

Amendment No. 853

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| Senate Amendment to Senate Bill No. 163 First Reprint                                | (BDR 57-129) |
| <b>Proposed by:</b> Senate Committee on Finance                                      |              |
| <b>Amends:</b> Summary: No Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes |              |

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| Adoption of this amendment will:<br>(1) MAINTAIN the unfunded mandate not requested by the affected local government to S.B. 163 R1 (§§ 13, 14).<br>(2) ADD an appropriation where one does not currently exist in S.B. 163 R1. |
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| ASSEMBLY ACTION |                          |      | Initial and Date         | SENATE ACTION |              |                          | Initial and Date |                          |       |
|-----------------|--------------------------|------|--------------------------|---------------|--------------|--------------------------|------------------|--------------------------|-------|
| Adopted         | <input type="checkbox"/> | Lost | <input type="checkbox"/> | _____         | Adopted      | <input type="checkbox"/> | Lost             | <input type="checkbox"/> | _____ |
| Concurred In    | <input type="checkbox"/> | Not  | <input type="checkbox"/> | _____         | Concurred In | <input type="checkbox"/> | Not              | <input type="checkbox"/> | _____ |
| Receded         | <input type="checkbox"/> | Not  | <input type="checkbox"/> | _____         | Receded      | <input type="checkbox"/> | Not              | <input type="checkbox"/> | _____ |

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

JDK/EWR



Date: 6/1/2023

S.B. No. 163—Requires certain health insurance to cover treatment of certain conditions relating to gender dysphoria and gender incongruence. (BDR 57-129)





SENATE BILL NO. 163—SENATORS SCHEIBLE, D. HARRIS AND SPEARMAN

FEBRUARY 15, 2023

JOINT SPONSOR: ASSEMBLYWOMAN GONZÁLEZ

Referred to Committee on Commerce and Labor

SUMMARY—Requires certain health insurance to cover treatment of certain conditions relating to gender dysphoria and gender incongruence. (BDR 57-129)

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

CONTAINS UNFUNDED MANDATE (§§ 13, 14)  
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

AN ACT relating to insurance; requiring certain health insurance to include coverage for the treatment of conditions relating to gender dysphoria and gender incongruence; prohibiting such insurers from engaging in certain discrimination on the basis of gender identity or expression; making appropriations and authorizing certain expenditures; and providing other matters properly relating thereto.

**Legislative Counsel’s Digest:**

1 Existing law requires public and private policies of health insurance regulated under  
2 Nevada law to include certain coverage. (NRS 287.010, 287.04335, 422.2712-422.27241,  
3 689A.04033-689A.0465, 689B.0303-689B.0379, 689C.1655-689C.169, 689C.194,  
4 689C.1945, 689C.195, 695A.184-695A.1875, 695B.1901-695B.1948, 695C.1691-695C.176,  
5 695G.162-695G.177) Existing law also requires employers to provide certain benefits for  
6 health care to employees, including the coverage required of health insurers, if the employer  
7 provides health benefits for its employees. (NRS 608.1555) **Sections 1.3, 3, 4, 6, 7, 8, 11, 13,**  
8 **14 and 15** of this bill: (1) require certain public and private policies of health insurance and  
9 health care plans, including Medicaid, to cover the treatment of conditions relating to gender  
10 dysphoria and gender incongruence; (2) authorize those policies and plans to prescribe  
11 requirements that must be satisfied before the insurer will cover surgical treatment for  
12 conditions relating to gender dysphoria or gender incongruence for persons who are less than  
13 18 years of age; and (3) require an insurer to consult with a provider of health care with  
14 experience in prescribing or delivering gender-affirming treatment when considering certain  
15 appeals of a denial of coverage. **Sections 1.6, 3.6, 4.6, 6.6, 7.6, 8.6, 11.6 and 15.6** of this bill  
16 prohibit an insurer from engaging in certain discrimination on the basis of gender identity or  
17 expression. **Sections 2, 5, 9 and 12** of this bill make conforming changes to indicate the  
18 proper placement of **sections 1.3, 1.6, 4, 4.6, 8, 8.6, 15 and 15.6** in the Nevada Revised  
19 Statutes.

20 **Section 10** of this bill authorizes the Commissioner of Insurance to suspend or revoke the  
21 certificate of a health maintenance organization that fails to comply with the requirements of  
22 **sections 8 and 8.6**. The Commissioner would also be authorized to take such action against  
23 other health insurers who fail to comply with the requirements of **sections 1.3, 1.6, 3, 3.6, 4,**  
24 **4.6, 6, 6.6, 7, 7.6, 11 and 11.6** ~~of this bill~~ (NRS 680A.200) **Sections 16 and 17 of this bill**  
25 **make appropriations to the Division of Health Care Financing and Policy of the**  
26 **Department of Health and Human Services and authorize certain related expenditures**  
27 **for: (1) the costs of providing the coverage under Medicaid required by section 15; and**  
28 **(2) certain other costs associated with carrying out the provisions of this bill.**

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

1 **Section 1.** Chapter 689A of NRS is hereby amended by adding thereto the  
2 provisions set forth as sections 1.3 and 1.6 of this act.

3 **Sec. 1.3. 1.** *Except as otherwise provided in this section, an insurer that*  
4 *issues a policy of health insurance shall include in the policy coverage for the*  
5 *medically necessary treatment of conditions relating to gender dysphoria and*  
6 *gender incongruence. Such coverage must include coverage of medically*  
7 *necessary psychosocial and surgical intervention and any other medically*  
8 *necessary treatment for such disorders provided by:*

- 9 (a) *Endocrinologists;*  
10 (b) *Pediatric endocrinologists;*  
11 (c) *Social workers;*  
12 (d) *Psychiatrists;*  
13 (e) *Psychologists;*  
14 (f) *Gynecologists;*  
15 (g) *Speech-language pathologists;*  
16 (h) *Primary care physicians;*  
17 (i) *Advanced practice registered nurses;*  
18 (j) *Physician assistants; and*  
19 (k) *Any other providers of medically necessary services for the treatment of*  
20 *gender dysphoria or gender incongruence.*

21 2. *This section does not require a policy of health insurance to include*  
22 *coverage for cosmetic surgery performed by a plastic surgeon or reconstructive*  
23 *surgeon that is not medically necessary.*

24 3. *An insurer that issues a policy of health insurance shall not categorically*  
25 *refuse to cover medically necessary gender-affirming treatments or procedures or*  
26 *revisions to prior treatments if the policy provides coverage for any such services,*  
27 *procedures or revisions for purposes other than gender transition or affirmation.*

28 4. *An insurer that issues a policy of health insurance may prescribe*  
29 *requirements that must be satisfied before the insurer covers surgical treatment*  
30 *of conditions relating to gender dysphoria or gender incongruence for an insured*  
31 *who is less than 18 years of age. Such requirements may include, without*  
32 *limitation, requirements that:*

- 33 (a) *The treatment must be recommended by a psychologist, psychiatrist or*  
34 *other mental health professional;*  
35 (b) *The treatment must be recommended by a physician;*  
36 (c) *The insured must provide a written expression of the desire of the insured*  
37 *to undergo the treatment;*  
38 (d) *A written plan for treatment that covers at least 1 year must be developed*  
39 *and approved by at least two providers of health care; and*

1           (e) Parental consent is provided for the insured unless the insured is  
2 expressly authorized by law to consent on his or her own behalf.

3           5. When determining whether treatment is medically necessary for the  
4 purposes of this section, an insurer must consider the most recent Standards of  
5 Care published by the World Professional Association for Transgender Health,  
6 or its successor organization.

7           6. An insurer shall make a reasonable effort to ensure that the benefits  
8 required by subsection 1 are made available to an insured through a provider of  
9 health care who participates in the network plan of the insurer. If, after a  
10 reasonable effort, the insurer is unable to make such benefits available through  
11 such a provider of health care, the insurer may treat the treatment that the  
12 insurer is unable to make available through such a provider of health care in the  
13 same manner as other services provided by a provider of health care who does not  
14 participate in the network plan of the insurer.

15           7. If an insured appeals the denial of a claim or coverage under this section  
16 on the grounds that the treatment requested by the insured is not medically  
17 necessary, the insurer must consult with a provider of health care who has  
18 experience in prescribing or delivering gender-affirming treatment concerning  
19 the medical necessity of the treatment requested by the insured when considering  
20 the appeal.

21           8. A policy of health insurance subject to the provisions of this chapter that  
22 is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal  
23 effect of including the coverage required by subsection 1, and any provision of  
24 the policy or the renewal which is in conflict with this section is void.

25           9. As used in this section:

26           (a) "Cosmetic surgery":

27           (1) Means a surgical procedure that:

28           (I) Does not meaningfully promote the proper function of the body;

29           (II) Does not prevent or treat illness or disease; and

30           (III) Is primarily directed at improving the appearance of a person.

31           (2) Includes, without limitation, cosmetic surgery directed at preserving  
32 beauty.

33           (b) "Gender dysphoria" means distress or impairment in social, occupational  
34 or other areas of functioning caused by a marked difference between the gender  
35 identity or expression of a person and the sex assigned to the person at birth  
36 which lasts at least 6 months and is shown by at least two of the following:

37           (1) A marked difference between gender identity or expression and  
38 primary or secondary sex characteristics or anticipated secondary sex  
39 characteristics in young adolescents.

