

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; and providing other matters properly relating thereto.

Legislative Counsel’s Digest:

1 Existing law requires public and private policies of health insurance regulated
2 under Nevada law to include certain coverage. (NRS 287.010, 287.04335,
3 422.2712-422.27241, 689A.04033-689A.0465, 689B.0303-689B.0379, 689C.1655-
4 689C.169, 689C.194, 689C.1945, 689C.195, 695A.184-695A.1875, 695B.1901-
5 695B.1948, 695C.1691-695C.176, 695G.162-695G.177) Existing law also requires
6 employers to provide certain benefits for health care to employees, including the
7 coverage required of health insurers, if the employer provides health benefits for its
8 employees. (NRS 608.1555) **Sections 1.3, 3, 4, 6, 7, 8, 11, 13, 14 and 15** of this
9 bill: (1) require certain public and private policies of health insurance and health
10 care plans, including Medicaid, to cover the treatment of conditions relating to
11 gender dysphoria and gender incongruence; (2) authorize those policies and plans
12 to prescribe requirements that must be satisfied before the insurer will cover
13 surgical treatment for conditions relating to gender dysphoria or gender
14 incongruence for persons who are less than 18 years of age; and (3) require an



15 insurer to consult with a provider of health care with experience in prescribing or
16 delivering gender-affirming treatment when considering certain appeals of a denial
17 of coverage. **Sections 1.6, 3.6, 4.6, 6.6, 7.6, 8.6, 11.6 and 15.6** of this bill prohibit
18 an insurer from engaging in certain discrimination on the basis of gender identity or
19 expression. **Sections 2, 5, 9 and 12** of this bill make conforming changes to
20 indicate the proper placement of **sections 1.3, 1.6, 4, 4.6, 8, 8.6, 15 and 15.6** in the
21 Nevada Revised Statutes.

22 **Section 10** of this bill authorizes the Commissioner of Insurance to suspend or
23 revoke the certificate of a health maintenance organization that fails to comply with
24 the requirements of **sections 8 and 8.6**. The Commissioner would also be
25 authorized to take such action against other health insurers who fail to comply with
26 the requirements of **sections 1.3, 1.6, 3, 3.6, 4, 4.6, 6, 6.6, 7, 7.6, 11 and 11.6** of
27 this bill. (NRS 680A.200)

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
2 adding thereto the provisions set forth as sections 1.3 and 1.6 of this
3 act.

4 **Sec. 1.3. 1. *Except as otherwise provided in this section, an***
5 ***insurer that issues a policy of health insurance shall include in the***
6 ***policy coverage for the medically necessary treatment of***
7 ***conditions relating to gender dysphoria and gender incongruence.***
8 ***Such coverage must include coverage of medically necessary***
9 ***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*
22 ***treatment of gender dysphoria or gender incongruence.***

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

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



1 or revisions for purposes other than gender transition or
2 affirmation.

3 4. An insurer that issues a policy of health insurance may
4 prescribe requirements that must be satisfied before the insurer
5 covers surgical treatment of conditions relating to gender
6 dysphoria or gender incongruence for an insured who is less than
7 18 years of age. Such requirements may include, without
8 limitation, requirements that:

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

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

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

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

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

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

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

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

42 8. A policy of health insurance subject to the provisions of
43 this chapter that is delivered, issued for delivery or renewed on or
44 after July 1, 2023, has the legal effect of including the coverage



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

3 *9. As used in this section:*

4 *(a) "Cosmetic surgery":*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



1 (4) Required to improve a specific health condition of a
2 patient or to preserve the existing state of health of the patient;
3 and

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

6 ↪ A provider of health care prescribing, ordering, recommending
7 or approving a health care service or product does not, by itself,
8 make that health care service or product medically necessary.

