

Amendment No. 504

Senate Amendment to Senate Bill No. 330	(BDR 57-161)
Proposed by: Senator Lange	
Amends: Summary: No Title: No Preamble: No Joint Sponsorship: No Digest: Yes	

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.



SENATE BILL NO. 330—SENATOR LANGE

MARCH 20, 2023

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions related to health care. (BDR 57-161)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: Yes.

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

AN ACT relating to health care; revising requirements for certain health insurance plans to provide certain benefits for preventative health care relating to breast cancer; and providing other matters properly relating thereto.

Legislative Counsel’s Digest:

1 Existing law requires most health insurance plans, including individual, group and
2 blanket health insurance policies, small employer plans, benefit contracts provided by
3 fraternal benefit societies, contracts for hospital or medical service, health care plans of health
4 maintenance organizations and plans issued by managed care organizations to include
5 coverage for mammograms. (NRS 689A.0405, 689B.0374, 689C.1674, 695A.1855,
6 695B.1912, 695C.1735, 695G.1713) **Sections ~~1-7~~ 1-5, 6 and 7** of this bill revise existing
7 provisions requiring coverage for mammograms to require such policies, plans and contracts
8 of health care to additionally provide coverage for imaging tests to screen for breast cancer
9 and diagnostic imaging tests for breast cancer for certain covered persons without requiring
10 any deductible, copayment, coinsurance or any other form of cost-sharing. ~~Section~~ **Sections**
11 **5.5, 6.5, 7.5 and 8** of this bill ~~makes a conforming change~~ **make various changes** to
12 exclude the Public Employees’ Benefits Program **and plans of self-insurance for employees**
13 **of local governments** from the ~~requirement~~ **requirements** of this bill and, thus, the Program
14 **and such plans** may, but ~~is~~ **are** not required to, provide the coverage set forth in this bill.
15 **Sections 7.2 and 7.3 of this bill make changes necessary so that requirements concerning**
16 **mammograms that currently apply to the Program and plans of self-insurance for**
17 **employees of local governments continue to apply to the Program and such plans.**
18 **Sections 7.7 and 7.9 of this bill make conforming changes to indicate the proper**
19 **placement of sections 7.2 and 7.3, respectively, in the Nevada Revised Statutes.**

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

1 **Section 1.** NRS 689A.0405 is hereby amended to read as follows:
2 689A.0405 1. A policy of health insurance must provide coverage for
3 benefits payable for expenses incurred for ~~it~~ **:**
4 (a) A mammogram ~~every 2 years, or~~ **to screen for breast cancer** annually ~~if~~
5 ~~ordered by a provider of health care,~~ **for** ~~women~~ **insureds who are** 40 years of
6 age or older.

1 ***(b) An imaging test to screen for breast cancer on an interval and at the age***
2 ***deemed most appropriate, when medically necessary, as recommended by the***
3 ***insured's provider of health care based on personal or family medical history or***
4 ***additional factors that may increase the risk of breast cancer for the insured.***

5 ***(c) A diagnostic imaging test for breast cancer at the age deemed most***
6 ***appropriate, when medically necessary, as recommended by the insured's***
7 ***provider of health care to evaluate an abnormality which is:***

8 ***(1) Seen or suspected from a mammogram described in paragraph (a) or***
9 ***an imaging test described in paragraph (b); or***

10 ***(2) Detected by other means of examination.***

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

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

16 (a) Require an insured to pay a ~~higher~~ deductible, ~~any~~ copayment, ~~or~~
17 coinsurance ***or any other form of cost-sharing*** or require a longer waiting period or
18 other condition to obtain any benefit provided in the policy of health insurance
19 pursuant to subsection 1;

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

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

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

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

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

33 4. A policy subject to the provisions of this chapter which is delivered, issued
34 for delivery or renewed on or after January 1, ~~2018~~ **2024**, has the legal effect of
35 including the coverage required by subsection 1, and any provision of the policy or
36 the renewal which is in conflict with this section is void.