40           (2) A strong desire to be rid of primary or secondary sex characteristics  
41 because of a marked difference between such sex characteristics and gender  
42 identity or expression or a desire to prevent the development of anticipated  
43 secondary sex characteristics in young adolescents.

44           (3) A strong desire for the primary or secondary sex characteristics of the  
45 gender opposite from the sex assigned at birth.

46           (4) A strong desire to be of the opposite gender or a gender different from  
47 the sex assigned at birth.

48           (5) A strong desire to be treated as the opposite gender or a gender  
49 different from the sex assigned at birth.

50           (6) A strong conviction of experiencing typical feelings and reactions of  
51 the opposite gender or a gender different from the sex assigned at birth.

52           (c) "Medically necessary" means health care services or products that a  
53 prudent provider of health care would provide to a patient to prevent, diagnose or

1 *treat an illness, injury or disease, or any symptoms thereof, that are necessary*  
2 *and:*

3 *(1) Provided in accordance with generally accepted standards of medical*  
4 *practice;*

5 *(2) Clinically appropriate with regard to type, frequency, extent, location*  
6 *and duration;*

7 *(3) Not provided primarily for the convenience of the patient or provider*  
8 *of health care;*

9 *(4) Required to improve a specific health condition of a patient or to*  
10 *preserve the existing state of health of the patient; and*

11 *(5) The most clinically appropriate level of health care that may be safely*  
12 *provided to the patient.*

13 *↳ A provider of health care prescribing, ordering, recommending or approving a*  
14 *health care service or product does not, by itself, make that health care service or*  
15 *product medically necessary.*

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

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

22 **Sec. 1.6.** *An insurer that issues a policy of health insurance shall not*  
23 *discriminate against any person with respect to participation or coverage under*  
24 *the policy on the basis of actual or perceived gender identity or expression.*  
25 *Prohibited discrimination includes, without limitation:*

26 *1. Denying, cancelling, limiting or refusing to issue or renew a policy of*  
27 *health insurance on the basis of the actual or perceived gender identity or*  
28 *expression of a person or a family member of the person;*

29 *2. Imposing a payment or premium that is based on the actual or perceived*  
30 *gender identity or expression of an insured or a family member of the insured;*

31 *3. Designating the actual or perceived gender identity or expression of a*  
32 *person or a family member of the person as grounds to deny, cancel or limit*  
33 *participation or coverage; and*

34 *4. Denying, cancelling or limiting participation or coverage on the basis of*  
35 *actual or perceived gender identity or expression, including, without limitation,*  
36 *by limiting or denying coverage for health care services that are:*

37 *(a) Related to gender transition, provided that there is coverage under the*  
38 *policy for the services when the services are not related to gender transition; or*

39 *(b) Ordinarily or exclusively available to persons of any sex.*

40 **Sec. 2.** *NRS 689A.330 is hereby amended to read as follows:*

41 *689A.330 If any policy is issued by a domestic insurer for delivery to a*  
42 *person residing in another state, and if the insurance commissioner or*  
43 *corresponding public officer of that other state has informed the Commissioner that*  
44 *the policy is not subject to approval or disapproval by that officer, the*  
45 *Commissioner may by ruling require that the policy meet the standards set forth in*  
46 *NRS 689A.030 to 689A.320, inclusive ~~F~~, and sections 1.3 and 1.6 of this act.*

47 **Sec. 2.8.** *Chapter 689B of NRS is hereby amended by adding thereto the*  
48 *provisions set forth as sections 3 and 3.6 of this act.*

49 **Sec. 3.** *1. Except as otherwise provided in this section, an insurer that*  
50 *issues a policy of group health insurance shall include in the policy coverage for*  
51 *the medically necessary treatment of conditions relating to gender dysphoria and*  
52 *gender incongruence. Such coverage must include coverage of medically*

1 *necessary psychosocial and surgical intervention and any other medically*  
2 *necessary treatment for such disorders provided by:*

- 3 (a) *Endocrinologists;*  
4 (b) *Pediatric endocrinologists;*  
5 (c) *Social workers;*  
6 (d) *Psychiatrists;*  
7 (e) *Psychologists;*  
8 (f) *Gynecologists;*  
9 (g) *Speech-language pathologists;*  
10 (h) *Primary care physicians;*  
11 (i) *Advanced practice registered nurses;*  
12 (j) *Physician assistants; and*  
13 (k) *Any other providers of medically necessary services for the treatment of*  
14 *gender dysphoria or gender incongruence.*

15 2. *This section does not require a policy of group health insurance to*  
16 *include coverage for cosmetic surgery performed by a plastic surgeon or*  
17 *reconstructive surgeon that is not medically necessary.*

18 3. *An insurer that issues a policy of group health insurance shall not*  
19 *categorically refuse to cover medically necessary gender-affirming treatments or*  
20 *procedures or revisions to prior treatments if the policy provides coverage for any*  
21 *such services, procedures or revisions for purposes other than gender transition*  
22 *or affirmation.*

23 4. *An insurer that issues a policy of group health insurance may prescribe*  
24 *requirements that must be satisfied before the insurer covers surgical treatment*  
25 *of conditions relating to gender dysphoria or gender incongruence for an insured*  
26 *who is less than 18 years of age. Such requirements may include, without*  
27 *limitation, requirements that:*

- 28 (a) *The treatment must be recommended by a psychologist, psychiatrist or*  
29 *other mental health professional;*  
30 (b) *The treatment must be recommended by a physician;*  
31 (c) *The insured must provide a written expression of the desire of the insured*  
32 *to undergo the treatment;*  
33 (d) *A written plan for treatment that covers at least 1 year must be developed*  
34 *and approved by at least two providers of health care; and*  
35 (e) *Parental consent is provided for the insured unless the insured is*  
36 *expressly authorized by law to consent on his or her own behalf.*

37 5. *When determining whether treatment is medically necessary for the*  
38 *purposes of this section, an insurer must consider the most recent Standards of*  
39 *Care published by the World Professional Association for Transgender Health,*  
40 *or its successor organization.*

41 6. *An insurer shall make a reasonable effort to ensure that the benefits*  
42 *required by subsection 1 are made available to an insured through a provider of*  
43 *health care who participates in the network plan of the insurer. If, after a*  
44 *reasonable effort, the insurer is unable to make such benefits available through*  
45 *such a provider of health care, the insurer may treat the treatment that the*  
46 *insurer is unable to make available through such a provider of health care in the*  
47 *same manner as other services provided by a provider of health care who does not*  
48 *participate in the network plan of the insurer.*

49 7. *If an insured appeals the denial of a claim or coverage under this section*  
50 *on the grounds that the treatment requested by the insured is not medically*  
51 *necessary, the insurer must consult with a provider of health care who has*  
52 *experience in prescribing or delivering gender-affirming treatment concerning*

1 *the medical necessity of the treatment requested by the insured when considering*  
2 *the appeal.*

3 8. *A policy of group health insurance subject to the provisions of this*  
4 *chapter that is delivered, issued for delivery or renewed on or after July 1, 2023,*  
5 *has the legal effect of including the coverage required by subsection 1, and any*  
6 *provision of the policy or renewal which is in conflict with the provisions of this*  
7 *section is void.*

8 9. *As used in this section:*

9 (a) *“Cosmetic surgery”:*

10 (1) *Means a surgical procedure that:*

11 (I) *Does not meaningfully promote the proper function of the body;*

12 (II) *Does not prevent or treat illness or disease; and*

13 (III) *Is primarily directed at improving the appearance of a person.*

14 (2) *Includes, without limitation, cosmetic surgery directed at preserving*  
15 *beauty.*

16 (b) *“Gender dysphoria” means distress or impairment in social, occupational*  
17 *or other areas of functioning caused by a marked difference between the gender*  
18 *identity or expression of a person and the sex assigned to the person at birth*  
19 *which lasts at least 6 months and is shown by at least two of the following:*

20 (1) *A marked difference between gender identity or expression and*  
21 *primary or secondary sex characteristics or anticipated secondary sex*  
22 *characteristics in young adolescents.*

23 (2) *A strong desire to rid of primary or secondary sex characteristics*  
24 *because of a marked difference between such sex characteristics and gender*  
25 *identity or expression or a desire to prevent the development of anticipated*  
26 *secondary sex characteristics in young adolescents.*

27 (3) *A strong desire for the primary or secondary sex characteristics of the*  
28 *gender opposite from the sex assigned at birth.*

29 (4) *A strong desire to be of the opposite gender or a gender different from*  
30 *the sex assigned at birth.*

31 (5) *A strong desire to be treated as the opposite gender or a gender*  
32 *different from the sex assigned at birth.*

33 (6) *A strong conviction of experiencing typical feelings and reactions of*  
34 *the opposite gender or a gender different from the sex assigned at birth.*

35 (c) *“Medically necessary” means health care services or products that a*  
36 *prudent provider of health care would provide to a patient to prevent, diagnose or*  
37 *treat an illness, injury or disease, or any symptoms thereof, that are necessary*  
38 *and:*

39 (1) *Provided in accordance with generally accepted standards of medical*  
40 *practice;*

41 (2) *Clinically appropriate with regard to type, frequency, extent, location*  
42 *and duration;*

