

ASSEMBLY BILL NO. 408—ASSEMBLYMEN JOINER, SPIEGEL, BILBRAY-AXELROD, FUMO, SPRINKLE; ARAUJO, BENITEZ-THOMPSON, BROOKS, BUSTAMANTE ADAMS, CARLTON, CARRILLO, COHEN, DALY, DIAZ, FLORES, FRIERSON, MCCURDY II, MONROE-MORENO, NEAL, OHRENSCHALL, SWANK AND THOMPSON

MARCH 20, 2017

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to Medicaid and health insurance. (BDR 38-957)

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

CONTAINS UNFUNDED MANDATE (§ 9)
(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 health care; requiring the State Plan for Medicaid to cover certain preventive health care services and maternity and newborn care; requiring insurers to offer health insurance coverage regardless of the health status of a person; requiring insurers to allow the covered adult child of an insured to remain covered by the health insurance of the insured until 26 years of age; requiring insurers to provide coverage for certain preventive health care services for women, adults and children at no cost; requiring insurers to provide coverage for maternity and newborn care; prohibiting providers of health care, insurers and the Silver State Health Insurance Exchange from discriminating against a person on certain grounds; and providing other matters properly relating thereto.

Legislative Counsel’s Digest:

- 1 Existing law provides that an insurer may not deny, limit or exclude a benefit
- 2 provided by a health care plan in certain limited circumstances, including, without
- 3 limitation, when a person has contracted for a blanket policy of accident or health
- 4 insurance or in certain cases relating to adoption. (NRS 689B.500, 689C.190,



* A B 4 0 8 *

5 695A.159, 695B.193, 695C.173, 695F.480) The Patient Protection and Affordable
6 Care Act (Public Law 111-148, as amended) prohibits an insurer from establishing
7 rules for eligibility for a health care plan based on sex or certain health status
8 factors, including, without limitation, preexisting conditions, claims history or
9 genetic information, and also prohibits an insurer from charging a higher premium,
10 deductible or copay based on sex or these health status factors. (42 U.S.C. § 300gg-
11 4) **Sections 15, 31, 41, 48, 57, 68, 80, 83 and 94** of this bill align Nevada law with
12 federal law and require all insurers to offer health insurance coverage regardless of
13 the health status of a person and prohibits an insurer from denying, limiting or
14 excluding a benefit or requiring an insured to pay a higher premium, deductible,
15 coinsurance or copay based on the health status of the insured or the covered
16 spouse or dependent of the insured.

17 The Patient Protection and Affordable Care Act (Public Law 111-148, as
18 amended) requires all insurers to extend coverage for the covered adult child of an
19 insured until such child reaches 26 years of age. (42 U.S.C. § 300gg-14) **Sections**
20 **16, 25, 34, 49, 58, 69, 81 and 84** of this bill align Nevada law with federal law in
21 this manner.

22 The Patient Protection and Affordable Care Act (Public Law 111-148, as
23 amended) requires all health insurance plans to include coverage for maternity and
24 newborn care. (42 U.S.C. § 18022(b)) **Sections 21, 32, 43, 53, 62, 73 and 88** of this
25 bill align Nevada law with federal law in this manner. **Section 5** of this bill also
26 requires the State Plan for Medicaid to include coverage for maternity and newborn
27 care.

28 The Patient Protection and Affordable Care Act (Public Law 111-148, as
29 amended) requires all health insurance plans to include coverage, without any
30 higher deductible or any copay or coinsurance, for certain preventive health care
31 services for women, adults and children, including, without limitation, screenings
32 and tests for certain diseases, counseling, contraceptive drugs, devices and services
33 as well as vaccinations. (42 U.S.C. § 300gg-13; 45 C.F.R. § 147.130) **Sections 17-**
34 **20, 22, 26-30, 35-39, 50-52, 54, 55, 59-61, 63, 64, 70-72, 76, 77, 85-87, 89 and 90**
35 of this bill align Nevada law with federal law in this manner, and extend these
36 requirements to health insurance purchased by local governments and the Public
37 Employees' Benefits Program. **Sections 2, 3, 4, 6 and 7** of this bill also require the
38 State Plan for Medicaid to include these preventive health care services for women,
39 adults and children. **Section 93** of this bill requires the Director of the Department
40 of Health and Human Services to adopt regulations specifying the preventive health
41 care services which are required to be covered by insurers and that these
42 requirements must include, without limitation, the preventive health care services
43 currently required by federal law.