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

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

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

22 1. Denying, cancelling, limiting or refusing to issue or renew
23 a policy of health insurance on the basis of the actual or perceived
24 gender identity or expression of a person or a family member of
25 the person;

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

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

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

36 (a) Related to gender transition, provided that there is
37 coverage under the policy for the services when the services are
38 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
42 delivery to a person residing in another state, and if the insurance
43 commissioner or corresponding public officer of that other state has
44 informed the Commissioner that the policy is not subject to approval
45 or disapproval by that officer, the Commissioner may by ruling



1 require that the policy meet the standards set forth in NRS 689A.030
2 to 689A.320, inclusive **[H]**, *and sections 1.3 and 1.6 of this act.*

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

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

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

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

28 **3.** *An insurer that issues a policy of group health insurance*
29 *shall not categorically refuse to cover medically necessary gender-*
30 *affirming treatments or procedures or revisions to prior treatments*
31 *if the policy provides coverage for any such services, procedures*
32 *or revisions for purposes other than gender transition or*
33 *affirmation.*

34 **4.** *An insurer that issues a policy of group health insurance*
35 *may prescribe requirements that must be satisfied before the*
36 *insurer covers surgical treatment of conditions relating to gender*
37 *dysphoria or gender incongruence for an insured who is less than*
38 *18 years of age. Such requirements may include, without*
39 *limitation, requirements that:*

- 40 (a) *The treatment must be recommended by a psychologist,*
41 *psychiatrist or other mental health professional;*
- 42 (b) *The treatment must be recommended by a physician;*
- 43 (c) *The insured must provide a written expression of the desire*
44 *of the insured to undergo the treatment;*



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

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

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

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

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

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

35 9. As used in this section:

36 (a) "Cosmetic surgery":

37 (1) Means a surgical procedure that:

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

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

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

43 (2) Includes, without limitation, cosmetic surgery directed
44 at preserving beauty.



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

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

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

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

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

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

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

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

28 (1) Provided in accordance with generally accepted
29 standards of medical practice;

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

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

34 (4) Required to improve a specific health condition of a
35 patient or to preserve the existing state of health of the patient;
36 and

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

39 ↪ A provider of health care prescribing, ordering, recommending
40 or approving a health care service or product does not, by itself,
41 make that health care service or product medically necessary.

42 (d) "Network plan" means a policy of group health insurance
43 offered by an insurer under which the financing and delivery of
44 medical care, including items and services paid for as medical
45 care, are provided, in whole or in part, through a defined set of



1 *providers under contract with the insurer. The term does not*
2 *include an arrangement for the financing of premiums.*

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

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

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

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

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

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

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

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

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

30 **Sec. 4.** 1. *Except as otherwise provided in this section, a*
31 *carrier that issues a health benefit plan shall include in the health*
32 *benefit plan coverage for the medically necessary treatment of*
33 *conditions relating to gender dysphoria and gender incongruence.*
34 *Such coverage must include coverage of medically necessary*
35 *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;*



1 (j) *Physician assistants; and*

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

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

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

12 4. *A carrier that issues a health benefit plan may prescribe*
13 *requirements that must be satisfied before the carrier covers*
14 *surgical treatment of conditions relating to gender dysphoria or*
15 *gender incongruence for an insured who is less than 18 years of*
16 *age. Such requirements may include, without limitation,*
17 *requirements that:*

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

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

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

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

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

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

34 6. *A carrier shall make a reasonable effort to ensure that the*
35 *benefits required by subsection 1 are made available to an insured*
36 *through a provider of health care who participates in the network*
37 *plan of the carrier. If, after a reasonable effort, the carrier is*
38 *unable to make such benefits available through such a provider of*
39 *health care, the carrier may treat the treatment that the carrier is*
40 *unable to make available through such a provider of health care*
41 *in the same manner as other services provided by a provider of*
42 *health care who does not participate in the network plan of the*
43 *carrier.*

44 7. *If an insured appeals the denial of a claim or coverage*
45 *under this section on the grounds that the treatment requested by*



1 *the insured is not medically necessary, the carrier must consult*
2 *with a provider of health care who has experience in prescribing*
3 *or delivering gender-affirming treatment concerning the medical*
4 *necessity of the treatment requested by the insured when*
5 *considering the appeal*

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

11 9. *As used in this section:*

12 (a) *“Cosmetic surgery”:*

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

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

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

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

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

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

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

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

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

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

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

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

44 (c) *“Medically necessary” means health care services or*
45 *products that a prudent provider of health care would provide to a*



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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

6 689C.425 A voluntary purchasing group and any contract
7 issued to such a group pursuant to NRS 689C.360 to 689C.600,
8 inclusive, are subject to the provisions of NRS 689C.015 to
9 689C.355, inclusive, *and sections 4 and 4.6 of this act*, to the extent
10 applicable and not in conflict with the express provisions of NRS
11 687B.408 and 689C.360 to 689C.600, inclusive.