43 (3) *Not provided primarily for the convenience of the patient or provider*  
44 *of health care;*

45 (4) *Required to improve a specific health condition of a patient or to*  
46 *preserve the existing state of health of the patient; and*

47 (5) *The most clinically appropriate level of health care that may be safely*  
48 *provided to the patient.*

49 ↪ *A provider of health care prescribing, ordering, recommending or approving a*  
50 *health care service or product does not, by itself, make that health care service or*  
51 *product medically necessary.*

52 (d) *“Network plan” means a policy of group health insurance offered by an*  
53 *insurer under which the financing and delivery of medical care, including items*



1 *and services paid for as medical care, are provided, in whole or in part, through a*  
2 *defined set of providers under contract with the insurer. The term does not*  
3 *include an arrangement for the financing of premiums.*

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

5 **Sec. 3.6.** *An insurer that issues a policy of group health insurance shall not*  
6 *discriminate against any person with respect to participation or coverage under*  
7 *the policy on the basis of actual or perceived gender identity or expression.*  
8 *Prohibited discrimination includes, without limitation:*

9 *1. Denying, cancelling, limiting or refusing to issue or renew a policy of*  
10 *group health insurance on the basis of the actual or perceived gender identity or*  
11 *expression of a person or a family member of the person;*

12 *2. Imposing a payment or premium that is based on the actual or perceived*  
13 *gender identity or expression of an insured or a family member of the insured;*

14 *3. Designating the actual or perceived gender identity or expression of a*  
15 *person or a family member of the person as grounds to deny, cancel or limit*  
16 *participation or coverage; and*

17 *4. Denying, cancelling or limiting participation or coverage on the basis of*  
18 *actual or perceived gender identity or expression, including, without limitation,*  
19 *by limiting or denying coverage for health care services that are:*

20 *(a) Related to gender transition, provided that there is coverage under the*  
21 *policy for the services when the services are not related to gender transition; or*

22 *(b) Ordinarily or exclusively available to persons of any sex.*

23 **Sec. 3.8.** Chapter 689C of NRS is hereby amended by adding thereto the  
24 provisions set forth as sections 4 and 4.6 of this act.

25 **Sec. 4. 1.** *Except as otherwise provided in this section, a carrier that*  
26 *issues a health benefit plan shall include in the health benefit plan coverage for*  
27 *the medically necessary treatment of conditions relating to gender dysphoria and*  
28 *gender incongruence. Such coverage must include coverage of medically*  
29 *necessary psychosocial and surgical intervention and any other medically*  
30 *necessary treatment for such disorders provided by:*

31 *(a) Endocrinologists;*

32 *(b) Pediatric endocrinologists;*

33 *(c) Social workers;*

34 *(d) Psychiatrists;*

35 *(e) Psychologists;*

36 *(f) Gynecologists;*

37 *(g) Speech-language pathologists;*

38 *(h) Primary care physicians;*

39 *(i) Advanced practice registered nurses;*

40 *(j) Physician assistants; and*

41 *(k) Any other providers of medically necessary services for the treatment of*  
42 *gender dysphoria or gender incongruence.*

43 *2. This section does not require a health benefit plan to include coverage*  
44 *for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon*  
45 *that is not medically necessary.*

46 *3. A carrier that issues a health benefit plan shall not categorically refuse to*  
47 *cover medically necessary gender-affirming treatments or procedures or revisions*  
48 *prior treatments if the plan provides coverage for any such services,*  
49 *procedures or revisions for purposes other than gender transition or affirmation.*

50 *4. A carrier that issues a health benefit plan may prescribe requirements*  
51 *that must be satisfied before the carrier covers surgical treatment of conditions*  
52 *relating to gender dysphoria or gender incongruence for an insured who is less*

1 *than 18 years of age. Such requirements may include, without limitation,*  
2 *requirements that:*

3 *(a) The treatment must be recommended by a psychologist, psychiatrist or*  
4 *other mental health professional;*

5 *(b) The treatment must be recommended by a physician;*

6 *(c) The insured must provide a written expression of the desire of the insured*  
7 *to undergo the treatment;*

8 *(d) A written plan for treatment that covers at least 1 year must be developed*  
9 *and approved by at least two providers of health care; and*

10 *(e) Parental consent is provided for the insured unless the insured is*  
11 *expressly authorized by law to consent on his or her own behalf.*

12 *5. When determining whether treatment is medically necessary for the*  
13 *purposes of this section, a carrier must consider the most recent Standards of*  
14 *Care published by the World Professional Association for Transgender Health,*  
15 *or its successor organization.*

16 *6. A carrier shall make a reasonable effort to ensure that the benefits*  
17 *required by subsection 1 are made available to an insured through a provider of*  
18 *health care who participates in the network plan of the carrier. If, after a*  
19 *reasonable effort, the carrier is unable to make such benefits available through*  
20 *such a provider of health care, the carrier may treat the treatment that the carrier*  
21 *is unable to make available through such a provider of health care in the same*  
22 *manner as other services provided by a provider of health care who does not*  
23 *participate in the network plan of the carrier.*

24 *7. If an insured appeals the denial of a claim or coverage under this section*  
25 *on the grounds that the treatment requested by the insured is not medically*  
26 *necessary, the carrier must consult with a provider of health care who has*  
27 *experience in prescribing or delivering gender-affirming treatment concerning*  
28 *the medical necessity of the treatment requested by the insured when considering*  
29 *the appeal*

30 *8. A health benefit plan subject to the provisions of this chapter that is*  
31 *delivered, issued for delivery or renewed on or after July 1, 2023, has the legal*  
32 *effect of including the coverage required by subsection 1, and any provision of*  
33 *the plan or renewal which is in conflict with the provisions of this section is void.*

34 *9. As used in this section:*

35 *(a) "Cosmetic surgery":*

36 *(1) Means a surgical procedure that:*

37 *(I) Does not meaningfully promote the proper function of the body;*

38 *(II) Does not prevent or treat illness or disease; and*

39 *(III) Is primarily directed at improving the appearance of a person.*

40 *(2) Includes, without limitation, cosmetic surgery directed at preserving*  
41 *beauty.*

42 *(b) "Gender dysphoria" means distress or impairment in social, occupational*  
43 *or other areas of functioning caused by a marked difference between the gender*  
44 *identity or expression of a person and the sex assigned to the person at birth*  
45 *which lasts at least 6 months and is shown by at least two of the following:*

46 *(1) A marked difference between gender identity or expression and*  
47 *primary or secondary sex characteristics or anticipated secondary sex*  
48 *characteristics in young adolescents.*

49 *(2) A strong desire to be rid of primary or secondary sex characteristics*  
50 *because of a marked difference between such sex characteristics and gender*  
51 *identity or expression or a desire to prevent the development of anticipated*  
52 *secondary sex characteristics in young adolescents.*

1 (3) *A strong desire for the primary or secondary sex characteristics of the*  
2 *gender opposite from the sex assigned at birth.*

3 (4) *A strong desire to be of the opposite gender or a gender different from*  
4 *the sex assigned at birth.*

5 (5) *A strong desire to be treated as the opposite gender or a gender*  
6 *different from the sex assigned at birth.*

7 (6) *A strong conviction of experiencing typical feelings and reactions of*  
8 *the opposite gender or a gender different from the sex assigned at birth.*

9 (c) *“Medically necessary” means health care services or products that a*  
10 *prudent provider of health care would provide to a patient to prevent, diagnose or*  
11 *treat an illness, injury or disease, or any symptoms thereof, that are necessary*  
12 *and:*

13 (1) *Provided in accordance with generally accepted standards of medical*  
14 *practice;*

15 (2) *Clinically appropriate with regard to type, frequency, extent, location*  
16 *and duration;*

17 (3) *Not provided primarily for the convenience of the patient or provider*  
18 *of health care;*

19 (4) *Required to improve a specific health condition of a patient or to*  
20 *preserve the existing state of health of the patient; and*

21 (5) *The most clinically appropriate level of health care that may be safely*  
22 *provided to the patient.*

23 *↳ A provider of health care prescribing, ordering, recommending or approving a*  
24 *health care service or product does not, by itself, make that health care service or*  
25 *product medically necessary.*

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

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

32 **Sec. 4.6.** *A carrier that issues a health benefit plan shall not discriminate*  
33 *against any person with respect to participation or coverage under the plan on*  
34 *the basis of actual or perceived gender identity or expression. Prohibited*  
35 *discrimination includes, without limitation:*

36 1. *Denying, cancelling, limiting or refusing to issue or renew a health*  
37 *benefit plan on the basis of the actual or perceived gender identity or expression*  
38 *of a person or a family member of the person;*

39 2. *Imposing a payment or premium that is based on the actual or perceived*  
40 *gender identity or expression of an insured or a family member of the insured;*

41 3. *Designating the actual or perceived gender identity or expression of a*  
42 *person or a family member of the person as grounds to deny, cancel or limit*  
43 *participation or coverage; and*

44 4. *Denying, cancelling or limiting participation or coverage on the basis of*  
45 *actual or perceived gender identity or expression, including, without limitation,*  
46 *by limiting or denying coverage for health care services that are:*

47 (a) *Related to gender transition, provided that there is coverage under the*  
48 *plan for the services when the services are not related to gender transition; or*

49 (b) *Ordinarily or exclusively available to persons of any sex.*

50 **Sec. 5.** NRS 689C.425 is hereby amended to read as follows:

51 689C.425 A voluntary purchasing group and any contract issued to such a  
52 group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the  
53 provisions of NRS 689C.015 to 689C.355, inclusive, *and sections 4 and 4.6 of this*

1 *act*, to the extent applicable and not in conflict with the express provisions of NRS  
2 687B.408 and 689C.360 to 689C.600, inclusive.

