coverage, that the health maintenance organization~~
43 ~~refused to provide coverage pursuant to this subsection.~~

44 ~~6. If a health maintenance organization refuses, pursuant to~~
45 ~~subsection 5, to provide the coverage required by paragraph (a) of~~



* A B 4 0 8 R 2 *

1 ~~subsection 1, an employer may otherwise provide for the coverage~~
2 ~~for the employees of the employer.~~

3 ~~—7.1~~ As used in this section, “provider of health care” has the
4 meaning ascribed to it in NRS 629.031.

5 **Sec. 74.6.** NRS 695C.1695 is hereby amended to read as
6 follows:

7 695C.1695 1. ~~{Except as otherwise provided in subsection 5,~~
8 ~~a} A health maintenance organization that offers or issues a health
9 care plan which provides coverage for outpatient care shall include
10 in the plan coverage for any health care service related to
11 ~~{contraceptives or}~~ hormone replacement therapy.~~

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

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

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

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

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

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

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

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



* A B 4 0 8 R 2 *

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

15 ~~—6. If a health maintenance organization refuses, pursuant to~~
16 ~~subsection 5, to provide the coverage required by paragraph (a) of~~
17 ~~subsection 1, an employer may otherwise provide for the coverage~~
18 ~~for the employees of the employer.~~

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

21 **Sec. 75.** NRS 695C.173 is hereby amended to read as follows:

22 695C.173 1. All individual and group health care plans which
23 provide coverage for a family member of the enrollee must as to
24 such coverage provide that the health care services applicable for
25 children are payable with respect to:

26 (a) A newly born child of the enrollee from the moment of birth;

27 (b) An adopted child from the date the adoption becomes
28 effective, if the child was not placed in the home before adoption;
29 and

30 (c) A child placed with the enrollee for the purpose of adoption
31 from the moment of placement as certified by the public or private
32 agency making the placement. The coverage of such a child ceases
33 if the adoption proceedings are terminated as certified by the public
34 or private agency making the placement.

35 ➔ The plans must provide the coverage specified in subsection 3,
36 and must not exclude premature births.

37 2. The evidence of coverage may require that notification of:

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

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

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

41 ➔ and payments of the required charge, if any, must be furnished to
42 the health maintenance organization within 31 days after the date of
43 birth, adoption or placement for adoption in order to have the
44 coverage continue beyond the 31-day period.



1 3. The coverage for newly born and adopted children and
2 children placed for adoption consists of preventive health care
3 services as well as coverage of injury or sickness, including the
4 necessary care and treatment of medically diagnosed congenital
5 defects and birth abnormalities and, within the limits of the policy,
6 necessary transportation costs from place of birth to the nearest
7 specialized treatment center under major medical policies, and with
8 respect to basic policies to the extent such costs are charged by the
9 treatment center.

10 4. ~~[A health maintenance organization shall not restrict the~~
11 ~~coverage of a dependent child adopted or placed for adoption solely~~
12 ~~because of a preexisting condition the child has at the time the child~~
13 ~~would otherwise become eligible for coverage pursuant to that plan.~~
14 ~~Any provision relating to an exclusion for a preexisting condition~~
15 ~~must comply with NRS 689B.500 or 689C.190, as appropriate.~~

16 ~~—5.]~~ For covered services provided to the child, the health
17 maintenance organization shall reimburse noncontracted providers
18 of health care to an amount equal to the average amount of payment
19 for which the organization has agreements, contracts or
20 arrangements for those covered services.