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

14 **Sec. 6. 1.** *Except as otherwise provided in this section, a*
15 *society that issues a benefit contract shall include in the benefit*
16 *contract coverage for the medically necessary treatment of*
17 *conditions relating to gender dysphoria and gender incongruence.*
18 *Such coverage must include coverage of medically necessary*
19 *psychosocial and surgical intervention and any other medically*
20 *necessary treatment for such disorders provided by:*

21 *(a) Endocrinologists;*

22 *(b) Pediatric endocrinologists;*

23 *(c) Social workers;*

24 *(d) Psychiatrists;*

25 *(e) Psychologists;*

26 *(f) Gynecologists;*

27 *(g) Speech-language pathologists;*

28 *(h) Primary care physicians;*

29 *(i) Advanced practice registered nurses;*

30 *(j) Physician assistants; and*

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

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

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

41 *4. A society that issues a benefit contract may prescribe*
42 *requirements that must be satisfied before the society covers*
43 *surgical treatment of conditions relating to gender dysphoria or*
44 *gender incongruence for an insured who is less than 18 years of*



1 *age. Such requirements may include, without limitation,*
2 *requirements that:*

3 *(a) The treatment must be recommended by a psychologist,*
4 *psychiatrist or 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*
7 *of the insured to undergo the treatment;*

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

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

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

19 *6. A society shall make a reasonable effort to ensure that the*
20 *benefits required by subsection 1 are made available to an insured*
21 *through a provider of health care who participates in the network*
22 *plan of the society. If, after a reasonable effort, the society is*
23 *unable to make such benefits available through such a provider of*
24 *health care, the society may treat the treatment that the society is*
25 *unable to make available through such a provider of health care*
26 *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*
28 *society.*

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

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

41 *9. As used in this section:*

42 *(a) "Cosmetic surgery":*

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

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



1 (II) Does not prevent or treat illness or disease; and
2 (III) Is primarily directed at improving the appearance
3 of a person.

4 (2) Includes, without limitation, cosmetic surgery directed
5 at preserving beauty.

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

11 (1) A marked difference between gender identity or
12 expression and primary or secondary sex characteristics or
13 anticipated secondary sex characteristics in young adolescents.

14 (2) A strong desire to be rid of primary or secondary sex
15 characteristics because of a marked difference between such sex
16 characteristics and gender identity or expression or a desire to
17 prevent the development of anticipated secondary sex
18 characteristics in young adolescents.

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

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

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

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

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

33 (1) Provided in accordance with generally accepted
34 standards of medical practice;

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

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

39 (4) Required to improve a specific health condition of a
40 patient or to preserve the existing state of health of the patient;
41 and

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



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

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

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

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

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

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

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

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

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

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

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

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

45 (a) *Endocrinologists;*



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

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

15 3. *A hospital or medical services corporation that issues a*
16 *policy of health insurance shall not categorically refuse to cover*
17 *medically necessary gender-affirming treatments or procedures or*
18 *revisions to prior treatments if the policy provides coverage for any*
19 *such services, procedures or revisions for purposes other than*
20 *gender transition or affirmation.*

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

28 (a) *The treatment must be recommended by a psychologist,*
29 *psychiatrist or 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*
32 *of the insured to undergo the treatment;*

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

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

39 5. *When determining whether treatment is medically*
40 *necessary for the purposes of this section, a hospital or medical*
41 *services corporation must consider the most recent Standards of*
42 *Care published by the World Professional Association for*
43 *Transgender Health, or its successor organization.*

44 6. *A hospital or medical services corporation shall make a*
45 *reasonable effort to ensure that the benefits required by subsection*



1 *I are made available to an insured through a provider of health*
2 *care who participates in the network plan of the hospital or*
3 *medical services corporation. If, after a reasonable effort, the*
4 *hospital or medical services corporation is unable to make such*
5 *benefits available through such a provider of health care, the*
6 *hospital or medical services corporation may treat the treatment*
7 *that the hospital or medical services corporation is unable to make*
8 *available through such a provider of health care in the same*
9 *manner as other services provided by a provider of health care*
10 *who does not participate in the network plan of the hospital or*
11 *medical services corporation.*

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

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

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

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

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

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

40 (1) *A marked difference between gender identity or*
41 *expression and primary or secondary sex characteristics or*
42 *anticipated secondary sex characteristics in young adolescents.*