44 The Patient Protection and Affordable Care Act (Public Law 111-148, as
45 amended) prohibits a provider of health care or state health insurance exchange
46 who receives federal money from discriminating against a person on the basis of
47 race, color, national origin, sex, age, or disability in providing health care services
48 to the person. The Act also prohibits an insurer who receives federal money from
49 discriminating against a person on those same grounds, as well as gender identity or
50 expression. (42 U.S.C. § 18116; 45 C.F.R. § 92.207) The federal regulation that
51 prohibits insurers from discriminating on the basis of gender identity or expression
52 is no longer enforceable, however, because it was recently held to exceed the
53 statutory authority granted by the Act. (*Franciscan Alliance Inc., v. Burwell*, 2016
54 WL 7638311 (N.D. Tex. Dec. 31, 2016)) Federal regulations also require providers
55 of health care, state health insurance exchanges and insurers to provide certain
56 assistive services and notice of these nondiscrimination provisions to all persons
57 who receive health care services. (45 C.F.R. §§ 92.8, 92.201, 92.202) **Sections 11,**
58 **12 and 91** of this bill align Nevada law with federal law, prohibiting a provider of
59 health care, an insurer or the Silver State Health Insurance Exchange from



60 discriminating against a person on these grounds, including, without limitation,
61 discrimination based on gender identity or expression or sexual orientation.

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

1 **Section 1.** Chapter 422 of NRS is hereby amended by adding
2 thereto the provisions set forth as sections 2 to 6, inclusive, of this
3 act.

4 **Sec. 2. 1.** *The Director shall include in the State Plan for*
5 *Medicaid a requirement that the State pay the nonfederal share of*
6 *expenditures incurred for such preventive health care services*
7 *relating to women as the Director establishes by regulation, which*
8 *must include, without limitation:*

9 (a) *Such prenatal screenings and tests as recommended by the*
10 *American College of Obstetricians and Gynecologists or its*
11 *successor organization;*

12 (b) *Screening and counseling for interpersonal and domestic*
13 *violence;*

14 (c) *Screening, tests and counseling for such other health*
15 *conditions and diseases as recommended by the Health Resources*
16 *and Services Administration;*

17 (d) *Contraceptive drugs, devices and services;*

18 (e) *Such well-woman preventive visits as recommended by the*
19 *Health Resources and Services Administration;*

20 (f) *Any supplements, drugs or devices recommended by the*
21 *Health Resources and Services Administration; and*

22 (g) *All vaccinations recommended by the Advisory Committee*
23 *on Immunization Practices of the Centers for Disease Control and*
24 *Prevention of the United States Department of Health and Human*
25 *Services or its successor organization.*

26 2. *A person enrolled in Medicaid must not be required pay a*
27 *higher deductible, any copayment or coinsurance to obtain the*
28 *services required by this section.*

29 **Sec. 3. 1.** *The Director shall include in the State Plan for*
30 *Medicaid a requirement that the State pay the nonfederal share of*
31 *expenditures incurred for such preventive health care services*
32 *relating to persons 18 years of age or older as the Director*
33 *establishes by regulation, which must include, without limitation:*

34 (a) *Screening, tests and counseling for such other health*
35 *conditions and diseases as recommended by the United States*
36 *Preventive Services Task Force or its successor organization;*

37 (b) *Counseling relating to the dietary needs of certain adults*
38 *who are at high-risk of chronic diseases;*

39 (c) *Smoking cessation programs;*



1 (d) Any supplements, drugs or devices recommended by the
2 United States Preventive Services Task Force or its successor
3 organization; and

4 (e) All vaccinations recommended by the Advisory Committee
5 on Immunization Practices of the Centers for Disease Control and
6 Prevention of the United States Department of Health and Human
7 Services or its successor organization.