21 **Sec. 76.** NRS 695C.1735 is hereby amended to read as
22 follows:

23 695C.1735 1. A health maintenance *organization which*
24 *offers or issues a health care* plan must provide coverage for
25 benefits payable for expenses incurred for:

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

28 ~~—(b) A baseline mammogram for women between the ages of 35~~
29 ~~and 40; and~~

30 ~~—(c) An annual.]~~ *A mammogram every 2 years, or annually if*
31 *ordered by a provider of health care, for women 40 years of age or*
32 *older [H];*

33 *(b) Counseling concerning genetic testing for breast cancer for*
34 *women who are at a high risk of developing breast cancer; and*

35 *(c) Counseling concerning breast cancer chemoprevention for*
36 *women who are at risk of developing breast cancer.*

37 2. A health maintenance ~~[plan must not require an insured to~~
38 ~~obtain prior authorization for any service provided pursuant to~~
39 ~~subsection 1.]~~ *organization must ensure that the benefits required*
40 *by subsection 1 are made available to an enrollee through a*
41 *provider of health care who participates in the network plan of the*
42 *health maintenance organization.*

43 3. *Except as otherwise provided in subsection 5, a health*
44 *maintenance organization that offers or issues a health care plan*
45 *shall not:*



1 (a) *Require an enrollee 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 health care*
4 *plan pursuant to subsection 1;*

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

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

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

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

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

21 4. ~~{A policy}~~ *An evidence of coverage* subject to the provisions
22 of this chapter which is delivered, issued for delivery or renewed on
23 or after ~~{October 1, 1989,}~~ *January 1, 2018*, has the legal effect of
24 including the coverage required by subsection 1, and any provision
25 of the ~~{policy}~~ *evidence of coverage* or the renewal which is in
26 conflict with ~~{subsection 1}~~ *this section* is void.

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

33 6. *As used in this section:*

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

39 (b) *“Network plan” means a health care plan offered by a*
40 *health maintenance organization under which the financing and*
41 *delivery of medical care, including items and services paid for as*
42 *medical care, are provided, in whole or in part, through a defined*
43 *set of providers of health care under contract with the health*
44 *maintenance organization. The term does not include an*
45 *arrangement for the financing of premiums.*



1 (c) "Provider of health care" has the meaning ascribed to it in
2 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 every 3 years for women 30 years of age or*
10 *older; and*

11 (b) *Administering* the human papillomavirus vaccine as
12 recommended for vaccination by a competent authority, including,
13 without limitation, the Centers for Disease Control and Prevention
14 of the United States Department of Health and Human Services, the
15 Food and Drug Administration or the manufacturer of the vaccine.

16 2. A health ~~care plan of a health maintenance organization~~
17 ~~must not require an insured to obtain prior authorization for any~~
18 ~~service provided pursuant to subsection 1.]~~ *maintenance*
19 *organization must ensure that the benefits required by subsection*
20 *1 are made available to an enrollee through a provider of health*
21 *care who participates in the network plan of the health*
22 *maintenance organization.*

23 3. *Except as otherwise provided in subsection 5, a health*
24 *maintenance organization that offers or issues a health care plan*
25 *shall not:*

26 (a) *Require an enrollee 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 care*
29 *plan pursuant to subsection 1;*

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

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

37 (d) *Penalize a provider of health care who provides any such*
38 *benefit to an enrollee, 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 *enrollee; or*

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



1 4. Any evidence of coverage subject to the provisions of this
2 chapter which is delivered, issued for delivery or renewed on or
3 after ~~July 1, 2007,~~ **January 1, 2018**, has the legal effect of
4 including the coverage required by subsection 1, and any provision
5 of the evidence of coverage or the renewal which is in conflict with
6 ~~subsection 1~~ **this section** is void.

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

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

14 **6. As used in this section:**

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

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

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

31 (d) **"Provider of health care"** has the meaning ascribed to it in
32 **NRS 629.031.**

33 **Sec. 78.** NRS 695C.330 is hereby amended to read as follows:

34 695C.330 1. The Commissioner may suspend or revoke any
35 certificate of authority issued to a health maintenance organization
36 pursuant to the provisions of this chapter if the Commissioner finds
37 that any of the following conditions exist:

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



1 (b) The health maintenance organization issues evidence of
2 coverage or uses a schedule of charges for health care services
3 which do not comply with the requirements of NRS 695C.1691 to
4 695C.200, inclusive, *and sections 68 to 73, inclusive, of this act* or
5 695C.207;

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

8 (d) The Commissioner certifies that the health maintenance
9 organization:

10 (1) Does not meet the requirements of subsection 1 of NRS
11 695C.080; or

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

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

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

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

23 (1) Resolving complaints in a manner reasonably to dispose
24 of valid complaints; and

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

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

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

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

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

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

39 3. If the certificate of authority of a health maintenance
40 organization is suspended, the health maintenance organization shall
41 not, during the period of that suspension, enroll any additional
42 groups or new individual contracts, unless those groups or persons
43 were contracted for before the date of suspension.