3 **Sec. 5.8.** Chapter 695A of NRS is hereby amended by adding thereto the  
4 provisions set forth as sections 6 and 6.6 of this act.

5 **Sec. 6. 1.** *Except as otherwise provided in this section, a society that*  
6 *issues a benefit contract shall include in the benefit contract coverage for the*  
7 *medically necessary treatment of conditions relating to gender dysphoria and*  
8 *gender incongruence. Such coverage must include coverage of medically*  
9 *necessary psychosocial and surgical intervention and any other medically*  
10 *necessary treatment for such disorders provided by:*

11 (a) *Endocrinologists;*

12 (b) *Pediatric endocrinologists;*

13 (c) *Social workers;*

14 (d) *Psychiatrists;*

15 (e) *Psychologists;*

16 (f) *Gynecologists;*

17 (g) *Speech-language pathologists;*

18 (h) *Primary care physicians;*

19 (i) *Advanced practice registered nurses;*

20 (j) *Physician assistants; and*

21 (k) *Any other providers of medically necessary services for the treatment of*  
22 *gender dysphoria or gender incongruence.*

23 2. *This section does not require a benefit contract to include coverage for*  
24 *cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is*  
25 *not medically necessary.*

26 3. *A society that issues a benefit contract shall not categorically refuse to*  
27 *cover medically necessary gender-affirming treatments or procedures or revisions*  
28 *to prior treatments if the contract provides coverage for any such services,*  
29 *procedures or revisions for purposes other than gender transition or affirmation.*

30 4. *A society that issues a benefit contract may prescribe requirements that*  
31 *must be satisfied before the society covers surgical treatment of conditions*  
32 *relating to gender dysphoria or gender incongruence for an insured who is less*  
33 *than 18 years of age. Such requirements may include, without limitation,*  
34 *requirements that:*

35 (a) *The treatment must be recommended by a psychologist, psychiatrist or*  
36 *other mental health professional;*

37 (b) *The treatment must be recommended by a physician;*

38 (c) *The insured must provide a written expression of the desire of the insured*  
39 *to undergo the treatment;*

40 (d) *A written plan for treatment that covers at least 1 year must be developed*  
41 *and approved by at least two providers of health care; and*

42 (e) *Parental consent is provided for the insured unless the insured is*  
43 *expressly authorized by law to consent on his or her own behalf.*

44 5. *When determining whether treatment is medically necessary for the*  
45 *purposes of this section, a society must consider the most recent Standards of*  
46 *Care published by the World Professional Association for Transgender Health,*  
47 *or its successor organization.*

48 6. *A society shall make a reasonable effort to ensure that the benefits*  
49 *required by subsection 1 are made available to an insured through a provider of*  
50 *health care who participates in the network plan of the society. If, after a*  
51 *reasonable effort, the society is unable to make such benefits available through*  
52 *such a provider of health care, the society may treat the treatment that the society*  
53 *is unable to make available through such a provider of health care in the same*

1 manner as other services provided by a provider of health care who does not  
2 participate in the network plan of the society.

3 7. If an insured appeals the denial of a claim or coverage under this section  
4 on the grounds that the treatment requested by the insured is not medically  
5 necessary, the society must consult with a provider of health care who has  
6 experience in prescribing or delivering gender-affirming treatment concerning  
7 the medical necessity of the treatment requested by the insured when considering  
8 the appeal.

9 8. A benefit contract subject to the provisions of this chapter that is  
10 delivered, issued for delivery or renewed on or after July 1, 2023, has the legal  
11 effect of including the coverage required by subsection 1, and any provision of  
12 the benefit contract or renewal which is in conflict with the provisions of this  
13 section is void.

14 9. As used in this section:

15 (a) "Cosmetic surgery":

16 (1) Means a surgical procedure that:

17 (I) Does not meaningfully promote the proper function of the body;

18 (II) Does not prevent or treat illness or disease; and

19 (III) Is primarily directed at improving the appearance of a person.

20 (2) Includes, without limitation, cosmetic surgery directed at preserving  
21 beauty.

22 (b) "Gender dysphoria" means distress or impairment in social, occupational  
23 or other areas of functioning caused by a marked difference between the gender  
24 identity or expression of a person and the sex assigned to the person at birth  
25 which lasts at least 6 months and is shown by at least two of the following:

26 (1) A marked difference between gender identity or expression and  
27 primary or secondary sex characteristics or anticipated secondary sex  
28 characteristics in young adolescents.

29 (2) A strong desire to be rid of primary or secondary sex characteristics  
30 because of a marked difference between such sex characteristics and gender  
31 identity or expression or a desire to prevent the development of anticipated  
32 secondary sex characteristics in young adolescents.

33 (3) A strong desire for the primary or secondary sex characteristics of the  
34 gender opposite from the sex assigned at birth.

35 (4) A strong desire to be of the opposite gender or a gender different from  
36 the sex assigned at birth.

37 (5) A strong desire to be treated as the opposite gender or a gender  
38 different from the sex assigned at birth.

39 (6) A strong conviction of experiencing typical feelings and reactions of  
40 the opposite gender or a gender different from the sex assigned at birth.

41 (c) "Medically necessary" means health care services or products that a  
42 prudent provider of health care would provide to a patient to prevent, diagnose or  
43 treat an illness, injury or disease, or any symptoms thereof, that are necessary  
44 and:

45 (1) Provided in accordance with generally accepted standards of medical  
46 practice;

47 (2) Clinically appropriate with regard to type, frequency, extent, location  
48 and duration;

49 (3) Not provided primarily for the convenience of the patient or provider  
50 of health care;

51 (4) Required to improve a specific health condition of a patient or to  
52 preserve the existing state of health of the patient; and

1           (5) *The most clinically appropriate level of health care that may be safely*  
2 *provided to the patient.*

3           ↳ *A provider of health care prescribing, ordering, recommending or approving a*  
4 *health care service or product does not, by itself, make that health care service or*  
5 *product medically necessary.*

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

11           (e) *“Provider of health care” has the meaning ascribed to it in NRS 629.031.*

12           **Sec. 6.6.** *A society that issues a benefit contract shall not discriminate*  
13 *against any person with respect to participation or coverage under the contract*  
14 *on the basis of actual or perceived gender identity or expression. Prohibited*  
15 *discrimination includes, without limitation:*

16           1. *Denying, cancelling, limiting or refusing to issue or renew a benefit*  
17 *contract on the basis of the actual or perceived gender identity or expression of a*  
18 *person or a family member of the person;*

19           2. *Imposing a payment or premium that is based on the actual or perceived*  
20 *gender identity or expression of an insured or a family member of the insured;*

21           3. *Designating the actual or perceived gender identity or expression of a*  
22 *person or a family member of the person as grounds to deny, cancel or limit*  
23 *participation or coverage; and*

24           4. *Denying, cancelling or limiting participation or coverage on the basis of*  
25 *actual or perceived gender identity or expression, including, without limitation,*  
26 *by limiting or denying coverage for health care services that are:*

27           (a) *Related to gender transition, provided that there is coverage under the*  
28 *contract for the services when the services are not related to gender transition; or*

29           (b) *Ordinarily or exclusively available to persons of any sex.*

30           **Sec. 6.8.** Chapter 695B of NRS is hereby amended by adding thereto the  
31 provisions set forth as sections 7 and 7.6 of this act.

32           **Sec. 7.** 1. *Except as otherwise provided in this section, a hospital or*  
33 *medical services corporation that issues a policy of health insurance shall include*  
34 *in the policy coverage for the medically necessary treatment of conditions*  
35 *relating to gender dysphoria and gender incongruence. Such coverage must*  
36 *include coverage of medically necessary psychosocial and surgical intervention*  
37 *and any other medically necessary treatment for such disorders provided by:*

38           (a) *Endocrinologists;*

39           (b) *Pediatric endocrinologists;*

40           (c) *Social workers;*

41           (d) *Psychiatrists;*

42           (e) *Psychologists;*

43           (f) *Gynecologists;*

44           (g) *Speech-language pathologists;*

45           (h) *Primary care physicians;*

46           (i) *Advanced practice registered nurses;*

47           (j) *Physician assistants; and*

48           (k) *Any other providers of medically necessary services for the treatment of*  
49 *gender dysphoria or gender incongruence.*

50           2. *This section does not require a policy of health insurance to include*  
51 *coverage for cosmetic surgery performed by a plastic surgeon or reconstructive*  
52 *surgeon that is not medically necessary.*

1           3. A hospital or medical services corporation that issues a policy of health  
2 insurance shall not categorically refuse to cover medically necessary gender-  
3 affirming treatments or procedures or revisions to prior treatments if the policy  
4 provides coverage for any such services, procedures or revisions for purposes  
5 other than gender transition or affirmation.