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

42 6. As used in this section:

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

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

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

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

2 689B.0374 1. A policy of group health insurance must provide coverage for
3 benefits payable for expenses incurred for ~~[a]~~ :

4 (a) A mammogram ~~[every 2 years, or]~~ *to screen for breast cancer* annually ~~[if~~
5 ~~ordered by a provider of health care,]~~ for ~~[women]~~ *insureds who are* 40 years of
6 age or older.

7 (b) *An imaging test to screen for breast cancer on an interval and at the age*
8 *deemed most appropriate, when medically necessary, as recommended by the*
9 *insured's provider of health care based on personal or family medical history or*
10 *additional factors that may increase the risk of breast cancer for the insured.*

11 (c) *A diagnostic imaging test for breast cancer at the age deemed most*
12 *appropriate, when medically necessary, as recommended by the insured's*
13 *provider of health care to evaluate an abnormality which is:*

14 (1) *Seen or suspected from a mammogram described in paragraph (a) or*
15 *an imaging test described in paragraph (b); or*

16 (2) *Detected by other means of examination.*

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

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

22 (a) Require an insured to pay a ~~[higher]~~ deductible, ~~[any]~~ copayment , ~~[or]~~
23 coinsurance *or any other form of cost-sharing* or require a longer waiting period or
24 other condition to obtain any benefit provided in the policy of group health
25 insurance pursuant to subsection 1;

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

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

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

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

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

39 4. A policy subject to the provisions of this chapter which is delivered, issued
40 for delivery or renewed on or after January 1, ~~[2018,]~~ **2024**, has the legal effect of
41 including the coverage required by subsection 1, and any provision of the policy or
42 the renewal which is in conflict with this section is void.

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

48 6. As used in this section:

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

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

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

7 **Sec. 3.** NRS 689C.1674 is hereby amended to read as follows:

8 689C.1674 1. A health benefit plan must provide coverage for benefits
9 payable for expenses incurred for ~~[a]~~ :

10 (a) A mammogram ~~[every 2 years, or] to screen for breast cancer~~ annually ~~[if~~
11 ~~ordered by a provider of health care,]~~ for ~~[women]~~ insureds who are 40 years of
12 age or older.

13 (b) *An imaging test to screen for breast cancer on an interval and at the age*
14 *deemed most appropriate, when medically necessary, as recommended by the*
15 *insured's provider of health care based on personal or family medical history or*
16 *additional factors that may increase the risk of breast cancer for the insured.*

17 (c) *A diagnostic imaging test for breast cancer at the age deemed most*
18 *appropriate, when medically necessary, as recommended by the insured's*
19 *provider of health care to evaluate an abnormality which is:*

20 (1) *Seen or suspected from a mammogram described in paragraph (a) or*
21 *an imaging test described in paragraph (b); or*

22 (2) *Detected by other means of examination.*

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

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

28 (a) Require an insured to pay a ~~[higher]~~ deductible, ~~[any]~~ copayment, ~~[or]~~
29 coinsurance *or any other form of cost-sharing* or require a longer waiting period or
30 other condition to obtain any benefit provided in the health benefit plan pursuant to
31 subsection 1;

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

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

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

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

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

45 4. A plan subject to the provisions of this chapter which is delivered, issued
46 for delivery or renewed on or after January 1, ~~[2018,]~~ 2024, has the legal effect of
47 including the coverage required by subsection 1, and any provision of the plan or
48 the renewal which is in conflict with this section is void.

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

1 6. As used in this section:

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

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

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

12 **Sec. 4.** NRS 695A.1855 is hereby amended to read as follows:

13 695A.1855 1. A benefit contract must provide coverage for benefits payable
14 for expenses incurred for ~~it~~:

15 (a) A mammogram ~~every 2 years, or~~ to screen for breast cancer annually ~~if~~
16 ~~ordered by a provider of health care,~~ for ~~women~~ insureds who are 40 years of
17 age or older.