43 (2) *A strong desire to be rid of primary or secondary sex*
44 *characteristics because of a marked difference between such sex*
45 *characteristics and gender identity or expression or a desire to*



1 *prevent the development of anticipated secondary sex*
2 *characteristics in young adolescents.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

21 **Sec. 8. 1.** *Except as otherwise provided in this section, a*
22 *health maintenance organization that issues a health care plan*
23 *shall include in the health care plan coverage for the medically*
24 *necessary treatment of conditions relating to gender dysphoria and*
25 *gender incongruence. Such coverage must include coverage of*
26 *medically necessary psychosocial and surgical intervention and*
27 *any other medically necessary treatment for such disorders*
28 *provided by:*

29 *(a) Endocrinologists;*

30 *(b) Pediatric endocrinologists;*

31 *(c) Social workers;*

32 *(d) Psychiatrists;*

33 *(e) Psychologists;*

34 *(f) Gynecologists;*

35 *(g) Speech-language pathologists;*

36 *(h) Primary care physicians;*

37 *(i) Advanced practice registered nurses;*

38 *(j) Physician assistants; and*

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

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

44 *3. A health maintenance organization that issues a health*
45 *care plan shall not categorically refuse to cover medically*



1 *necessary gender-affirming treatments or procedures or revisions*
2 *to prior treatments if the plan provides coverage for any such*
3 *services, procedures or revisions for purposes other than gender*
4 *transition or affirmation.*

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

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

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

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

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

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

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

27 *6. A health maintenance organization shall make a*
28 *reasonable effort to ensure that the benefits required by subsection*
29 *1 are made available to an enrollee through a provider of health*
30 *care who participates in the network plan of the*
31 *health maintenance organization. If, after a reasonable effort, the*
32 *health maintenance organization is unable to make such benefits*
33 *available through such a provider of health care, the health*
34 *maintenance organization may treat the treatment that the health*
35 *maintenance organization is unable to make available through*
36 *such a provider of health care in the same manner as other*
37 *services provided by a provider of health care who does not*
38 *participate in the network plan of the health maintenance*
39 *organization.*

40 *7. If an enrollee appeals the denial of a claim or coverage*
41 *under this section on the grounds that the treatment requested by*
42 *the enrollee is not medically necessary, the health maintenance*
43 *organization must consult with a provider of health care who has*
44 *experience in prescribing or delivering gender-affirming treatment*



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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

3 695C.050 1. Except as otherwise provided in this chapter or
4 in specific provisions of this title, the provisions of this title are not
5 applicable to any health maintenance organization granted a
6 certificate of authority under this chapter. This provision does not
7 apply to an insurer licensed and regulated pursuant to this title
8 except with respect to its activities as a health maintenance
9 organization authorized and regulated pursuant to this chapter.

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

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

17 4. The provisions of NRS 695C.110, 695C.125, 695C.1691,
18 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to
19 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734,
20 695C.1751, 695C.1755, 695C.1759, 695C.176 to 695C.200,
21 inclusive, and 695C.265 do not apply to a health maintenance
22 organization that provides health care services through managed
23 care to recipients of Medicaid under the State Plan for Medicaid or
24 insurance pursuant to the Children's Health Insurance Program
25 pursuant to a contract with the Division of Health Care Financing
26 and Policy of the Department of Health and Human Services. This
27 subsection does not exempt a health maintenance organization from
28 any provision of this chapter for services provided pursuant to any
29 other contract.

30 5. The provisions of NRS 695C.1694 to 695C.1698, inclusive,
31 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333,
32 695C.17345, 695C.17347, 695C.1735, 695C.1737, 695C.1743,
33 695C.1745 and 695C.1757 **and sections 8 and 8.6 of this act** apply
34 to a health maintenance organization that provides health care
35 services through managed care to recipients of Medicaid under the
36 State Plan for Medicaid.

