

SENATE BILL NO. 330—SENATOR LANGE

MARCH 20, 2023

Referred to Committee on Commerce and Labor

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

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

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

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

Legislative Counsel’s Digest:

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



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

1 **Section 1.** NRS 689A.0405 is hereby amended to read as
2 follows:

3 689A.0405 1. A policy of health insurance must provide
4 coverage for benefits payable for expenses incurred for ~~[a]~~:

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

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

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

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

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

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

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

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

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

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

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

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



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

3 4. A policy subject to the provisions of this chapter which is
4 delivered, issued for delivery or renewed on or after January 1,
5 ~~[2018,]~~ 2024, has the legal effect of including the coverage required
6 by subsection 1, and any provision of the policy or the renewal
7 which is in conflict with this section is void.

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

14 6. As used in this section:

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

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

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

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

29 689B.0374 1. A policy of group health insurance must
30 provide coverage for benefits payable for expenses incurred for ~~{a}~~:

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

36 6. As used in this section:

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

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



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

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

5 **Sec. 3.** NRS 689C.1674 is hereby amended to read as follows:
6 689C.1674 1. A health benefit plan must provide coverage
7 for benefits payable for expenses incurred for ~~[a]~~ :

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

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

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

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

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

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

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

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

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

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

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

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

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



1 4. A plan subject to the provisions of this chapter which is
2 delivered, issued for delivery or renewed on or after January 1,
3 ~~[2018,]~~ 2024, has the legal effect of including the coverage required
4 by subsection 1, and any provision of the plan or the renewal which
5 is in conflict with this section is void.

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

12 6. As used in this section:

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

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

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

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

27 695A.1855 1. A benefit contract must provide coverage for
28 benefits payable for expenses incurred for ~~[a]~~ :

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

36 6. As used in this section:

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

42 (b) "Network plan" means a benefit contract offered by a society
43 under which the financing and delivery of medical care, including
44 items and services paid for as medical care, are provided, in whole
45 or in part, through a defined set of providers under contract with the



1 society. The term does not include an arrangement for the financing
2 of premiums.

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

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

6 695B.1912 1. An insurer that offers or issues a contract for
7 hospital or medical service must provide coverage for benefits
8 payable for expenses incurred for ~~[a]~~:

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

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

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

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

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

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

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

29 (a) Require an insured to pay a ~~[higher]~~ deductible, ~~[any]~~
30 copayment, ~~[or]~~ coinsurance *or any other form of cost-sharing* or
31 require a longer waiting period or other condition to obtain any
32 benefit provided in a contract for hospital or medical service
33 pursuant to subsection 1;

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

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

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



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

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

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

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

18 6. As used in this section:

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

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

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

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

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

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



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

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

17 5. The provisions of NRS 695C.1694 to 695C.1698, inclusive,
18 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333,
19 695C.17345, 695C.17347, 695C.1735, 695C.1737, 695C.1743,
20 695C.1745 and 695C.1757 apply to a health maintenance
21 organization that provides health care services through managed
22 care to recipients of Medicaid under the State Plan for Medicaid.

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

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

30 695C.1735 1. A health care plan of a health maintenance
31 organization must provide coverage for benefits payable for
32 expenses incurred for ~~[a]~~:

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

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

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



1 (1) *Seen or suspected from a mammogram described in*
2 *paragraph (a) or an imaging test described in paragraph (b); or*
3 *(2) Detected by other means of examination.*

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

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

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

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

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

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

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

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

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

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

41 6. As used in this section:

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



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

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

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

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

13 695G.090 1. Except as otherwise provided in subsection 3,
14 the provisions of this chapter apply to each organization and insurer
15 that operates as a managed care organization and may include,
16 without limitation, an insurer that issues a policy of health
17 insurance, an insurer that issues a policy of individual or group
18 health insurance, a carrier serving small employers, a fraternal
19 benefit society, a hospital or medical service corporation and a
20 health maintenance organization.

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

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

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

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

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

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

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

41 695G.1713 1. A health care plan issued by a managed care
42 organization must provide coverage for benefits payable for
43 expenses incurred for ~~fa~~:



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

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

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

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

15 (2) Detected by other means of examination.

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

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

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

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

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

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

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

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

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



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

7 6. As used in this section:

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

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

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

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

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

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

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

43 *(a) Require an insured to pay a higher deductible, any*
44 *copayment or coinsurance or require a longer waiting period or*



1 *other condition to obtain any benefit provided in the plan of self-*
2 *insurance pursuant to subsection 1;*

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

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

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

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

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

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

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

32 6. *As used in this section:*

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

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



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

3 **Sec. 7.3.** 1. If the Board provides health insurance through
4 a plan of self-insurance, it shall provide coverage for benefits
5 payable for expenses incurred for a mammogram every 2 years, or
6 annually if ordered by a provider of health care, for women 40
7 years of age or older.

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

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

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

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

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

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

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

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

34 4. A plan of self-insurance described in subsection 1 which is
35 delivered, issued for delivery or renewed on or after January 1,
36 2024, has the legal effect of including the coverage required by
37 subsection 1, and any provision of the policy or the renewal which
38 is in conflict with this section is void.

39 5. Except as otherwise provided in this section and federal
40 law, if the Board provides health insurance through a plan of self-
41 insurance, the Board may use medical management techniques,
42 including, without limitation, any available clinical evidence, to
43 determine the frequency of or treatment relating to any benefit
44 required by this section or the type of provider of health care to
45 use for such treatment.



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

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

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

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

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

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

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

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

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



1 chapter 683A of NRS, and must be a resident of this State. Any
2 contract with an independent administrator must be approved by the
3 Commissioner of Insurance as to the reasonableness of
4 administrative charges in relation to contributions collected and
5 benefits provided. The provisions of NRS 686A.135, 687B.352,
6 687B.408, 687B.723, 687B.725, 689B.030 to **689B.0369, inclusive,**
7 **689B.0375 to** 689B.050, inclusive, 689B.265, 689B.287 and
8 689B.500 apply to coverage provided pursuant to this paragraph,
9 except that the provisions of NRS 689B.0378, 689B.03785 and
10 689B.500 only apply to coverage for active officers and employees
11 of the governing body, or the dependents of such officers and
12 employees.

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

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

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

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

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



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

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

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

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

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

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

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

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

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

35 287.0402 As used in NRS 287.0402 to 287.049, inclusive, *and*
36 *section 7.3 of this act*, unless the context otherwise requires, the
37 words and terms defined in NRS 287.0404 to 287.04064, inclusive,
38 have the meanings ascribed to them in those sections.

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

40 287.04335 If the Board provides health insurance through a
41 plan of self-insurance, it shall comply with the provisions of NRS
42 686A.135, 687B.352, 687B.409, 687B.723, 687B.725, 689B.0353,
43 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162,
44 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167,
45 695G.1675, 695G.170 to *695G.1712, inclusive, 695G.1714 to*



1 695G.174, inclusive, 695G.176, 695G.177, 695G.200 to 695G.230,
2 inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, in the
3 same manner as an insurer that is licensed pursuant to title 57 of
4 NRS is required to comply with those provisions.

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

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