18 (b) *An imaging test to screen for breast cancer on an interval and at the age*
19 *deemed most appropriate, when medically necessary, as recommended by the*
20 *insured’s provider of health care based on personal or family medical history or*
21 *additional factors that may increase the risk of breast cancer for the insured.*

22 (c) *A diagnostic imaging test for breast cancer at the age deemed most*
23 *appropriate, when medically necessary, as recommended by the insured’s*
24 *provider of health care to evaluate an abnormality which is:*

25 (1) *Seen or suspected from a mammogram described in paragraph (a) or*
26 *an imaging test described in paragraph (b); or*

27 (2) *Detected by other means of examination.*

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

31 3. Except as otherwise provided in subsection 5, a society that offers or issues
32 a benefit contract shall not:

33 (a) Require an insured to pay a ~~higher~~ deductible, ~~any~~ copayment, ~~or~~
34 coinsurance *or any other form of cost-sharing* or require a longer waiting period or
35 other condition for coverage to obtain any benefit provided in a benefit contract
36 pursuant to subsection 1;

37 (b) Refuse to issue a benefit contract or cancel a benefit contract solely because
38 the person applying for or covered by the contract uses or may use any such
39 benefit;

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

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

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

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

50 4. A benefit contract subject to the provisions of this chapter which is
51 delivered, issued for delivery or renewed on or after January 1, ~~2018,~~ 2024, has
52 the legal effect of including the coverage required by subsection 1, and any

1 provision of the benefit contract or the renewal which is in conflict with this section
2 is void.

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

8 6. As used in this section:

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

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

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

19 **Sec. 5.** NRS 695B.1912 is hereby amended to read as follows:

20 695B.1912 1. An insurer that offers or issues a contract for hospital or
21 medical service must provide coverage for benefits payable for expenses incurred
22 for ~~it~~:

23 (a) A mammogram ~~every 2 years, or~~ to screen for breast cancer annually ~~if~~
24 ~~ordered by a provider of health care,~~ for ~~women~~ insureds who are 40 years of
25 age or older.

26 (b) *An imaging test to screen for breast cancer on an interval and at the age*
27 *deemed most appropriate, when medically necessary, as recommended by the*
28 *insured's provider of health care based on personal or family medical history or*
29 *additional factors that may increase the risk of breast cancer for the insured.*

30 (c) *A diagnostic imaging test for breast cancer at the age deemed most*
31 *appropriate, when medically necessary, as recommended by the insured's*
32 *provider of health care to evaluate an abnormality which is:*

33 (1) *Seen or suspected from a mammogram described in paragraph (a) or*
34 *an imaging test described in paragraph (b); or*

35 (2) *Detected by other means of examination.*

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

39 3. Except as otherwise provided in subsection 5, an insurer that offers or
40 issues a contract for hospital or medical service shall not:

41 (a) Require an insured to pay a ~~higher~~ deductible, ~~any~~ copayment, ~~or~~
42 coinsurance *or any other form of cost-sharing* or require a longer waiting period or
43 other condition to obtain any benefit provided in a contract for hospital or medical
44 service pursuant to subsection 1;

45 (b) Refuse to issue a contract for hospital or medical service or cancel a
46 contract for hospital or medical service solely because the person applying for or
47 covered by the contract uses or may use any such benefit;

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

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

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

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

6 4. A contract for hospital or medical service subject to the provisions of this
7 chapter which is delivered, issued for delivery or renewed on or after January 1,
8 ~~2018,~~ 2024, has the legal effect of including the coverage required by subsection
9 1, and any provision of the contract or the renewal which is in conflict with this
10 section is void.

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

16 6. As used in this section:

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

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

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

27 **Sec. 5.5. NRS 695C.050 is hereby amended to read as follows:**

28 695C.050 1. Except as otherwise provided in this chapter or in specific
29 provisions of this title, the provisions of this title are not applicable to any health
30 maintenance organization granted a certificate of authority under this chapter. This
31 provision does not apply to an insurer licensed and regulated pursuant to this title
32 except with respect to its activities as a health maintenance organization authorized
33 and regulated pursuant to this chapter.