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

38 695C.330 1. The Commissioner may suspend or revoke any
39 certificate of authority issued to a health maintenance organization
40 pursuant to the provisions of this chapter if the Commissioner finds
41 that any of the following conditions exist:

42 (a) The health maintenance organization is operating
43 significantly in contravention of its basic organizational document,
44 its health care plan or in a manner contrary to that described in and
45 reasonably inferred from any other information submitted pursuant



1 to NRS 695C.060, 695C.070 and 695C.140, unless any amendments
2 to those submissions have been filed with and approved by the
3 Commissioner;

4 (b) The health maintenance organization issues evidence of
5 coverage or uses a schedule of charges for health care services
6 which do not comply with the requirements of NRS 695C.1691 to
7 695C.200, inclusive, or 695C.207 ~~H~~ *or sections 8 and 8.6 of this*
8 *act*;

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

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

13 (1) Does not meet the requirements of subsection 1 of NRS
14 695C.080; or

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

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

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

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

26 (1) Resolving complaints in a manner reasonably to dispose
27 of valid complaints; and

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

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

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

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

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

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

43 3. If the certificate of authority of a health maintenance
44 organization is suspended, the health maintenance organization shall
45 not, during the period of that suspension, enroll any additional



1 groups or new individual contracts, unless those groups or persons
2 were contracted for before the date of suspension.

3 4. If the certificate of authority of a health maintenance
4 organization is revoked, the organization shall proceed, immediately
5 following the effective date of the order of revocation, to wind up its
6 affairs and shall conduct no further business except as may be
7 essential to the orderly conclusion of the affairs of the organization.
8 It shall engage in no further advertising or solicitation of any kind.
9 The Commissioner may, by written order, permit such further
10 operation of the organization as the Commissioner may find to be in
11 the best interest of enrollees to the end that enrollees are afforded
12 the greatest practical opportunity to obtain continuing coverage for
13 health care.

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

16 **Sec. 11. 1.** *Except as otherwise provided in this section, a*
17 *managed care organization that issues a health care plan shall*
18 *include in the health care plan coverage for the medically*
19 *necessary treatment of conditions relating to gender dysphoria and*
20 *gender incongruence. Such coverage must include coverage of*
21 *medically necessary psychosocial and surgical intervention and*
22 *any other medically necessary treatment for such disorders*
23 *provided by:*

24 (a) *Endocrinologists;*

25 (b) *Pediatric endocrinologists;*

26 (c) *Social workers;*

27 (d) *Psychiatrists;*

28 (e) *Psychologists;*

29 (f) *Gynecologists;*

30 (g) *Speech-language pathologists;*

31 (h) *Primary care physicians;*

32 (i) *Advanced practice registered nurses;*

33 (j) *Physician assistants; and*

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

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

39 3. *A managed care organization that issues a health care*
40 *plan shall not categorically refuse to cover medically necessary*
41 *gender-affirming treatments or procedures or revisions to prior*
42 *treatments if the plan provides coverage for any such services,*
43 *procedures or revisions for purposes other than gender transition*
44 *or affirmation.*



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

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

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

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

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

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

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

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

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

42 8. Evidence of coverage subject to the provisions of this
43 chapter that is delivered, issued for delivery or renewed on or after
44 July 1, 2023, has the legal effect of including the coverage



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

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

4 (a) **“Cosmetic surgery”:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

41 **Sec. 12.** NRS 232.320 is hereby amended to read as follows:
42 232.320 1. The Director:

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



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

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

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

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

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

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

22 (c) Shall administer any state program for persons with
23 developmental disabilities established pursuant to the
24 Developmental Disabilities Assistance and Bill of Rights Act of
25 2000, 42 U.S.C. §§ 15001 et seq.

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

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

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

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

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

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

44 (6) Contain any other information necessary for the
45 Department to communicate effectively with the Federal



1 Government concerning demographic trends, formulas for the
2 distribution of federal money and any need for the modification of
3 programs administered by the Department.

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

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

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

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

15 287.010 1. The governing body of any county, school
16 district, municipal corporation, political subdivision, public
17 corporation or other local governmental agency of the State of
18 Nevada may:

19 (a) Adopt and carry into effect a system of group life, accident
20 or health insurance, or any combination thereof, for the benefit of its
21 officers and employees, and the dependents of officers and
22 employees who elect to accept the insurance and who, where
23 necessary, have authorized the governing body to make deductions
24 from their compensation for the payment of premiums on the
25 insurance.

26 (b) Purchase group policies of life, accident or health insurance,
27 or any combination thereof, for the benefit of such officers and
28 employees, and the dependents of such officers and employees, as
29 have authorized the purchase, from insurance companies authorized
30 to transact the business of such insurance in the State of Nevada,
31 and, where necessary, deduct from the compensation of officers and
32 employees the premiums upon insurance and pay the deductions
33 upon the premiums.