44 4. If the certificate of authority of a health maintenance
45 organization is revoked, the organization shall proceed, immediately



1 following the effective date of the order of revocation, to wind up its
2 affairs and shall conduct no further business except as may be
3 essential to the orderly conclusion of the affairs of the organization.
4 It shall engage in no further advertising or solicitation of any kind.
5 The Commissioner may, by written order, permit such further
6 operation of the organization as the Commissioner may find to be in
7 the best interest of enrollees to the end that enrollees are afforded
8 the greatest practical opportunity to obtain continuing coverage for
9 health care.

10 **Sec. 79.** Chapter 695F of NRS is hereby amended by adding
11 thereto the provisions set forth as sections 80 and 81 of this act.

12 **Sec. 80. 1.** *A prepaid limited health service organization*
13 *shall offer or issue evidence of coverage to any person regardless*
14 *of the health status of the person or any dependent of the person.*
15 *Such health status includes, without limitation:*

- 16 (a) *Any preexisting medical condition of the person, including,*
17 *without limitation, any physical or mental illness;*
18 (b) *The claims history of the person, including, without*
19 *limitation, any prior health care services received by the person;*
20 (c) *Genetic information relating to the person; and*
21 (d) *Any increased risk for illness, injury or any other medical*
22 *condition of the person, including, without limitation, any medical*
23 *condition caused by an act of domestic violence.*

24 **2.** *A prepaid limited health service organization that offers or*
25 *issues evidence of coverage shall not:*

- 26 (a) *Deny, limit or exclude a benefit based on the health status*
27 *of an enrollee; or*
28 (b) *Require an enrollee, as a condition of enrollment or*
29 *renewal, to pay a premium, deductible, copay or coinsurance*
30 *based on his or her health status which is greater than the*
31 *premium, deductible, copay or coinsurance charged to a similarly*
32 *situated enrollee or the covered dependent of such an enrollee who*
33 *does not have such a health status.*

34 **3.** *A prepaid limited health service organization that offers or*
35 *issues evidence of coverage shall not adjust a premium,*
36 *deductible, copay or coinsurance for any enrollee on the basis of*
37 *genetic information relating to the enrollee or the covered*
38 *dependent of the enrollee.*

39 **Sec. 81. 1.** *A prepaid limited health service organization*
40 *that offers or issues evidence of coverage which provides coverage*
41 *for dependent children shall continue to make such coverage*
42 *available for an adult child of an enrollee until such child reaches*
43 *26 years of age.*



1 2. *Nothing in this section shall be construed as requiring a*
2 *prepaid limited health service organization to make coverage*
3 *available for a dependent of an adult child of an enrollee.*

4 **Sec. 82.** Chapter 695G of NRS is hereby amended by adding
5 thereto the provisions set forth as sections 83 to 89, inclusive, of this
6 act.

7 **Sec. 83. 1.** *A managed care organization shall offer or*
8 *issue a health care plan to any person regardless of the health*
9 *status of the person or any dependent of the person. Such health*
10 *status includes, without limitation:*

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

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

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

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

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

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

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

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

33 **Sec. 84. 1.** *A managed care organization that offers or*
34 *issues a health care plan which provides coverage for dependent*
35 *children shall continue to make such coverage available for an*
36 *adult child of an insured until such child reaches 26 years of age.*

37 2. *Nothing in this section shall be construed as requiring a*
38 *managed care organization to make coverage available for a*
39 *dependent of an adult child of an insured.*