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

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

41 4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693,
42 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733,
43 695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.1759, 695C.176 to
44 695C.200, inclusive, and 695C.265 do not apply to a health maintenance
45 organization that provides health care services through managed care to recipients
46 of Medicaid under the State Plan for Medicaid or insurance pursuant to the
47 Children's Health Insurance Program pursuant to a contract with the Division of
48 Health Care Financing and Policy of the Department of Health and Human
49 Services. This subsection does not exempt a health maintenance organization from
50 any provision of this chapter for services provided pursuant to any other contract.

51 5. The provisions of NRS 695C.1694 to 695C.1698, inclusive, 695C.1701,
52 695C.1708, 695C.1728, 695C.1731, 695C.17333, 695C.17345, 695C.17347,
53 695C.1735, 695C.1737, 695C.1743, 695C.1745 and 695C.1757 apply to a health

1 maintenance organization that provides health care services through managed care
2 to recipients of Medicaid under the State Plan for Medicaid.

3 **6. The provisions of NRS 695C.1735 do not apply to a health maintenance**
4 **organization that provides health care services to members of the Public**
5 **Employees' Benefits Program. This subsection does not exempt a health**
6 **maintenance organization from any provision of this chapter for services**
7 **provided pursuant to any other contract.**

8 **Sec. 6.** NRS 695C.1735 is hereby amended to read as follows:

9 695C.1735 1. A health care plan of a health maintenance organization must
10 provide coverage for benefits payable for expenses incurred for ~~it~~:

11 (a) A mammogram ~~every 2 years, or~~ to screen for breast cancer annually ~~if~~
12 ~~ordered by a provider of health care,~~ for ~~women~~ enrollees who are 40 years of
13 age or older.

14 (b) An imaging test to screen for breast cancer on an interval and at the age
15 deemed most appropriate, when medically necessary, as recommended by the
16 enrollee's provider of health care based on personal or family medical history or
17 additional factors that may increase the risk of breast cancer for the enrollee.

18 (c) A diagnostic imaging test for breast cancer at the age deemed most
19 appropriate, when medically necessary, as recommended by the enrollee's
20 provider of health care to evaluate an abnormality which is:

21 (1) Seen or suspected from a mammogram described in paragraph (a) or
22 an imaging test described in paragraph (b); or

23 (2) Detected by other means of examination.

24 2. A health maintenance organization must ensure that the benefits required
25 by subsection 1 are made available to an enrollee through a provider of health care
26 who participates in the network plan of the health maintenance organization.

27 3. Except as otherwise provided in subsection 5, a health maintenance
28 organization that offers or issues a health care plan shall not:

29 (a) Require an enrollee to pay a ~~higher~~ deductible, ~~any~~ copayment, ~~or~~
30 coinsurance **or any other form of cost-sharing** or require a longer waiting period or
31 other condition to obtain any benefit provided in the health care plan pursuant to
32 subsection 1;

33 (b) Refuse to issue a health care plan or cancel a health care plan solely
34 because the person applying for or covered by the plan uses or may use any such
35 benefit;

36 (c) Offer or pay any type of material inducement or financial incentive to an
37 enrollee to discourage the enrollee from obtaining any benefit provided in the
38 health care plan pursuant to subsection 1;

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

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

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

47 4. A health care plan subject to the provisions of this chapter which is
48 delivered, issued for delivery or renewed on or after January 1, ~~2018,~~ 2024, has
49 the legal effect of including the coverage required by subsection 1, and any
50 provision of the plan or the renewal which is in conflict with this section is void.

