

(Reprinted with amendments adopted on June 2, 2023)

SECOND REPRINT

S.B. 163

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

FEBRUARY 15, 2023

JOINT SPONSOR: ASSEMBLYWOMAN GONZÁLEZ

Referred to Committee on Commerce and Labor

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

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

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

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

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

Legislative Counsel’s Digest:

1 Existing law requires public and private policies of health insurance regulated
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



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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**.
27 (NRS 680A.200) **Sections 16 and 17** of this bill make appropriations to the
28 Division of Health Care Financing and Policy of the Department of Health and
29 Human Services and authorize certain related expenditures for: (1) the costs of
30 providing the coverage under Medicaid required by **section 15**; and (2) certain
31 other costs associated with carrying out the provisions of this bill.

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.**



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

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

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

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

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

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

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

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

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

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



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

6 9. As used in this section:

7 (a) "Cosmetic surgery":

8 (1) Means a surgical procedure that:

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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



1 **Sec. 2.** NRS 689A.330 is hereby amended to read as follows:
2 689A.330 If any policy is issued by a domestic insurer for
3 delivery to a person residing in another state, and if the insurance
4 commissioner or corresponding public officer of that other state has
5 informed the Commissioner that the policy is not subject to approval
6 or disapproval by that officer, the Commissioner may by ruling
7 require that the policy meet the standards set forth in NRS 689A.030
8 to 689A.320, inclusive ~~[]~~, *and sections 1.3 and 1.6 of this act.*

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

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

- 18 (i) *Endocrinologists;*
- 19 (ii) *Pediatric endocrinologists;*
- 20 (iii) *Social workers;*
- 21 (iv) *Psychiatrists;*
- 22 (v) *Psychologists;*
- 23 (vi) *Gynecologists;*
- 24 (vii) *Speech-language pathologists;*
- 25 (viii) *Primary care physicians;*
- 26 (ix) *Advanced practice registered nurses;*
- 27 (x) *Physician assistants; and*
- 28 (xi) *Any other providers of medically necessary services for the*
29 *treatment of gender dysphoria or gender incongruence.*

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

34 **3.** *An insurer that issues a policy of group health insurance*
35 *shall not categorically refuse to cover medically necessary gender-*
36 *affirming treatments or procedures or revisions to prior treatments*
37 *if the policy provides coverage for any such services, procedures*
38 *or revisions for purposes other than gender transition or*
39 *affirmation.*

40 **4.** *An insurer that issues a policy of group health insurance*
41 *may prescribe requirements that must be satisfied before the*
42 *insurer covers surgical treatment of conditions relating to gender*
43 *dysphoria or gender incongruence for an insured who is less than*
44 *18 years of age. Such requirements may include, without*
45 *limitation, requirements that:*



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

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

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

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

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

12 5. *When determining whether treatment is medically*
13 *necessary for the purposes of this section, an insurer 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 6. *An insurer shall make a reasonable effort to ensure that*
18 *the benefits required by subsection 1 are made available to an*
19 *insured through a provider of health care who participates in the*
20 *network plan of the insurer. If, after a reasonable effort, the*
21 *insurer is unable to make such benefits available through such a*
22 *provider of health care, the insurer may treat the treatment that*
23 *the insurer is unable to make available through such a provider of*
24 *health care in the same manner as other services provided by a*
25 *provider of health care who does not participate in the network*
26 *plan of the insurer.*

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

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

40 9. *As used in this section:*

41 (a) *“Cosmetic surgery”:*

42 (I) *Means a surgical procedure that:*

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

14 1. Denying, cancelling, limiting or refusing to issue or renew
15 a policy of group health insurance on the basis of the actual or
16 perceived gender identity or expression of a person or a family
17 member of the person;

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

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

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

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

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

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

34 **Sec. 4. 1.** Except as otherwise provided in this section, a
35 carrier that issues a health benefit plan shall include in the health
36 benefit plan coverage for the medically necessary treatment of
37 conditions relating to gender dysphoria and gender incongruence.
38 Such coverage must include coverage of medically necessary
39 psychosocial and surgical intervention and any other medically
40 necessary treatment for such disorders provided by:

- 41 (a) Endocrinologists;
42 (b) Pediatric endocrinologists;
43 (c) Social workers;
44 (d) Psychiatrists;
45 (e) Psychologists;



1 (f) Gynecologists;
2 (g) Speech-language pathologists;
3 (h) Primary care physicians;
4 (i) Advanced practice registered nurses;
5 (j) Physician assistants; and
6 (k) Any other providers of medically necessary services for the
7 treatment of gender dysphoria or gender incongruence.