8 2. A person enrolled in Medicaid must not be required pay a
9 higher deductible, any copayment or coinsurance to obtain the
10 services required by this section.

11 **Sec. 4. 1.** The Director shall include in the State Plan for
12 Medicaid a requirement that the State pay the nonfederal share of
13 expenditures incurred for such preventive health care services
14 relating to persons less than 18 years of age as the Director
15 establishes by regulation, which must include, without limitation:

16 (a) Screening, tests and counseling for such other health
17 conditions and diseases as recommended by the Health Resources
18 and Services Administration;

19 (b) Assessments relating to height, weight, body mass index
20 and medical history;

21 (c) Any supplements, drugs or devices recommended by the
22 Health Resources and Services Administration; and

23 (d) All vaccinations recommended by the Advisory Committee
24 on Immunization Practices of the Centers for Disease Control and
25 Prevention of the United States Department of Health and Human
26 Services or its successor organization.

27 2. A person enrolled in Medicaid must not be required pay a
28 higher deductible, any copayment or coinsurance to obtain the
29 services required by this section.

30 **Sec. 5.** The Director shall include in the State Plan for
31 Medicaid a requirement that the State pay the nonfederal share of
32 expenditures incurred for such maternal and newborn care as the
33 Director establishes by regulation.

34 **Sec. 6. 1.** The Director shall include in the State Plan for
35 Medicaid a requirement that the State pay the nonfederal share of
36 expenditures incurred for:

37 (a) An annual cytologic screening test for women 18 years of
38 age or older;

39 (b) A baseline mammogram for women between the ages of 35
40 and 40 years;

41 (c) An annual mammogram for women 40 years of age or
42 older;

43 (d) Counseling concerning genetic testing for breast cancer;
44 and

45 (e) Counseling concerning breast cancer chemoprevention.



1 **2. A person enrolled in Medicaid must not be required pay a**
2 **higher deductible, any copayment or coinsurance or obtain prior**
3 **authorization for any service required by this section.**

4 **Sec. 7.** NRS 422.2718 is hereby amended to read as follows:

5 422.2718 1. The Director shall include in the State Plan for
6 Medicaid a requirement that the State shall pay the nonfederal share
7 of expenses incurred for ~~administering~~:

8 **(a) Deoxyribonucleic acid testing for high-risk strains of the**
9 **human papillomavirus; and**

10 **(b) Administering** the human papillomavirus vaccine to women
11 and girls at such ages as recommended for vaccination by a
12 competent authority, including, without limitation, the Centers for
13 Disease Control and Prevention of the United States Department of
14 Health and Human Services, the Food and Drug Administration or
15 the manufacturer of the vaccine.

16 **2. A person enrolled in Medicaid must not be required pay a**
17 **higher deductible, any copayment or coinsurance or obtain prior**
18 **authorization for any service required by this section.**

19 **3.** For the purposes of this section, “human papillomavirus
20 vaccine” means the Quadrivalent Human Papillomavirus
21 Recombinant Vaccine or its successor which is approved by the
22 Food and Drug Administration to be used for the prevention of
23 human papillomavirus infection and cervical cancer.

24 **Sec. 8.** NRS 422.403 is hereby amended to read as follows:

25 422.403 1. ~~The~~ **Except as otherwise provided in NRS**
26 **422.2718, the** Department shall, by regulation, establish and manage
27 the use by the Medicaid program of step therapy and prior
28 authorization for prescription drugs.

29 **2. ~~The~~ Except as otherwise provided in NRS 422.2718, the**
30 **Drug Use Review Board shall:**

31 (a) Advise the Department concerning the use by the Medicaid
32 program of step therapy and prior authorization for prescription
33 drugs;

34 (b) Develop step therapy protocols and prior authorization
35 policies and procedures for use by the Medicaid program for
36 prescription drugs; and

37 (c) Review and approve, based on clinical evidence and best
38 clinical practice guidelines and without consideration of the cost of
39 the prescription drugs being considered, step therapy protocols used
40 by the Medicaid program for prescription drugs.