40 **Sec. 84.5. 1.** *Except as otherwise provided in subsection 7,*
41 *a managed care organization that offers or issues a health care*
42 *plan shall include in the plan coverage for:*

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

45 (1) *Lawfully prescribed or ordered;*



* A B 4 0 8 R 2 *

- 1 (2) *Approved by the Food and Drug Administration;*
2 (3) *Listed in subsection 10; and*
3 (4) *Dispensed in accordance with section 11.3 of this act;*
4 (b) *Any type of device for contraception which is:*
5 (1) *Lawfully prescribed or ordered;*
6 (2) *Approved by the Food and Drug Administration; and*
7 (3) *Listed in subsection 10;*
8 (c) *Insertion of a device for contraception or removal of such a*
9 *device if the device was inserted while the insured was covered by*
10 *the same health care plan;*
11 (d) *Education and counseling relating to the initiation of the*
12 *use of contraception and any necessary follow-up after initiating*
13 *such use;*
14 (e) *Management of side effects relating to contraception; and*
15 (f) *Voluntary sterilization for women.*
16 2. *A managed care organization must ensure that the benefits*
17 *required by subsection 1 are made available to an insured through*
18 *a provider of health care who participates in the network plan of*
19 *the managed care organization.*
20 3. *If a covered therapeutic equivalent listed in subsection 1 is*
21 *not available or a provider of health care deems a covered*
22 *therapeutic equivalent to be medically inappropriate, an alternate*
23 *therapeutic equivalent prescribed by a provider of health care*
24 *must be covered by the managed care organization.*
25 4. *Except as otherwise provided in subsections 8, 9 and 11, a*
26 *managed care organization that offers or issues a health care plan*
27 *shall not:*
28 (a) *Require an insured to pay a higher deductible, any*
29 *copayment or coinsurance or require a longer waiting period or*
30 *other condition for coverage to obtain any benefit included in the*
31 *plan pursuant to subsection 1;*
32 (b) *Refuse to issue a health care plan or cancel a health care*
33 *plan solely because the person applying for or covered by the plan*
34 *uses or may use any such benefit;*
35 (c) *Offer or pay any type of material inducement or financial*
36 *incentive to an insured to discourage the insured from obtaining*
37 *any such benefit;*
38 (d) *Penalize a provider of health care who provides any such*
39 *benefit to an insured, including, without limitation, reducing the*
40 *reimbursement of the provider of health care;*
41 (e) *Offer or pay any type of material inducement, bonus or*
42 *other financial incentive to a provider of health care to deny,*
43 *reduce, withhold, limit or delay access to any such benefit to an*
44 *insured; or*



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

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

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

11 7. *A managed care organization that offers or issues a health*
12 *care plan and which is affiliated with a religious organization is*
13 *not required to provide the coverage required by subsection 1 if*
14 *the managed care organization objects on religious grounds. Such*
15 *a managed care organization shall, before the issuance of a health*
16 *care plan and before the renewal of such a plan, provide to the*
17 *prospective insured written notice of the coverage that the*
18 *managed care organization refuses to provide pursuant to this*
19 *subsection.*

20 8. *A managed care organization may require an insured to*
21 *pay a higher deductible, copayment or coinsurance for a drug for*
22 *contraception if the insured refuses to accept a therapeutic*
23 *equivalent of the drug.*

24 9. *For each of the 18 methods of contraception listed in*
25 *subsection 10 that have been approved by the Food and Drug*
26 *Administration, a health care plan must include at least one drug*
27 *or device for contraception within each method for which no*
28 *deductible, copayment or coinsurance may be charged to the*
29 *insured, but the managed care organization may charge a*
30 *deductible, copayment or coinsurance for any other drug or device*
31 *that provides the same method of contraception.*

32 10. *The following 18 methods of contraception must be*
33 *covered pursuant to this section:*

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



1 (m) Sponges with spermicide;

2 (n) Cervical caps with spermicide;

3 (o) Female condoms;

4 (p) Spermicide;

5 (q) Combined estrogen- and progestin-based drugs for
6 emergency contraception or progestin-based drugs for emergency
7 contraception; and

8 (r) Antiprogestin-based drugs for emergency contraception.