51 5. Except as otherwise provided in this section and federal law, a health
52 maintenance organization may use medical management techniques, including,
53 without limitation, any available clinical evidence, to determine the frequency of or

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

3 6. As used in this section:

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

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

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

15 **Sec. 6.5. NRS 695G.090 is hereby amended to read as follows:**

16 695G.090 1. Except as otherwise provided in subsection 3, the provisions of
17 this chapter apply to each organization and insurer that operates as a managed care
18 organization and may include, without limitation, an insurer that issues a policy of
19 health insurance, an insurer that issues a policy of individual or group health
20 insurance, a carrier serving small employers, a fraternal benefit society, a hospital
21 or medical service corporation and a health maintenance organization.

22 2. In addition to the provisions of this chapter, each managed care
23 organization shall comply with:

24 (a) The provisions of chapter 686A of NRS, including all obligations and
25 remedies set forth therein; and

26 (b) Any other applicable provision of this title.

27 3. The provisions of NRS 695G.127, 695G.164, 695G.1645, 695G.167 and
28 695G.200 to 695G.230, inclusive, do not apply to a managed care organization that
29 provides health care services to recipients of Medicaid under the State Plan for
30 Medicaid or insurance pursuant to the Children's Health Insurance Program
31 pursuant to a contract with the Division of Health Care Financing and Policy of the
32 Department of Health and Human Services. ~~[This subsection does]~~

33 **4. The provisions of NRS 695C.1735 do not apply to a managed care**
34 **organization that provides health care services to members of the Public**
35 **Employees' Benefits Program.**

36 **5. Subsections 3 and 4 do** not exempt a managed care organization from any
37 provision of this chapter for services provided pursuant to any other contract.

38 **Sec. 7.** NRS 695G.1713 is hereby amended to read as follows:

39 695G.1713 1. A health care plan issued by a managed care organization
40 must provide coverage for benefits payable for expenses incurred for ~~[a]~~ :

41 (a) A mammogram ~~every 2 years, or~~ **to screen for breast cancer** annually ~~if~~
42 ~~ordered by a provider of health care,~~ **for [women] insureds who are** 40 years of
43 age or older.

44 (b) **An imaging test to screen for breast cancer on an interval and at the age**
45 **deemed most appropriate, when medically necessary, as recommended by the**
46 **insured's provider of health care based on personal or family medical history or**
47 **additional factors that may increase the risk of breast cancer for the insured.**

48 (c) **A diagnostic imaging test for breast cancer at the age deemed most**
49 **appropriate, when medically necessary, as recommended by the insured's**
50 **provider of health care to evaluate an abnormality which is:**

51 (1) **Seen or suspected from a mammogram described in paragraph (a) or**
52 **an imaging test described in paragraph (b); or**

53 (2) **Detected by other means of examination.**

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

4 3. Except as otherwise provided in subsection 5, a managed care organization
5 that offers or issues a health care plan which provides coverage for prescription
6 drugs shall not:

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

11 (b) Refuse to issue a health care plan or cancel a health care plan solely
12 because the person applying for or covered by the plan uses or may use any such
13 benefit;

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

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

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

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

24 4. A health care plan subject to the provisions of this chapter that is delivered,
25 issued for delivery or renewed on or after January 1, ~~2018,~~ 2024, has the legal
26 effect of including the coverage required by subsection 1, and any provision of the
27 plan or the renewal which is in conflict with this section is void.

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

33 6. As used in this section:

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

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

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

45 **Sec. 7.1. Chapter 287 of NRS is hereby amended by adding thereto the**
46 **provisions set forth as sections 7.2 and 7.3 of this act.**

47 **Sec. 7.2. 1. The governing body of any county, school district, municipal**
48 **corporation, political subdivision, public corporation or other local governmental**
49 **agency of the State of Nevada that provides health insurance through a plan of**
50 **self-insurance shall provide coverage for benefits payable for expenses incurred**
51 **for a mammogram every 2 years, or annually if ordered by a provider of health**
52 **care, for women 40 years of age or older.**

1 2. The governing body of any county, school district, municipal
2 corporation, political subdivision, public corporation or other local governmental
3 agency of the State of Nevada that provides health insurance through a plan of
4 self-insurance must ensure that the benefits required by subsection 1 are made
5 available to an insured through a provider of health care who participates in the
6 network plan of the governing body.