8 2. This section does not require a health benefit plan to
9 include coverage for cosmetic surgery performed by a plastic
10 surgeon or reconstructive surgeon that is not medically necessary.

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

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

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

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

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

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

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

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

38 6. A carrier shall make a reasonable effort to ensure that the
39 benefits required by subsection 1 are made available to an insured
40 through a provider of health care who participates in the network
41 plan of the carrier. If, after a reasonable effort, the carrier is
42 unable to make such benefits available through such a provider of
43 health care, the carrier may treat the treatment that the carrier is
44 unable to make available through such a provider of health care
45 in the same manner as other services provided by a provider of



1 *health care who does not participate in the network plan of the*
2 *carrier.*

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

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

15 *9. As used in this section:*

16 *(a) "Cosmetic surgery":*

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

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

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

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

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

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

30 *(1) A marked difference between gender identity or*
31 *expression and primary or secondary sex characteristics or*
32 *anticipated secondary sex characteristics in young adolescents.*

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

10 689C.425 A voluntary purchasing group and any contract
11 issued to such a group pursuant to NRS 689C.360 to 689C.600,
12 inclusive, are subject to the provisions of NRS 689C.015 to
13 689C.355, inclusive, **and sections 4 and 4.6 of this act**, to the extent
14 applicable and not in conflict with the express provisions of NRS
15 687B.408 and 689C.360 to 689C.600, inclusive.

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

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

25 (a) **Endocrinologists;**

26 (b) **Pediatric endocrinologists;**

27 (c) **Social workers;**

28 (d) **Psychiatrists;**

29 (e) **Psychologists;**

30 (f) **Gynecologists;**

31 (g) **Speech-language pathologists;**

32 (h) **Primary care physicians;**

33 (i) **Advanced practice registered nurses;**

34 (j) **Physician assistants; and**

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

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

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



1 4. A society that issues a benefit contract may prescribe
2 requirements that must be satisfied before the society covers
3 surgical treatment of conditions relating to gender dysphoria or
4 gender incongruence for an insured who is less than 18 years of
5 age. Such requirements may include, without limitation,
6 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 society must consider
20 the most recent Standards of Care published by the World
21 Professional Association for Transgender Health, or its successor
22 organization.

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

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

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

45 9. As used in this section:



1 (a) "Cosmetic surgery":

2 (1) Means a surgical procedure that:

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

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

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

8 (2) Includes, without limitation, cosmetic surgery directed
9 at preserving beauty.

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

15 (1) A marked difference between gender identity or
16 expression and primary or secondary sex characteristics or
17 anticipated secondary sex characteristics in young adolescents.

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

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

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

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

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

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

37 (1) Provided in accordance with generally accepted
38 standards of medical practice;

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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



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

- 3 (a) *Endocrinologists;*
- 4 (b) *Pediatric endocrinologists;*
- 5 (c) *Social workers;*
- 6 (d) *Psychiatrists;*
- 7 (e) *Psychologists;*
- 8 (f) *Gynecologists;*
- 9 (g) *Speech-language pathologists;*
- 10 (h) *Primary care physicians;*
- 11 (i) *Advanced practice registered nurses;*
- 12 (j) *Physician assistants; and*

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

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

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

24 4. *A hospital or medical services corporation that issues a*
25 *policy of health insurance may prescribe requirements that must*
26 *be satisfied before the hospital or medical services corporation*
27 *covers surgical treatment of conditions relating to gender*
28 *dysphoria or gender incongruence for an insured who is less than*
29 *18 years of age. Such requirements may include, without*
30 *limitation, requirements that:*

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

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

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

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

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

42 5. *When determining whether treatment is medically*
43 *necessary for the purposes of this section, a hospital or medical*
44 *services corporation must consider the most recent Standards of*



1 Care published by the World Professional Association for
2 Transgender Health, or its successor organization.

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

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

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

29 9. As used in this section:

30 (a) "Cosmetic surgery":

31 (1) Means a surgical procedure that:

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

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

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

37 (2) Includes, without limitation, cosmetic surgery directed
38 at preserving beauty.