9 11. Except as otherwise provided in this section and federal
10 law, a managed care organization may use medical management
11 techniques, including, without limitation, any available clinical
12 evidence, to determine the frequency of or treatment relating to
13 any benefit required by this section or the type of provider of
14 health care to use for such treatment.

15 12. A managed care organization shall not use medical
16 management techniques to require an insured to use a different
17 method of contraception other than the method prescribed or
18 ordered by a provider of health care.

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

26 14. As used in this section:

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

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

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

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

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



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

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

6 **Sec. 85. 1.** *A managed care organization that offers or*
7 *issues a health care plan shall include in the plan coverage for:*

8 (a) *Counseling and support for breastfeeding, including*
9 *breastfeeding equipment, counseling and education during the*
10 *antenatal, perinatal and postpartum period for not more than 1*
11 *year;*

12 (b) *Screening and counseling for interpersonal and domestic*
13 *violence for women at least annually, with initial intervention*
14 *services consisting of education, strategies to reduce harm,*
15 *supportive services or a referral for any other appropriate*
16 *services;*

17 (c) *Behavioral counseling concerning sexually transmitted*
18 *diseases from a provider of health care for sexually active women*
19 *who are at increased risk for such diseases;*

20 (d) *Such prenatal screenings and tests as recommended by the*
21 *American College of Obstetricians and Gynecologists or its*
22 *successor organization;*

23 (e) *Screening for blood pressure abnormalities and diabetes,*
24 *including gestational diabetes, after at least 24 weeks of gestation*
25 *or as ordered by a provider of health care;*

26 (f) *Screening for cervical cancer at such intervals as are*
27 *recommended by the American College of Obstetricians and*
28 *Gynecologists or its successor organization;*

29 (g) *Such well-woman preventive visits as recommended by the*
30 *Health Resources and Services Administration, which must*
31 *include at least one such visit per year beginning at 14 years of*
32 *age;*

33 (h) *A daily dose of 0.4 to 0.8 milligrams of folic acid for*
34 *women who are capable of becoming pregnant;*

35 (i) *Aspirin for the prevention of preeclampsia for women who*
36 *are determined to be at a high risk of that condition after 12 weeks*
37 *of gestation;*

38 (j) *Medication to prevent breast cancer for women who are at*
39 *a high risk of developing breast cancer and have a low risk of*
40 *adverse side effects from the medication; and*

41 (k) *Prophylactic ocular tubal medication for the prevention of*
42 *gonococcal ophthalmia in newborns.*

43 **2.** *A managed care organization must ensure that the benefits*
44 *required by subsection 1 are made available to an insured through*



* A B 4 0 8 R 2 *

1 *a provider of health care who participates in the network plan of*
2 *the managed care organization.*

3 3. *Except as otherwise provided in subsection 5, a managed*
4 *care organization that offers or issues a health care plan shall not:*

5 (a) *Require an insured 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 insured to discourage the insured from obtaining*
15 *any such benefit;*

16 (d) *Penalize a provider of health care who provides any such*
17 *benefit to an insured 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 *insured; or*

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

25 4. *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 5. *Except as otherwise provided in this section and federal*
32 *law, a managed care organization may use medical management*
33 *techniques, including, without limitation, any available clinical*
34 *evidence, to determine the frequency of or treatment relating to*
35 *any benefit required by this section or the type of provider of*
36 *health care to use for such treatment.*

37 6. *As used in this section:*

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

43 (b) *“Network plan” means a health care plan offered by a*
44 *managed care organization under which the financing and*
45 *delivery of medical care, including items and services paid for as*



1 *medical care, are provided, in whole or in part, through a defined*
2 *set of providers of health care under contract with the managed*
3 *care organization. The term does not include an arrangement for*
4 *the financing of premiums.*

5 (c) *“Provider of health care” has the meaning ascribed to it in*
6 *NRS 629.031.*