6           4. A hospital or medical services corporation that issues a policy of health  
7 insurance may prescribe requirements that must be satisfied before the hospital  
8 or medical services corporation covers surgical treatment of conditions relating to  
9 gender dysphoria or gender incongruence for an insured who is less than 18  
10 years of age. Such requirements may include, without limitation, requirements  
11 that:

12           (a) The treatment must be recommended by a psychologist, psychiatrist or  
13 other mental health professional;

14           (b) The treatment must be recommended by a physician;

15           (c) The insured must provide a written expression of the desire of the insured  
16 to undergo the treatment;

17           (d) A written plan for treatment that covers at least 1 year must be developed  
18 and approved by at least two providers of health care; and

19           (e) Parental consent is provided for the insured unless the insured is  
20 expressly authorized by law to consent on his or her own behalf.

21           5. When determining whether treatment is medically necessary for the  
22 purposes of this section, a hospital or medical services corporation must consider  
23 the most recent Standards of Care published by the World Professional  
24 Association for Transgender Health, or its successor organization.

25           6. A hospital or medical services corporation shall make a reasonable effort  
26 to ensure that the benefits required by subsection 1 are made available to an  
27 insured through a provider of health care who participates in the network plan of  
28 the hospital or medical services corporation. If, after a reasonable effort, the  
29 hospital or medical services corporation is unable to make such benefits available  
30 through such a provider of health care, the hospital or medical services  
31 corporation may treat the treatment that the hospital or medical services  
32 corporation is unable to make available through such a provider of health care in  
33 the same manner as other services provided by a provider of health care who does  
34 not participate in the network plan of the hospital or medical services  
35 corporation.

36           7. If an insured appeals the denial of a claim or coverage under this section  
37 on the grounds that the treatment requested by the insured is not medically  
38 necessary, the hospital or medical services corporation must consult with a  
39 provider of health care who has experience in prescribing or delivering gender-  
40 affirming treatment concerning the medical necessity of the treatment requested  
41 by the insured when considering the appeal.

42           8. A policy of health insurance subject to the provisions of this chapter that  
43 is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal  
44 effect of including the coverage required by subsection 1, and any provision of  
45 the policy or renewal which is in conflict with the provisions of this section is  
46 void.

47           9. As used in this section:

48           (a) "Cosmetic surgery":

49           (1) Means a surgical procedure that:

50           (I) Does not meaningfully promote the proper function of the body;

51           (II) Does not prevent or treat illness or disease; and

52           (III) Is primarily directed at improving the appearance of a person.

1           (2) *Includes, without limitation, cosmetic surgery directed at preserving*  
2 *beauty.*

3           (b) *“Gender dysphoria” means distress or impairment in social, occupational*  
4 *or other areas of functioning caused by a marked difference between the gender*  
5 *identity or expression of a person and the sex assigned to the person at birth*  
6 *which lasts at least 6 months and is shown by at least two of the following:*

7           (1) *A marked difference between gender identity or expression and*  
8 *primary or secondary sex characteristics or anticipated secondary sex*  
9 *characteristics in young adolescents.*

10          (2) *A strong desire to be rid of primary or secondary sex characteristics*  
11 *because of a marked difference between such sex characteristics and gender*  
12 *identity or expression or a desire to prevent the development of anticipated*  
13 *secondary sex characteristics in young adolescents.*

14          (3) *A strong desire for the primary or secondary sex characteristics of the*  
15 *gender opposite from the sex assigned at birth.*

16          (4) *A strong desire to be of the opposite gender or a gender different from*  
17 *the sex assigned at birth.*

18          (5) *A strong desire to be treated as the opposite gender or a gender*  
19 *different from the sex assigned at birth.*

20          (6) *A strong conviction of experiencing typical feelings and reactions of*  
21 *the opposite gender or a gender different from the sex assigned at birth.*

22          (c) *“Medically necessary” means health care services or products that a*  
23 *prudent provider of health care would provide to a patient to prevent, diagnose or*  
24 *treat an illness, injury or disease, or any symptoms thereof, that are necessary*  
25 *and:*

26          (1) *Provided in accordance with generally accepted standards of medical*  
27 *practice;*

28          (2) *Clinically appropriate with regard to type, frequency, extent, location*  
29 *and duration;*

30          (3) *Not provided primarily for the convenience of the patient or provider*  
31 *of health care;*

32          (4) *Required to improve a specific health condition of a patient or to*  
33 *preserve the existing state of health of the patient; and*

34          (5) *The most clinically appropriate level of health care that may be safely*  
35 *provided to the patient.*

36          ↪ *A provider of health care prescribing, ordering, recommending or approving a*  
37 *health care service or product does not, by itself, make that health care service or*  
38 *product medically necessary.*

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

45          (e) *“Provider of health care” has the meaning ascribed to it in NRS 629.031.*

46          **Sec. 7.6.** *A hospital or medical services corporation that issues a policy of*  
47 *health insurance shall not discriminate against any person with respect to*  
48 *participation or coverage under the policy on the basis of actual or perceived*  
49 *gender identity or expression. Prohibited discrimination includes, without*  
50 *limitation:*

51          1. *Denying, cancelling, limiting or refusing to issue or renew a policy of*  
52 *health insurance on the basis of the actual or perceived gender identity or*  
53 *expression of a person or a family member of the person;*



1           2. *Imposing a payment or premium that is based on the actual or perceived*  
2 *gender identity or expression of an insured or a family member of the insured;*

3           3. *Designating the actual or perceived gender identity or expression of a*  
4 *person or a family member of the person as grounds to deny, cancel or limit*  
5 *participation or coverage; and*

6           4. *Denying, cancelling or limiting participation or coverage on the basis of*  
7 *actual or perceived gender identity or expression, including, without limitation,*  
8 *by limiting or denying coverage for health care services that are:*

9           (a) *Related to gender transition, provided that there is coverage under the*  
10 *policy for the services when the services are not related to gender transition; or*

11           (b) *Ordinarily or exclusively available to persons of any sex.*

12       **Sec. 7.8.** Chapter 695C of NRS is hereby amended by adding thereto the  
13 provisions set forth as sections 8 and 8.6 of this act.

14       **Sec. 8. 1.** *Except as otherwise provided in this section, a health*  
15 *maintenance organization that issues a health care plan shall include in the*  
16 *health care plan coverage for the medically necessary treatment of conditions*  
17 *relating to gender dysphoria and gender incongruence. Such coverage must*  
18 *include coverage of medically necessary psychosocial and surgical intervention*  
19 *and any other medically necessary treatment for such disorders provided by:*

20           (a) *Endocrinologists;*

21           (b) *Pediatric endocrinologists;*

22           (c) *Social workers;*

23           (d) *Psychiatrists;*

24           (e) *Psychologists;*

25           (f) *Gynecologists;*

26           (g) *Speech-language pathologists;*

27           (h) *Primary care physicians;*

28           (i) *Advanced practice registered nurses;*

29           (j) *Physician assistants; and*

30           (k) *Any other providers of medically necessary services for the treatment of*  
31 *gender dysphoria or gender incongruence.*

32           2. *This section does not require a health care plan to include coverage for*  
33 *cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is*  
34 *not medically necessary.*

35           3. *A health maintenance organization that issues a health care plan shall*  
36 *not categorically refuse to cover medically necessary gender-affirming treatments*  
37 *or procedures or revisions to prior treatments if the plan provides coverage for*  
38 *any such services, procedures or revisions for purposes other than gender*  
39 *transition or affirmation.*

40           4. *A health maintenance organization that issues a health care plan may*  
41 *prescribe requirements that must be satisfied before the health maintenance*  
42 *organization covers surgical treatment of conditions relating to gender dysphoria*  
43 *or gender incongruence for an enrollee who is less than 18 years of age. Such*  
44 *requirements may include, without limitation, requirements that:*

45           (a) *The treatment must be recommended by a psychologist, psychiatrist or*  
46 *other mental health professional;*

47           (b) *The treatment must be recommended by a physician;*

48           (c) *The enrollee must provide a written expression of the desire of the*  
49 *enrollee to undergo the treatment;*

50           (d) *A written plan for treatment that covers at least 1 year must be developed*  
51 *and approved by at least two providers of health care; and*

52           (e) *Parental consent is provided for the enrollee unless the enrollee is*  
53 *expressly authorized by law to consent on his or her own behalf.*

1           5. *When determining whether treatment is medically necessary for the*  
2 *purposes of this section, a health maintenance organization must consider the*  
3 *most recent Standards of Care prescribed by the World Professional Association*  
4 *for Transgender Health, or its successor organization.*

5           6. *A health maintenance organization shall make a reasonable effort to*  
6 *ensure that the benefits required by subsection 1 are made available to an*  
7 *enrollee through a provider of health care who participates in the network plan*  
8 *of the health maintenance organization. If, after a reasonable effort, the health*  
9 *maintenance organization is unable to make such benefits available through*  
10 *such a provider of health care, the health maintenance organization may treat*  
11 *the treatment that the health maintenance organization is unable to make*  
12 *available through such a provider of health care in the same manner as other*  
13 *services provided by a provider of health care who does not participate in the*  
14 *network plan of the health maintenance organization.*