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



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

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

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

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

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

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

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

23 (1) Provided in accordance with generally accepted
24 standards of medical practice;

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

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

29 (4) Required to improve a specific health condition of a
30 patient or to preserve the existing state of health of the patient;
31 and

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

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

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

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



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

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

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

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

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

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

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

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

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

34 (a) *Endocrinologists;*

35 (b) *Pediatric endocrinologists;*

36 (c) *Social workers;*

37 (d) *Psychiatrists;*

38 (e) *Psychologists;*

39 (f) *Gynecologists;*

40 (g) *Speech-language pathologists;*

41 (h) *Primary care physicians;*

42 (i) *Advanced practice registered nurses;*

43 (j) *Physician assistants; and*

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



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

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

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

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

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

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

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

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

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

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



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

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

13 9. As used in this section:

14 (a) "Cosmetic surgery":

15 (1) Means a surgical procedure that:

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

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

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

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

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

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

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

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

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

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

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



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

5 (1) Provided in accordance with generally accepted
6 standards of medical practice;

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

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

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

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

16 ➔ A provider of health care prescribing, ordering, recommending
17 or approving a health care service or product does not, by itself,
18 make that health care service or product medically necessary.

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

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

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

33 1. Denying, cancelling, limiting or refusing to issue or renew
34 a health care plan on the basis of the actual or perceived gender
35 identity or expression of a person or a family member of the
36 person;

37 2. Imposing a payment or premium that is based on the
38 actual or perceived gender identity or expression of an enrollee or
39 a family member of the enrollee;

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

43 4. Denying, cancelling or limiting participation or coverage
44 on the basis of actual or perceived gender identity or expression,



1 *including, without limitation, by limiting or denying coverage for*
2 *health care services that are:*

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

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

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

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

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

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

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

35 5. The provisions of NRS 695C.1694 to 695C.1698, inclusive,
36 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333,
37 695C.17345, 695C.17347, 695C.1735, 695C.1737, 695C.1743,
38 695C.1745 and 695C.1757 *and sections 8 and 8.6 of this act* apply
39 to a health maintenance organization that provides health care
40 services through managed care to recipients of Medicaid under the
41 State Plan for Medicaid.

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

43 695C.330 1. The Commissioner may suspend or revoke any
44 certificate of authority issued to a health maintenance organization



1 pursuant to the provisions of this chapter if the Commissioner finds
2 that any of the following conditions exist:

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

10 (b) The health maintenance organization issues evidence of
11 coverage or uses a schedule of charges for health care services
12 which do not comply with the requirements of NRS 695C.1691 to
13 695C.200, inclusive, or 695C.207 **or sections 8 and 8.6 of this**
14 **act;**

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

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

19 (1) Does not meet the requirements of subsection 1 of NRS
20 695C.080; or

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

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

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

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

32 (1) Resolving complaints in a manner reasonably to dispose
33 of valid complaints; and

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

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

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

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



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

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

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

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

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

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

31 (a) *Endocrinologists;*

32 (b) *Pediatric endocrinologists;*

33 (c) *Social workers;*

34 (d) *Psychiatrists;*

35 (e) *Psychologists;*

36 (f) *Gynecologists;*

37 (g) *Speech-language pathologists;*

38 (h) *Primary care physicians;*

39 (i) *Advanced practice registered nurses;*

40 (j) *Physician assistants; and*

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

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



1 3. A managed care organization that issues a health care
2 plan shall not categorically refuse to cover medically necessary
3 gender-affirming treatments or procedures or revisions to prior
4 treatments if the plan provides coverage for any such services,
5 procedures or revisions for purposes other than gender transition
6 or affirmation.

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

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

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

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

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

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

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

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

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



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

3 8. *Evidence of coverage subject to the provisions of this*
4 *chapter that is delivered, issued for delivery or renewed on or after*
5 *July 1, 2023, has the legal effect of including the coverage*
6 *required by subsection 1, and any provision of the plan or renewal*
7 *which is in 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 *managed care 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 managed care*
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. 11.6.** *A managed care organization that issues a health*
25 *care plan shall not discriminate against any person with respect to*
26 *participation or coverage under the plan on the basis of actual or*
27 *perceived gender identity or expression. Prohibited discrimination*
28 *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 insured or*
35 *a family member of the insured;*

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

3 232.320 1. The Director:

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

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

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

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

13 (4) The Administrator of the Division of Health Care
14 Financing and Policy; and

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

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

28 (c) Shall administer any state program for persons with
29 developmental disabilities established pursuant to the
30 Developmental Disabilities Assistance and Bill of Rights Act of
31 2000, 42 U.S.C. §§ 15001 et seq.