7 **Sec. 86. 1.** *A managed care organization that offers or*
8 *issues a health care plan shall include in the plan coverage for:*

9 (a) *Counseling relating to the dietary needs of adults who are*
10 *at a high risk of chronic diseases;*

11 (b) *Statin preventive medication for persons between the ages*
12 *of 40 and 75 years who do not have a history of cardiovascular*
13 *disease, but who have:*

14 (1) *One or more risk factors for cardiovascular disease;*
15 *and*

16 (2) *A calculated risk of at least 10 percent of acquiring*
17 *cardiovascular disease within the next 10 years;*

18 (c) *Aspirin for persons between the ages of 50 and 59 years*
19 *who have a calculated risk of at least 10 percent of acquiring*
20 *cardiovascular disease within the next 10 years and a life*
21 *expectancy of at least 10 years;*

22 (d) *Vitamin D supplements for persons who are at least 65*
23 *years of age to prevent the person from falling if the person:*

24 (1) *Does not reside in a medical facility or a facility for the*
25 *dependent; and*

26 (2) *Has an increased risk of falls;*

27 (e) *Tuberculosis screenings for latent tuberculosis infection in*
28 *persons with increased risk of contracting tuberculosis;*

29 (f) *Screening for high blood pressure to confirm a diagnosis*
30 *made outside a clinical setting before treatment is commenced;*

31 (g) *One abdominal aortic screening by ultrasound to detect*
32 *abdominal aortic aneurisms for men between the ages of 65 and*
33 *75 years who have smoked during their lifetimes;*

34 (h) *Screening for hepatitis B infection for persons who are at a*
35 *high risk of contracting hepatitis B;*

36 (i) *Screening for hepatitis C infection for persons who are at a*
37 *high risk of contracting hepatitis C;*

38 (j) *One screening for hepatitis C infection for persons born*
39 *between 1945 and 1965;*

40 (k) *Screening for osteoporosis for women who:*

41 (1) *Are 65 years of age and older; or*

42 (2) *Have a risk of fracturing a bone equal to or greater*
43 *than that of a woman who is 65 years of age without any*
44 *additional risk factors;*



1 *(l) Screening for alcohol misuse for persons 18 years of age or*
2 *older;*

3 *(m) If a person engages in risky or hazardous consumption of*
4 *alcohol, as determined by the screening described in paragraph*
5 *(l), behavioral counseling to reduce such behavior; and*

6 *(n) Screening for lung cancer using low-dose computed*
7 *tomography for persons between the ages of 55 and 80 years who:*

8 *(1) Have a smoking history of 30 pack-years;*

9 *(2) Smoke or have stopped smoking within the immediately*
10 *preceding 15 years; and*

11 *(3) Do not suffer from a health problem that substantially*
12 *limits the life expectancy of the person or the willingness of the*
13 *person to undergo curative surgery.*

14 *2. A managed care organization must ensure that the benefits*
15 *required by subsection 1 are made available to an insured through*
16 *a provider of health care who participates in the network plan of*
17 *the managed care organization.*

18 *3. Except as otherwise provided in subsection 5, a managed*
19 *care organization that offers or issues a health care plan shall not:*

20 *(a) Require an insured 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 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. An evidence of coverage subject to the provisions of this*
41 *chapter that is delivered, issued for delivery or renewed on or after*
42 *January 1, 2018, has the legal effect of including the coverage*
43 *required by subsection 1, and any provision of the evidence of*
44 *coverage or the renewal which is in conflict with this section is*
45 *void.*



* A B 4 0 8 R 2 *

1 5. *Except as otherwise provided in this section and federal*
2 *law, a managed care organization may use medical management*
3 *techniques, including, without limitation, any available clinical*
4 *evidence, to determine the frequency of or treatment relating to*
5 *any benefit required by this section or the type of provider of*
6 *health care to use for such treatment.*

7 6. *As used in this section:*

8 (a) *“Computed tomography” means the process of producing*
9 *sectional and three-dimensional images using external ionizing*
10 *radiation.*