15           7. *If an enrollee appeals the denial of a claim or coverage under this section*  
16 *on the grounds that the treatment requested by the enrollee is not medically*  
17 *necessary, the health maintenance organization must consult with a provider of*  
18 *health care who has experience in prescribing or delivering gender-affirming*  
19 *treatment concerning the medical necessity of the treatment requested by the*  
20 *enrollee when considering the appeal.*

21           8. *A health care plan subject to the provisions of this chapter that is*  
22 *delivered, issued for delivery or renewed on or after July 1, 2023, has the legal*  
23 *effect of including the coverage required by subsection 1, and any provision of*  
24 *the plan or renewal which is in conflict with the provisions of this section is void.*

25           9. *As used in this section:*

26           (a) *“Cosmetic surgery”:*

27               (1) *Means a surgical procedure that:*

28                   (I) *Does not meaningfully promote the proper function of the body;*

29                   (II) *Does not prevent or treat illness or disease; and*

30                   (III) *Is primarily directed at improving the appearance of a person.*

31               (2) *Includes, without limitation, cosmetic surgery directed at preserving*  
32 *beauty.*

33           (b) *“Gender dysphoria” means distress or impairment in social, occupational*  
34 *or other areas of functioning caused by a marked difference between the gender*  
35 *identity or expression of a person and the sex assigned to the person at birth*  
36 *which lasts at least 6 months and is shown by at least two of the following:*

37               (1) *A marked difference between gender identity or expression and*  
38 *primary or secondary sex characteristics or anticipated secondary sex*  
39 *characteristics in young adolescents.*

40               (2) *A strong desire to be rid of primary or secondary sex characteristics*  
41 *because of a marked difference between such sex characteristics and gender*  
42 *identity or expression or a desire to prevent the development of anticipated*  
43 *secondary sex characteristics in young adolescents.*

44               (3) *A strong desire for the primary or secondary sex characteristics of the*  
45 *gender opposite from the sex assigned at birth.*

46               (4) *A strong desire to be of the opposite gender or a gender different from*  
47 *the sex assigned at birth.*

48               (5) *A strong desire to be treated as the opposite gender or a gender*  
49 *different from the sex assigned at birth.*

50               (6) *A strong conviction of experiencing typical feelings and reactions of*  
51 *the opposite gender or a gender different from the sex assigned at birth.*

52           (c) *“Medically necessary” means health care services or products that a*  
53 *prudent provider of health care would provide to a patient to prevent, diagnose or*

1 *treat an illness, injury or disease, or any symptoms thereof, that are necessary*  
2 *and:*

3 *(1) Provided in accordance with generally accepted standards of medical*  
4 *practice;*

5 *(2) Clinically appropriate with regard to type, frequency, extent, location*  
6 *and duration;*

7 *(3) Not provided primarily for the convenience of the patient or provider*  
8 *of health care;*

9 *(4) Required to improve a specific health condition of a patient or to*  
10 *preserve the existing state of health of the patient; and*

11 *(5) The most clinically appropriate level of health care that may be safely*  
12 *provided to the patient.*

13 *↳ A provider of health care prescribing, ordering, recommending or approving a*  
14 *health care service or product does not, by itself, make that health care service or*  
15 *product medically necessary.*

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

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

23 **Sec. 8.6.** *A health maintenance organization that issues a health care plan*  
24 *shall not discriminate against any person with respect to participation or*  
25 *coverage under the plan on the basis of actual or perceived gender identity or*  
26 *expression. Prohibited discrimination includes, without limitation:*

27 *1. Denying, cancelling, limiting or refusing to issue or renew a health care*  
28 *plan on the basis of the actual or perceived gender identity or expression of a*  
29 *person or a family member of the person;*

30 *2. Imposing a payment or premium that is based on the actual or perceived*  
31 *gender identity or expression of an enrollee or a family member of the enrollee;*

32 *3. Designating the actual or perceived gender identity or expression of a*  
33 *person or a family member of the person as grounds to deny, cancel or limit*  
34 *participation or coverage; and*

35 *4. Denying, cancelling or limiting participation or coverage on the basis of*  
36 *actual or perceived gender identity or expression, including, without limitation,*  
37 *by limiting or denying coverage for health care services that are:*

38 *(a) Related to gender transition, provided that there is coverage under the*  
39 *plan for the services when the services are not related to gender transition; or*

40 *(b) Ordinarily or exclusively available to persons of any sex.*

41 **Sec. 9.** NRS 695C.050 is hereby amended to read as follows:

42 695C.050 1. Except as otherwise provided in this chapter or in specific  
43 provisions of this title, the provisions of this title are not applicable to any health  
44 maintenance organization granted a certificate of authority under this chapter. This  
45 provision does not apply to an insurer licensed and regulated pursuant to this title  
46 except with respect to its activities as a health maintenance organization authorized  
47 and regulated pursuant to this chapter.

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

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

4           4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693,  
5 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733,  
6 695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.1759, 695C.176 to  
7 695C.200, inclusive, and 695C.265 do not apply to a health maintenance  
8 organization that provides health care services through managed care to recipients  
9 of Medicaid under the State Plan for Medicaid or insurance pursuant to the  
10 Children's Health Insurance Program pursuant to a contract with the Division of  
11 Health Care Financing and Policy of the Department of Health and Human  
12 Services. This subsection does not exempt a health maintenance organization from  
13 any provision of this chapter for services provided pursuant to any other contract.

14           5. The provisions of NRS 695C.1694 to 695C.1698, inclusive, 695C.1701,  
15 695C.1708, 695C.1728, 695C.1731, 695C.17333, 695C.17345, 695C.17347,  
16 695C.1735, 695C.1737, 695C.1743, 695C.1745 and 695C.1757 *and sections 8 and*  
17 *8.6 of this act* apply to a health maintenance organization that provides health care  
18 services through managed care to recipients of Medicaid under the State Plan for  
19 Medicaid.

20           **Sec. 10.** NRS 695C.330 is hereby amended to read as follows:

21           695C.330 1. The Commissioner may suspend or revoke any certificate of  
22 authority issued to a health maintenance organization pursuant to the provisions of  
23 this chapter if the Commissioner finds that any of the following conditions exist:

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

30           (b) The health maintenance organization issues evidence of coverage or uses a  
31 schedule of charges for health care services which do not comply with the  
32 requirements of NRS 695C.1691 to 695C.200, inclusive, or 695C.207 ~~H~~ *or*  
33 *sections 8 and 8.6 of this act;*

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

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

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

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

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

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

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

48               (1) Resolving complaints in a manner reasonably to dispose of valid  
49 complaints; and

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

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

4 (i) The continued operation of the health maintenance organization would be  
5 hazardous to its enrollees or creditors or to the general public;

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

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

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

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

16 4. If the certificate of authority of a health maintenance organization is  
17 revoked, the organization shall proceed, immediately following the effective date of  
18 the order of revocation, to wind up its affairs and shall conduct no further business  
19 except as may be essential to the orderly conclusion of the affairs of the  
20 organization. It shall engage in no further advertising or solicitation of any kind.  
21 The Commissioner may, by written order, permit such further operation of the  
22 organization as the Commissioner may find to be in the best interest of enrollees to  
23 the end that enrollees are afforded the greatest practical opportunity to obtain  
24 continuing coverage for health care.

25 **Sec. 10.8.** Chapter 695G of NRS is hereby amended by adding thereto the  
26 provisions set forth as sections 11 and 11.6 of this act.

27 **Sec. 11. 1.** *Except as otherwise provided in this section, a managed care*  
28 *organization that issues a health care plan shall include in the health care plan*  
29 *coverage for the medically necessary treatment of conditions relating to gender*  
30 *dysphoria and gender incongruence. Such coverage must include coverage of*  
31 *medically necessary psychosocial and surgical intervention and any other*  
32 *medically necessary treatment for such disorders provided by:*

33 (a) *Endocrinologists;*

34 (b) *Pediatric endocrinologists;*

35 (c) *Social workers;*

36 (d) *Psychiatrists;*

37 (e) *Psychologists;*

38 (f) *Gynecologists;*

39 (g) *Speech-language pathologists;*

40 (h) *Primary care physicians;*

41 (i) *Advanced practice registered nurses;*

42 (j) *Physician assistants; and*

43 (k) *Any other providers of medically necessary services for the treatment of*  
44 *gender dysphoria or gender incongruence.*

45 2. *This section does not require a health care plan to include coverage for*  
46 *cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is*  
47 *not medically necessary.*

48 3. *A managed care organization that issues a health care plan shall not*  
49 *categorically refuse to cover medically necessary gender-affirming treatments or*  
50 *procedures or revisions to prior treatments if the plan provides coverage for any*  
51 *such services, procedures or revisions for purposes other than gender transition*  
52 *or affirmation.*

1           4. A managed care organization that issues a health care plan may  
2 prescribe requirements that must be satisfied before the managed care  
3 organization covers surgical treatment of conditions relating to gender dysphoria  
4 or gender incongruence for an insured who is less than 18 years of age. Such  
5 requirements may include, without limitation, requirements that:

6           (a) The treatment must be recommended by a psychologist, psychiatrist or  
7 other mental health professional;

8           (b) The treatment must be recommended by a physician;

9           (c) The insured must provide a written expression of the desire of the insured  
10 to undergo the treatment;

11           (d) A written plan for treatment that covers at least 1 year must be developed  
12 and approved by at least two providers of health care; and

13           (e) Parental consent is provided for the insured unless the insured is  
14 expressly authorized by law to consent on his or her own behalf.