7 3. Except as otherwise provided in subsection 5, the governing body of any
8 county, school district, municipal corporation, political subdivision, public
9 corporation or other local governmental agency of the State of Nevada that
10 provides health insurance through a plan of self-insurance shall not:

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

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

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

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

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

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

27 4. A plan of self-insurance subject to the provisions of this chapter which is
28 delivered, issued for delivery or renewed on or after January 1, 2024, has the
29 legal effect of including the coverage required by subsection 1, and any provision
30 of the policy or the renewal which is in conflict with this section is void.

31 5. Except as otherwise provided in this section and federal law, the
32 governing body of any county, school district, municipal corporation, political
33 subdivision, public corporation or other local governmental agency of the State of
34 Nevada that provides health insurance through a plan of self-insurance may use
35 medical management techniques, including, without limitation, any available
36 clinical evidence, to determine the frequency of or treatment relating to any
37 benefit required by this section or the type of provider of health care to use for
38 such treatment.

39 6. As used in this section:

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

44 (b) "Network plan" means a plan of self-insurance provided by the
45 governing body of a local governmental agency under which the financing and
46 delivery of medical care, including items and services paid for as medical care,
47 are provided, in whole or in part, through a defined set of providers under
48 contract with the governing body. The term does not include an arrangement for
49 the financing of premiums.

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

51 Sec. 7.3. 1. If the Board provides health insurance through a plan of self-
52 insurance, it shall provide coverage for benefits payable for expenses incurred for

1 a mammogram every 2 years, or annually if ordered by a provider of health care,
2 for women 40 years of age or older.

3 2. If the Board provides health insurance through a plan of self-insurance,
4 it must ensure that the benefits required by subsection 1 are made available to an
5 insured through a provider of health care who participates in the network plan of
6 the Board.

7 3. Except as otherwise provided in subsection 5, if the Board provides
8 health insurance through a plan of self-insurance, it shall not:

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

12 (b) Refuse to issue a plan of self-insurance or cancel a plan of self-insurance
13 solely because the person applying for or covered by the plan uses or may use any
14 such benefit;

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

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

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

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

25 4. A plan of self-insurance described in subsection 1 which is delivered,
26 issued for delivery or renewed on or after January 1, 2024, has the legal effect of
27 including the coverage required by subsection 1, and any provision of the policy
28 or the renewal which is in conflict with this section is void.

29 5. Except as otherwise provided in this section and federal law, if the Board
30 provides health insurance through a plan of self-insurance, the Board may use
31 medical management techniques, including, without limitation, any available
32 clinical evidence, to determine the frequency of or treatment relating to any
33 benefit required by this section or the type of provider of health care to use for
34 such treatment.

35 6. As used in this section:

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

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

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

46 Sec. 7.5. NRS 287.010 is hereby amended to read as follows:

47 287.010 1. The governing body of any county, school district, municipal
48 corporation, political subdivision, public corporation or other local governmental
49 agency of the State of Nevada may:

50 (a) Adopt and carry into effect a system of group life, accident or health
51 insurance, or any combination thereof, for the benefit of its officers and employees,
52 and the dependents of officers and employees who elect to accept the insurance and

1 who, where necessary, have authorized the governing body to make deductions
2 from their compensation for the payment of premiums on the insurance.

3 (b) Purchase group policies of life, accident or health insurance, or any
4 combination thereof, for the benefit of such officers and employees, and the
5 dependents of such officers and employees, as have authorized the purchase, from
6 insurance companies authorized to transact the business of such insurance in the
7 State of Nevada, and, where necessary, deduct from the compensation of officers
8 and employees the premiums upon insurance and pay the deductions upon the
9 premiums.