11 (b) *“Facility for the dependent” has the meaning ascribed to it*
12 *in NRS 449.0045.*

13 (c) *“Medical facility” has the meaning ascribed to it in*
14 *NRS 449.0151.*

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

20 (e) *“Network plan” means a health care plan offered by a*
21 *managed care organization under which the financing and*
22 *delivery of medical care, including items and services paid for as*
23 *medical care, are provided, in whole or in part, through a defined*
24 *set of providers of health care under contract with the managed*
25 *care organization. The term does not include an arrangement for*
26 *the financing of premiums.*

27 (f) *“Pack-year” means the product of the number of packs of*
28 *cigarettes smoked per day and the number of years that the person*
29 *has smoked.*

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

32 **Sec. 87. 1.** *A managed care organization that offers or*
33 *issues a health care plan shall include in the plan coverage for:*

34 (a) *Screening for depression;*

35 (b) *All vaccinations recommended by the Advisory Committee*
36 *on Immunization Practices of the Centers for Disease Control and*
37 *Prevention of the United States Department of Health and Human*
38 *Services or its successor organization;*

39 (c) *Screening, tests and counseling for such other health*
40 *conditions and diseases as recommended by the Health Resources*
41 *and Services Administration for persons less than 18 years of age;*
42 *and*

43 (d) *Assessments relating to height, weight, body mass index*
44 *and medical history for persons less than 18 years of age.*



1 2. *A managed care organization must ensure that the benefits*
2 *required by subsection 1 are made available to an insured through*
3 *a provider of health care who participates in the network plan of*
4 *the managed care organization.*

5 3. *Except as otherwise provided in subsection 5, a managed*
6 *care organization that offers or issues a health care plan shall not:*

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

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

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

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

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

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

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

33 5. *Except as otherwise provided in this section and federal*
34 *law, a managed care organization may use medical management*
35 *techniques, including, without limitation, any available clinical*
36 *evidence, to determine the frequency of or treatment relating to*
37 *any benefit required by this section or the type of provider of*
38 *health care to use for such treatment.*

39 6. *As used in this section:*

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



* A B 4 0 8 R 2 *

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

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

10 **Sec. 88. 1.** Except as otherwise provided in this subsection,
11 an evidence of coverage issued pursuant to this chapter may not
12 restrict benefits for any length of stay in a hospital in connection
13 with childbirth for a mother or newborn infant covered by the
14 health care plan to:

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

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

17 ↪ If a different length of stay is provided in the guidelines
18 established by the American College of Obstetricians and
19 Gynecologists, or its successor organization, and the American
20 Academy of Pediatrics, or its successor organization, the health
21 care plan may follow such guidelines in lieu of following the
22 length of stay set forth above. The provisions of this subsection do
23 not apply to any health care plan in any case in which the decision
24 to discharge the mother or newborn infant before the expiration of
25 the minimum length of stay set forth in this subsection is made by
26 the attending physician of the mother or newborn infant.

27 2. Nothing in this section requires a mother to:

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

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

31 3. A health care plan may not:

32 (a) Deny a mother or her newborn infant coverage or
33 continued coverage under the terms of the plan or coverage if the
34 sole purpose of the denial of coverage or continued coverage is to
35 avoid the requirements of this section;

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

39 (c) Penalize, or otherwise reduce or limit, the reimbursement
40 of an attending provider of health care because the attending
41 provider of health care provided care to a mother or newborn
42 infant in accordance with the provisions of this section;

43 (d) Provide incentives of any kind to an attending physician to
44 induce the attending physician to provide care to a mother or



1 *newborn infant in a manner that is inconsistent with the*
2 *provisions of this section; or*

3 *(e) Except as otherwise provided in subsection 4, restrict*
4 *benefits for any portion of a hospital stay required pursuant to the*
5 *provisions of this section in a manner that is less favorable than*
6 *the benefits provided for any preceding portion of that stay.*