15           5. When determining whether treatment is medically necessary for the  
16 purposes of this section, a managed care organization must consider the most  
17 recent Standards of Care prescribed by the World Professional Association for  
18 Transgender Health, or its successor organization.

19           6. A managed care organization shall make a reasonable effort to ensure  
20 that the benefits required by subsection 1 are made available to an insured  
21 through a provider of health care who participates in the network plan of the  
22 managed care organization. If, after a reasonable effort, the managed care  
23 organization is unable to make such benefits available through such a provider of  
24 health care, the managed care organization may treat the treatment that the  
25 managed care organization is unable to make available through such a provider  
26 of health care in the same manner as other services provided by a provider of  
27 health care who does not participate in the network plan of the managed care  
28 organization.

29           7. If an insured appeals the denial of a claim or coverage under this section  
30 on the grounds that the treatment requested by the insured is not medically  
31 necessary, the managed care organization must consult with a provider of health  
32 care who has experience in prescribing or delivering gender-affirming treatment  
33 concerning the medical necessity of the treatment requested by the insured when  
34 considering the appeal.

35           8. Evidence of coverage subject to the provisions of this chapter that is  
36 delivered, issued for delivery or renewed on or after July 1, 2023, has the legal  
37 effect of including the coverage required by subsection 1, and any provision of  
38 the plan or renewal which is in conflict with the provisions of this section is void.

39           9. As used in this section:

40           (a) "Cosmetic surgery":

41           (1) Means a surgical procedure that:

42           (I) Does not meaningfully promote the proper function of the body;

43           (II) Does not prevent or treat illness or disease; and

44           (III) Is primarily directed at improving the appearance of a person.

45           (2) Includes, without limitation, cosmetic surgery directed at preserving  
46 beauty.

47           (b) "Gender dysphoria" means distress or impairment in social, occupational  
48 or other areas of functioning caused by a marked difference between the gender  
49 identity or expression of a person and the sex assigned to the person at birth  
50 which lasts at least 6 months and is shown by at least two of the following:

51           (1) A marked difference between gender identity or expression and  
52 primary or secondary sex characteristics or anticipated secondary sex  
53 characteristics in young adolescents.

1           (2) *A strong desire to be rid of primary or secondary sex characteristics*  
2 *because of a marked difference between such sex characteristics and gender*  
3 *identity or expression or a desire to prevent the development of anticipated*  
4 *secondary sex characteristics in young adolescents.*

5           (3) *A strong desire for the primary or secondary sex characteristics of the*  
6 *gender opposite from the sex assigned at birth.*

7           (4) *A strong desire to be of the opposite gender or a gender different from*  
8 *the sex assigned at birth.*

9           (5) *A strong desire to be treated as the opposite gender or a gender*  
10 *different from the sex assigned at birth.*

11           (6) *A strong conviction of experiencing typical feelings and reactions of*  
12 *the opposite gender or a gender different from the sex assigned at birth.*

13           (c) *“Medically necessary” means health care services or products that a*  
14 *prudent provider of health care would provide to a patient to prevent, diagnose or*  
15 *treat an illness, injury or disease, or any symptoms thereof, that are necessary*  
16 *and:*

17           (1) *Provided in accordance with generally accepted standards of medical*  
18 *practice;*

19           (2) *Clinically appropriate with regard to type, frequency, extent, location*  
20 *and duration;*

21           (3) *Not provided primarily for the convenience of the patient or provider*  
22 *of health care;*

23           (4) *Required to improve a specific health condition of a patient or to*  
24 *preserve the existing state of health of the patient; and*

25           (5) *The most clinically appropriate level of health care that may be safely*  
26 *provided to the patient.*

27           ↪ *A provider of health care prescribing, ordering, recommending or approving a*  
28 *health care service or product does not, by itself, make that health care service or*  
29 *product medically necessary.*

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

36           (e) *“Provider of health care” has the meaning ascribed to it in NRS 629.031.*

37           **Sec. 11.6.** *A managed care organization that issues a health care plan shall*  
38 *not discriminate against any person with respect to participation or coverage*  
39 *under the plan on the basis of actual or perceived gender identity or expression.*  
40 *Prohibited discrimination includes, without limitation:*

41           1. *Denying, cancelling, limiting or refusing to issue or renew a health care*  
42 *plan on the basis of the actual or perceived gender identity or expression of a*  
43 *person or a family member of the person;*

44           2. *Imposing a payment or premium that is based on the actual or perceived*  
45 *gender identity or expression of an insured or a family member of the insured;*

46           3. *Designating the actual or perceived gender identity or expression of a*  
47 *person or a family member of the person as grounds to deny, cancel or limit*  
48 *participation or coverage; and*

49           4. *Denying, cancelling or limiting participation or coverage on the basis of*  
50 *actual or perceived gender identity or expression, including, without limitation,*  
51 *by limiting or denying coverage for health care services that are:*

52           (a) *Related to gender transition, provided that there is coverage under the*  
53 *plan for the services when the services are not related to gender transition; or*

1           **(b) Ordinarily or exclusively available to persons of any sex.**

2           **Sec. 12.** NRS 232.320 is hereby amended to read as follows:

3           232.320 1. The Director:

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

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

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

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

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

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

12           (b) Shall administer, through the divisions of the Department, the provisions of  
13 chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A  
14 and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410,  
15 inclusive, *and sections 15 and 15.6 of this act*, 422.580, 432.010 to 432.133,  
16 inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and  
17 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the  
18 functions of the divisions of the Department, but is not responsible for the clinical  
19 activities of the Division of Public and Behavioral Health or the professional line  
20 activities of the other divisions.

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

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

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

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

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

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

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

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

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

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

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



1       **Sec. 13.** NRS 287.010 is hereby amended to read as follows:

2       287.010 1. The governing body of any county, school district, municipal  
3 corporation, political subdivision, public corporation or other local governmental  
4 agency of the State of Nevada may:

5       (a) Adopt and carry into effect a system of group life, accident or health  
6 insurance, or any combination thereof, for the benefit of its officers and employees,  
7 and the dependents of officers and employees who elect to accept the insurance and  
8 who, where necessary, have authorized the governing body to make deductions  
9 from their compensation for the payment of premiums on the insurance.

10       (b) Purchase group policies of life, accident or health insurance, or any  
11 combination thereof, for the benefit of such officers and employees, and the  
12 dependents of such officers and employees, as have authorized the purchase, from  
13 insurance companies authorized to transact the business of such insurance in the  
14 State of Nevada, and, where necessary, deduct from the compensation of officers  
15 and employees the premiums upon insurance and pay the deductions upon the  
16 premiums.

17       (c) Provide group life, accident or health coverage through a self-insurance  
18 reserve fund and, where necessary, deduct contributions to the maintenance of the  
19 fund from the compensation of officers and employees and pay the deductions into  
20 the fund. The money accumulated for this purpose through deductions from the  
21 compensation of officers and employees and contributions of the governing body  
22 must be maintained as an internal service fund as defined by NRS 354.543. The  
23 money must be deposited in a state or national bank or credit union authorized to  
24 transact business in the State of Nevada. Any independent administrator of a fund  
25 created under this section is subject to the licensing requirements of chapter 683A  
26 of NRS, and must be a resident of this State. Any contract with an independent  
27 administrator must be approved by the Commissioner of Insurance as to the  
28 reasonableness of administrative charges in relation to contributions collected and  
29 benefits provided. The provisions of NRS 686A.135, 687B.352, 687B.408,  
30 687B.723, 687B.725, 689B.030 to 689B.050, inclusive, *and sections 3 and 3.6 of*  
31 *this act*, 689B.265, 689B.287 and 689B.500 apply to coverage provided pursuant to  
32 this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and  
33 689B.500 only apply to coverage for active officers and employees of the  
34 governing body, or the dependents of such officers and employees.

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

40       2. If a school district offers group insurance to its officers and employees  
41 pursuant to this section, members of the board of trustees of the school district must  
42 not be excluded from participating in the group insurance. If the amount of the  
43 deductions from compensation required to pay for the group insurance exceeds the  
44 compensation to which a trustee is entitled, the difference must be paid by the  
45 trustee.

46       3. In any county in which a legal services organization exists, the governing  
47 body of the county, or of any school district, municipal corporation, political  
48 subdivision, public corporation or other local governmental agency of the State of  
49 Nevada in the county, may enter into a contract with the legal services organization  
50 pursuant to which the officers and employees of the legal services organization, and  
51 the dependents of those officers and employees, are eligible for any life, accident or  
52 health insurance provided pursuant to this section to the officers and employees,  
53 and the dependents of the officers and employees, of the county, school district,

1 municipal corporation, political subdivision, public corporation or other local  
2 governmental agency.

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

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

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

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

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

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

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

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

19 **Sec. 14.** NRS 287.04335 is hereby amended to read as follows:

20 287.04335 If the Board provides health insurance through a plan of self-  
21 insurance, it shall comply with the provisions of NRS 686A.135, 687B.352,  
22 687B.409, 687B.723, 687B.725, 689B.0353, 689B.255, 695C.1723, 695G.150,  
23 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665,  
24 695G.167, 695G.1675, 695G.170 to 695G.174, inclusive, *and sections 11 and 11.6*  
25 *of this act*, 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to  
26 695G.310, inclusive, and 695G.405, in the same manner as an insurer that is  
27 licensed pursuant to title 57 of NRS is required to comply with those provisions.