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

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

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

42 (3) Provide for communication and the coordination of those
43 services among nonprofit organizations, agencies of local
44 government, the State and the Federal Government;



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

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

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

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

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

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

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

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

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

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

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



1 the compensation of officers and employees and contributions of the
2 governing body must be maintained as an internal service fund as
3 defined by NRS 354.543. The money must be deposited in a state or
4 national bank or credit union authorized to transact business in the
5 State of Nevada. Any independent administrator of a fund created
6 under this section is subject to the licensing requirements of chapter
7 683A of NRS, and must be a resident of this State. Any contract
8 with an independent administrator must be approved by the
9 Commissioner of Insurance as to the reasonableness of
10 administrative charges in relation to contributions collected and
11 benefits provided. The provisions of NRS 686A.135, 687B.352,
12 687B.408, 687B.723, 687B.725, 689B.030 to 689B.050, inclusive,
13 *and sections 3 and 3.6 of this act*, 689B.265, 689B.287 and
14 689B.500 apply to coverage provided pursuant to this paragraph,
15 except that the provisions of NRS 689B.0378, 689B.03785 and
16 689B.500 only apply to coverage for active officers and employees
17 of the governing body, or the dependents of such officers and
18 employees.

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

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

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

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



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

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

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

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

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

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

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

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

22 287.04335 If the Board provides health insurance through a
23 plan of self-insurance, it shall comply with the provisions of NRS
24 686A.135, 687B.352, 687B.409, 687B.723, 687B.725, 689B.0353,
25 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162,
26 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167,
27 695G.1675, 695G.170 to 695G.174, inclusive, *and sections 11 and*
28 *11.6 of this act*, 695G.176, 695G.177, 695G.200 to 695G.230,
29 inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, in the
30 same manner as an insurer that is licensed pursuant to title 57 of
31 NRS is required to comply with those provisions.

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

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

43 (a) *Endocrinologists;*

44 (b) *Pediatric endocrinologists;*

45 (c) *Social workers;*



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

10 2. *This section does not require the Director to include in the*

11 *State Plan for Medicaid coverage for cosmetic surgery performed*

12 *by a plastic surgeon or reconstructive surgeon that is not*

13 *medically necessary.*

14 3. *The Department shall not categorically refuse to cover any*

15 *medically necessary gender-affirming treatments or procedures or*

16 *revisions to prior treatments if the State Plan for Medicaid*

17 *provides coverage for any such services, procedures or revisions*

18 *for purposes other than gender transition or affirmation.*

19 4. *When determining whether treatment is medically*

20 *necessary for the purposes of this section, the Department must*

21 *consider the most recent Standards of Care published by the*

22 *World Professional Association for Transgender Health, or its*

23 *successor organization.*

24 5. *If a person appeals the denial of a payment or coverage*

25 *under this section on the grounds that the treatment requested by*

26 *the person is not medically necessary, the Division must consult*

27 *with a provider of health care who has experience in prescribing*

28 *or delivering gender-affirming treatment concerning the medical*

29 *necessity of the treatment requested by the person when*

30 *considering the appeal.*

31 6. *As used in this section:*

32 (a) *“Cosmetic surgery”:*

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

34 (I) *Does not meaningfully promote the proper function*

35 *of the body;*

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

37 (III) *Is primarily directed at improving the appearance*

38 *of a person.*

39 (2) *Includes, without limitation, cosmetic surgery directed*

40 *at preserving beauty.*

41 (b) *“Gender dysphoria” means distress or impairment in*

42 *social, occupational or other areas of functioning caused by a*

43 *marked difference between the gender identity or expression of a*

44 *person and the sex assigned to the person at birth which lasts at*

45 *least 6 months and is shown by at least two of the following:*



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

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

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

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

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

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

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

23 (1) Provided in accordance with generally accepted
24 standards of medical practice;

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

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

29 (4) Required to improve a specific health condition of a
30 patient or to preserve the existing state of health of the patient;
31 and

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

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

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

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

43 1. Denying, cancelling, limiting or refusing to issue a
44 payment or coverage on the basis of the actual or perceived gender



1 *identity or expression of a person or a family member of the*
2 *person;*

3 *2. Imposing a payment that is based on the actual or*
4 *perceived gender identity or expression of a recipient of Medicaid*
5 *or a family member of the recipient;*

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

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

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

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

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

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

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

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

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

42 4. Expenditure of \$1,076,246 not appropriated from the State
43 General Fund or the State Highway Fund is hereby authorized
44 during Fiscal Year 2024-2025 by the Division of Health Care



1 Financing and Policy of the Department of Health and Human
2 Services for the same purposes as set forth in subsection 1.

3 **Sec. 17.** 1. There is hereby appropriated from the State
4 General Fund to the Division of Health Care Financing and Policy
5 of the Department of Health and Human Services the sum of
6 \$19,500 for the costs of information system upgrades and actuarial
7 rate setting associated with carrying out the provisions of this act.

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

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

23 **Sec. 18.** The provisions of NRS 354.599 do not apply to any
24 additional expenses of a local government that are related to the
25 provisions of this act.

26 **Sec. 19.** This act becomes effective on July 1, 2023.