10 (c) Provide group life, accident or health coverage through a self-insurance
11 reserve fund and, where necessary, deduct contributions to the maintenance of the
12 fund from the compensation of officers and employees and pay the deductions into
13 the fund. The money accumulated for this purpose through deductions from the
14 compensation of officers and employees and contributions of the governing body
15 must be maintained as an internal service fund as defined by NRS 354.543. The
16 money must be deposited in a state or national bank or credit union authorized to
17 transact business in the State of Nevada. Any independent administrator of a fund
18 created under this section is subject to the licensing requirements of chapter 683A
19 of NRS, and must be a resident of this State. Any contract with an independent
20 administrator must be approved by the Commissioner of Insurance as to the
21 reasonableness of administrative charges in relation to contributions collected and
22 benefits provided. The provisions of NRS 686A.135, 687B.352, 687B.408,
23 687B.723, 687B.725, 689B.030 to 689B.0369, inclusive, 689B.0375 to 689B.050,
24 inclusive, 689B.265, 689B.287 and 689B.500 apply to coverage provided pursuant
25 to this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and
26 689B.500 only apply to coverage for active officers and employees of the
27 governing body, or the dependents of such officers and employees.

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

33 2. If a school district offers group insurance to its officers and employees
34 pursuant to this section, members of the board of trustees of the school district must
35 not be excluded from participating in the group insurance. If the amount of the
36 deductions from compensation required to pay for the group insurance exceeds the
37 compensation to which a trustee is entitled, the difference must be paid by the
38 trustee.

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

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

51 (a) Shall be deemed, solely for the purposes of this section, to be officers and
52 employees of the county, school district, municipal corporation, political

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

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

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

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

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

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

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

13 **Sec. 7.7. NRS 287.040 is hereby amended to read as follows:**

14 287.040 The provisions of NRS 287.010 to 287.040, inclusive, **and section**
15 **7.2 of this act** do not make it compulsory upon any governing body of any county,
16 school district, municipal corporation, political subdivision, public corporation or
17 other local governmental agency of the State of Nevada, except as otherwise
18 provided in NRS 287.021 or subsection 4 of NRS 287.023 or in an agreement
19 entered into pursuant to subsection 3 of NRS 287.015, to pay any premiums,
20 contributions or other costs for group insurance, a plan of benefits or medical or
21 hospital services established pursuant to NRS 287.010, 287.015, 287.020 or
22 paragraph (b), (c) or (d) of subsection 1 of NRS 287.025, for coverage under the
23 Public Employees' Benefits Program, or to make any contributions to a trust fund
24 established pursuant to NRS 287.017, or upon any officer or employee of any
25 county, school district, municipal corporation, political subdivision, public
26 corporation or other local governmental agency of this State to accept any such
27 coverage or to assign his or her wages or salary in payment of premiums or
28 contributions therefor.

29 **Sec. 7.9. NRS 287.0402 is hereby amended to read as follows:**

30 287.0402 As used in NRS 287.0402 to 287.049, inclusive, **and section 7.3 of**
31 **this act**, unless the context otherwise requires, the words and terms defined in NRS
32 287.0404 to 287.04064, inclusive, have the meanings ascribed to them in those
33 sections.

34 **Sec. 8. NRS 287.04335 is hereby amended to read as follows:**

35 287.04335 If the Board provides health insurance through a plan of self-
36 insurance, it shall comply with the provisions of NRS 686A.135, 687B.352,
37 687B.409, 687B.723, 687B.725, 689B.0353, 689B.255, 695C.1723, 695G.150,
38 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665,
39 695G.167, 695G.1675, 695G.170 to **695G.1712, inclusive, 695G.1714 to**
40 **695G.174, inclusive, 695G.176, 695G.177, 695G.200 to 695G.230, inclusive,**
41 **695G.241 to 695G.310, inclusive, and 695G.405, in the same manner as an insurer**
42 **that is licensed pursuant to title 57 of NRS is required to comply with those**
43 **provisions.**

44 **Sec. 9. This act becomes effective on January 1, 2024.**