28 **Sec. 14.8.** Chapter 422 of NRS is hereby amended by adding thereto the  
29 provisions set forth as sections 15 and 15.6 of this act.

30 **Sec. 15. 1.** *Except as otherwise provided in this section, the Director shall*  
31 *include in the State Plan for Medicaid a requirement that the State, to the extent*  
32 *authorized by federal law, must pay the nonfederal share of expenditures*  
33 *incurred for the medically necessary treatment of conditions relating to gender*  
34 *dysphoria and gender incongruence. Such treatment includes medically*  
35 *necessary psychosocial and surgical intervention and any other medically*  
36 *necessary treatment for such disorders provided by:*

37 (a) *Endocrinologists;*

38 (b) *Pediatric endocrinologists;*

39 (c) *Social workers;*

40 (d) *Psychiatrists;*

41 (e) *Psychologists;*

42 (f) *Gynecologists;*

43 (g) *Speech-language pathologists;*

44 (h) *Primary care physicians;*

45 (i) *Advanced practice registered nurses;*

46 (j) *Physician assistants; and*

47 (k) *Any other providers of medically necessary services for the treatment of*  
48 *gender dysphoria or gender incongruence.*

49 2. *This section does not require the Director to include in the State Plan for*  
50 *Medicaid coverage for cosmetic surgery performed by a plastic surgeon or*  
51 *reconstructive surgeon that is not medically necessary.*

52 3. *The Department shall not categorically refuse to cover any medically*  
53 *necessary gender-affirming treatments or procedures or revisions to prior*

1 *treatments if the State Plan for Medicaid provides coverage for any such services,*  
2 *procedures or revisions for purposes other than gender transition or affirmation.*

3 4. *When determining whether treatment is medically necessary for the*  
4 *purposes of this section, the Department must consider the most recent Standards*  
5 *of Care published by the World Professional Association for Transgender Health,*  
6 *or its successor organization.*

7 5. *If a person appeals the denial of a payment or coverage under this*  
8 *section on the grounds that the treatment requested by the person is not medically*  
9 *necessary, the Division must consult with a provider of health care who has*  
10 *experience in prescribing or delivering gender-affirming treatment concerning*  
11 *the medical necessity of the treatment requested by the person when considering*  
12 *the appeal.*

13 6. *As used in this section:*

14 (a) *“Cosmetic surgery”:*

15 (1) *Means a surgical procedure that:*

16 (I) *Does not meaningfully promote the proper function of the body;*

17 (II) *Does not prevent or treat illness or disease; and*

18 (III) *Is primarily directed at improving the appearance of a person.*

19 (2) *Includes, without limitation, cosmetic surgery directed at preserving*  
20 *beauty.*

21 (b) *“Gender dysphoria” means distress or impairment in social, occupational*  
22 *or other areas of functioning caused by a marked difference between the gender*  
23 *identity or expression of a person and the sex assigned to the person at birth*  
24 *which lasts at least 6 months and is shown by at least two of the following:*

25 (1) *A marked difference between gender identity or expression and*  
26 *primary or secondary sex characteristics or anticipated secondary sex*  
27 *characteristics in young adolescents.*

28 (2) *A strong desire to be rid of primary or secondary sex characteristics*  
29 *because of a marked difference between such sex characteristics and gender*  
30 *identity or expression or a desire to prevent the development of anticipated*  
31 *secondary sex characteristics in young adolescents.*

32 (3) *A strong desire for the primary or secondary sex characteristics of the*  
33 *gender opposite from the sex assigned at birth.*

34 (4) *A strong desire to be of the opposite gender or a gender different from*  
35 *the sex assigned at birth.*

36 (5) *A strong desire to be treated as the opposite gender or a gender*  
37 *different from the sex assigned at birth.*

38 (6) *A strong conviction of experiencing typical feelings and reactions of*  
39 *the opposite gender or a gender different from the sex assigned at birth.*

40 (c) *“Medically necessary” means health care services or products that a*  
41 *prudent provider of health care would provide to a patient to prevent, diagnose or*  
42 *treat an illness, injury or disease, or any symptoms thereof, that are necessary*  
43 *and:*

44 (1) *Provided in accordance with generally accepted standards of medical*  
45 *practice;*

46 (2) *Clinically appropriate with regard to type, frequency, extent, location*  
47 *and duration;*

48 (3) *Not provided primarily for the convenience of the patient or provider*  
49 *of health care;*

50 (4) *Required to improve a specific health condition of a patient or to*  
51 *preserve the existing state of health of the patient; and*

52 (5) *The most clinically appropriate level of health care that may be safely*  
53 *provided to the patient.*

1 *↳ A provider of health care prescribing, ordering, recommending or approving a*  
2 *health care service or product does not, by itself, make that health care service or*  
3 *product medically necessary.*

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

5 **Sec. 15.6.** *The Department shall not discriminate against any person with*  
6 *respect to participation or coverage under Medicaid on the basis of actual or*  
7 *perceived gender identity or expression. Prohibited discrimination includes,*  
8 *without limitation:*

9 *1. Denying, cancelling, limiting or refusing to issue a payment or coverage*  
10 *on the basis of the actual or perceived gender identity or expression of a person*  
11 *or a family member of the person;*

12 *2. Imposing a payment that is based on the actual or perceived gender*  
13 *identity or expression of a recipient of Medicaid or a family member of the*  
14 *recipient;*

15 *3. Designating the actual or perceived gender identity or expression of a*  
16 *person or a family member of the person as grounds to deny, cancel or limit*  
17 *participation or coverage; and*

18 *4. Denying, cancelling or limiting participation or coverage on the basis of*  
19 *actual or perceived gender identity or expression, including, without limitation,*  
20 *by limiting or denying payment or coverage for health care services that are:*

21 *(a) Related to gender transition, provided that there is coverage under*  
22 *Medicaid for the services when the services are not related to gender transition;*  
23 *or*

24 *(b) Ordinarily or exclusively available to persons of any sex.*

25 **Sec. 16. 1.** There is hereby appropriated from the State General Fund  
26 to the Division of Health Care Financing and Policy of the Department of  
27 Health and Human Services for the costs of providing coverage under  
28 Medicaid for the treatment of conditions relating to gender dysphoria and  
29 gender incongruence required by section 15 of this act the following sums:

30 For the Fiscal Year 2023-2024 ..... \$162,926

31 For the Fiscal Year 2024-2025 ..... \$182,654

32 2. Any balance of the sums appropriated by subsection 1 remaining at  
33 the end of the respective fiscal years must not be committed for expenditure  
34 after June 30 of the respective fiscal years by the entity to which the  
35 appropriation is made or any entity to which money from the appropriation is  
36 granted or otherwise transferred in any manner, and any portion of the  
37 appropriated money remaining must not be spent for any purpose after  
38 September 20, 2024, and September 19, 2025, respectively, by either the entity  
39 to which the money was appropriated or the entity to which the money was  
40 subsequently granted or transferred, and must be reverted to the State  
41 General Fund on or before September 20, 2024, and September 19, 2025,  
42 respectively.

43 3. Expenditure of \$1,239,172 not appropriated from the State General  
44 Fund or the State Highway Fund is hereby authorized during Fiscal Year  
45 2023-2024 by the Division of Health Care Financing and Policy of the  
46 Department of Health and Human Services for the same purposes as set forth  
47 in subsection 1.

48 4. Expenditure of \$1,076,246 not appropriated from the State General  
49 Fund or the State Highway Fund is hereby authorized during Fiscal Year  
50 2024-2025 by the Division of Health Care Financing and Policy of the  
51 Department of Health and Human Services for the same purposes as set forth  
52 in subsection 1.

1        Sec. 17. 1. There is hereby appropriated from the State General Fund  
2 to the Division of Health Care Financing and Policy of the Department of  
3 Health and Human Services the sum of \$19,500 for the costs of information  
4 system upgrades and actuarial rate setting associated with carrying out the  
5 provisions of this act.

6        2. Any remaining balance of the appropriation made by subsection 1  
7 must not be committed for expenditure after June 30, 2024, by the entity to  
8 which the appropriation is made or any entity to which money from the  
9 appropriation is granted or otherwise transferred in any manner, and any  
10 portion of the appropriated money remaining must not be spent for any  
11 purpose after September 20, 2024, by either the entity to which the money was  
12 appropriated or the entity to which the money was subsequently granted or  
13 transferred, and must be reverted to the State General Fund on or before  
14 September 20, 2024.

15        3. Expenditure of \$48,000 not appropriated from the State General Fund  
16 or the State Highway Fund is hereby authorized during Fiscal Year 2023-2024  
17 by the Division of Health Care Financing and Policy of the Department of  
18 Health and Human Services for the same purposes as set forth in subsection 1.

19        ~~[Sec. 16.]~~ *Sec. 18.* The provisions of NRS 354.599 do not apply to any  
20 additional expenses of a local government that are related to the provisions of this  
21 act.

22        ~~[Sec. 17.]~~ *Sec. 19.* This act becomes effective on July 1, 2023.