34 (c) Provide group life, accident or health coverage through a
35 self-insurance reserve fund and, where necessary, deduct
36 contributions to the maintenance of the fund from the compensation
37 of officers and employees and pay the deductions into the fund. The
38 money accumulated for this purpose through deductions from
39 the compensation of officers and employees and contributions of the
40 governing body must be maintained as an internal service fund as
41 defined by NRS 354.543. The money must be deposited in a state or
42 national bank or credit union authorized to transact business in the
43 State of Nevada. Any independent administrator of a fund created
44 under this section is subject to the licensing requirements of chapter
45 683A of NRS, and must be a resident of this State. Any contract



1 with an independent administrator must be approved by the
2 Commissioner of Insurance as to the reasonableness of
3 administrative charges in relation to contributions collected and
4 benefits provided. The provisions of NRS 686A.135, 687B.352,
5 687B.408, 687B.723, 687B.725, 689B.030 to 689B.050, inclusive,
6 *and sections 3 and 3.6 of this act*, 689B.265, 689B.287 and
7 689B.500 apply to coverage provided pursuant to this paragraph,
8 except that the provisions of NRS 689B.0378, 689B.03785 and
9 689B.500 only apply to coverage for active officers and employees
10 of the governing body, or the dependents of such officers and
11 employees.

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

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

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

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

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

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



1 5. A contract that is entered into pursuant to subsection 3:
2 (a) Must be submitted to the Commissioner of Insurance for
3 approval not less than 30 days before the date on which the contract
4 is to become effective.

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

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

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

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

14 287.04335 If the Board provides health insurance through a
15 plan of self-insurance, it shall comply with the provisions of NRS
16 686A.135, 687B.352, 687B.409, 687B.723, 687B.725, 689B.0353,
17 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162,
18 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167,
19 695G.1675, 695G.170 to 695G.174, inclusive, *and sections 11 and*
20 *11.6 of this act*, 695G.176, 695G.177, 695G.200 to 695G.230,
21 inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, in the
22 same manner as an insurer that is licensed pursuant to title 57 of
23 NRS is required to comply with those provisions.

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

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

- 35 (a) *Endocrinologists;*
36 (b) *Pediatric endocrinologists;*
37 (c) *Social workers;*
38 (d) *Psychiatrists;*
39 (e) *Psychologists;*
40 (f) *Gynecologists;*
41 (g) *Speech-language pathologists;*
42 (h) *Primary care physicians;*
43 (i) *Advanced practice registered nurses;*
44 (j) *Physician assistants; and*



1 (k) Any other providers of medically necessary services for the
2 treatment of gender dysphoria or gender incongruence.

3 2. This section does not require the Director to include in the
4 State Plan for Medicaid coverage for cosmetic surgery performed
5 by a plastic surgeon or reconstructive surgeon that is not
6 medically necessary.

7 3. The Department shall not categorically refuse to cover any
8 medically necessary gender-affirming treatments or procedures or
9 revisions to prior treatments if the State Plan for Medicaid
10 provides coverage for any such services, procedures or revisions
11 for purposes other than gender transition or affirmation.

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

17 5. If a person appeals the denial of a payment or coverage
18 under this section on the grounds that the treatment requested by
19 the person is not medically necessary, the Division must consult
20 with a provider of health care who has experience in prescribing
21 or delivering gender-affirming treatment concerning the medical
22 necessity of the treatment requested by the person when
23 considering the appeal.

24 6. As used in this section:

25 (a) "Cosmetic surgery":

26 (1) Means a surgical procedure that:

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

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

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

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

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

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

42 (2) A strong desire to be rid of primary or secondary sex
43 characteristics because of a marked difference between such sex
44 characteristics and gender identity or expression or a desire to



1 *prevent the development of anticipated secondary sex*
2 *characteristics in young adolescents.*

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

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

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

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

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

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

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

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

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

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

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

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

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

37 1. *Denying, cancelling, limiting or refusing to issue a*
38 *payment or coverage on the basis of the actual or perceived gender*
39 *identity or expression of a person or a family member of the*
40 *person;*

41 2. *Imposing a payment that is based on the actual or*
42 *perceived gender identity or expression of a recipient of Medicaid*
43 *or a family member of the recipient;*



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

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

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

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

12 **Sec. 16.** The provisions of NRS 354.599 do not apply to any
13 additional expenses of a local government that are related to the
14 provisions of this act.

15 **Sec. 17.** This act becomes effective on July 1, 2023.