7 **4. Nothing in this section:**

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

16 *(b) Prohibits an arrangement for payment between a managed*
17 *care organization and a provider of health care that uses*
18 *capitation or other financial incentives, if the arrangement is*
19 *designed to provide services efficiently and consistently in the best*
20 *interest of the mother and her newborn infant.*

21 *(c) Prevents a managed care organization from negotiating*
22 *with a provider of health care concerning the level and type of*
23 *reimbursement to be provided in accordance with this section.*

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

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

32 **Sec. 89. 1. A managed care organization which offers or**
33 **issues a health care plan must provide coverage for benefits**
34 **payable for expenses incurred for:**

35 *(a) A mammogram every 2 years, or annually if ordered by a*
36 *provider of health care, for women 40 years of age or older;*

37 *(b) Counseling concerning genetic testing for breast cancer for*
38 *women who are at a high risk of developing breast cancer; and*

39 *(c) Counseling concerning breast cancer chemoprevention for*
40 *women who are at risk of developing breast cancer.*

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



* A B 4 0 8 R 2 *

1 3. *Except as otherwise provided in subsection 5, a managed*
2 *care organization that offers or issues a health care plan 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 care*
6 *plan pursuant to subsection 1;*

7 (b) *Refuse to issue a health care plan or cancel a health care*
8 *plan solely because the person applying for or covered by the plan*
9 *uses or may use a benefit provided in the health care plan*
10 *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. *An evidence of coverage subject to the provisions of this*
24 *chapter which is delivered, issued for delivery or renewed on or*
25 *after January 1, 2018, has the legal effect of including the*
26 *coverage required by subsection 1, and any provision of the*
27 *evidence of coverage or the renewal which is in conflict with this*
28 *section is void.*

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

35 6. *As used in this section:*

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

41 (b) *“Network plan” means a health care plan offered by a*
42 *managed care organization under which the financing and*
43 *delivery of medical care, including items and services paid for as*
44 *medical care, are provided, in whole or in part, through a defined*
45 *set of providers of health care under contract with the managed*



1 *care organization. The term does not include an arrangement for*
2 *the financing of premiums.*

3 (c) *“Provider of health care” has the meaning ascribed to it in*
4 *NRS 629.031.*

5 **Sec. 90.** NRS 695G.171 is hereby amended to read as follows:

6 695G.171 1. A health care plan issued by a managed care
7 organization must provide coverage for benefits payable for
8 expenses incurred for ~~administering~~ :

9 (a) *Deoxyribonucleic acid testing for high-risk strains of the*
10 *human papillomavirus every 3 years for women 30 years of age or*
11 *older; and*

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

17 2. ~~{A health care plan must not require an insured to~~
18 ~~obtain prior authorization for any service provided pursuant to~~
19 ~~subsection 1.}~~ *A managed care organization must ensure that the*
20 *benefits required by subsection 1 are made available to an insured*
21 *through a provider of health care who participates in the network*
22 *plan of the managed care organization.*

23 3. *Except as otherwise provided in subsection 5, a managed*
24 *care organization that offers or issues a health care plan shall not:*

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

29 (b) *Refuse to issue a health care plan or cancel a health care*
30 *plan solely because the person applying for or covered by the plan*
31 *uses or may use a benefit provided in the health care plan*
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 4. An evidence of coverage for a health care plan subject to the
2 provisions of this chapter which is delivered, issued for delivery or
3 renewed on or after ~~July 1, 2007,~~ **January 1, 2018**, has the legal
4 effect of including the coverage required by subsection 1, and any
5 provision of the evidence of coverage or the renewal thereof which
6 is in conflict with ~~subsection 1~~ **this section** is void.

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

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

14 **6. As used in this section:**

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

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

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

31 (d) **"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.** (Deleted by amendment.)

38 **Sec. 94.** NRS 689A.523, 689A.585, 689B.450, 689C.082,
39 695A.159 and 695F.480 are hereby repealed.

40 **Sec. 95.** This act becomes effective:

41 1. Upon passage and approval for the purposes of performing
42 any preparatory administrative tasks that are necessary to carry out
43 the provisions of this act; and

44 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.