41 **3.** The Department shall not require the Drug Use Review
42 Board to develop, review or approve prior authorization policies or
43 procedures necessary for the operation of the list of preferred
44 prescription drugs developed for the Medicaid program pursuant to
45 NRS 422.4025.



1 4. The Department shall accept recommendations from the
2 Drug Use Review Board as the basis for developing or revising step
3 therapy protocols and prior authorization policies and procedures
4 used by the Medicaid program for prescription drugs.

5 **Sec. 9.** NRS 287.010 is hereby amended to read as follows:

6 287.010 1. The governing body of any county, school
7 district, municipal corporation, political subdivision, public
8 corporation or other local governmental agency of the State of
9 Nevada may:

10 (a) Adopt and carry into effect a system of group life, accident
11 or health insurance, or any combination thereof, for the benefit of its
12 officers and employees, and the dependents of officers and
13 employees who elect to accept the insurance and who, where
14 necessary, have authorized the governing body to make deductions
15 from their compensation for the payment of premiums on the
16 insurance.

17 (b) Purchase group policies of life, accident or health insurance,
18 or any combination thereof, for the benefit of such officers and
19 employees, and the dependents of such officers and employees, as
20 have authorized the purchase, from insurance companies authorized
21 to transact the business of such insurance in the State of Nevada,
22 and, where necessary, deduct from the compensation of officers and
23 employees the premiums upon insurance and pay the deductions
24 upon the premiums.

25 (c) Provide group life, accident or health coverage through a
26 self-insurance reserve fund and, where necessary, deduct
27 contributions to the maintenance of the fund from the compensation
28 of officers and employees and pay the deductions into the fund. The
29 money accumulated for this purpose through deductions from the
30 compensation of officers and employees and contributions of the
31 governing body must be maintained as an internal service fund as
32 defined by NRS 354.543. The money must be deposited in a state or
33 national bank or credit union authorized to transact business in the
34 State of Nevada. Any independent administrator of a fund created
35 under this section is subject to the licensing requirements of chapter
36 683A of NRS, and must be a resident of this State. Any contract
37 with an independent administrator must be approved by the
38 Commissioner of Insurance as to the reasonableness of
39 administrative charges in relation to contributions collected and
40 benefits provided. The provisions of NRS 687B.408, 689B.030 to
41 689B.050, inclusive, *and sections 25 to 28, inclusive, of this act*
42 *and 689B.287 and 689B.500 and 689B.520* apply to coverage
43 provided pursuant to this paragraph.

44 (d) Defray part or all of the cost of maintenance of a self-
45 insurance fund or of the premiums upon insurance. The money for



1 contributions must be budgeted for in accordance with the laws
2 governing the county, school district, municipal corporation,
3 political subdivision, public corporation or other local governmental
4 agency of the State of Nevada.

5 2. If a school district offers group insurance to its officers and
6 employees pursuant to this section, members of the board of trustees
7 of the school district must not be excluded from participating in the
8 group insurance. If the amount of the deductions from compensation
9 required to pay for the group insurance exceeds the compensation to
10 which a trustee is entitled, the difference must be paid by the trustee.

11 3. In any county in which a legal services organization exists,
12 the governing body of the county, or of any school district,
13 municipal corporation, political subdivision, public corporation or
14 other local governmental agency of the State of Nevada in the
15 county, may enter into a contract with the legal services
16 organization pursuant to which the officers and employees of the
17 legal services organization, and the dependents of those officers and
18 employees, are eligible for any life, accident or health insurance
19 provided pursuant to this section to the officers and employees, and
20 the dependents of the officers and employees, of the county, school
21 district, municipal corporation, political subdivision, public
22 corporation or other local governmental agency.

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

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

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

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

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

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

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

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



1 **Sec. 10.** NRS 287.04335 is hereby amended to read as
2 follows:

3 287.04335 If the Board provides health insurance through a
4 plan of self-insurance, it shall comply with the provisions of NRS
5 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645,
6 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177,
7 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive,
8 and 695G.405, *and sections 83 to 89, inclusive, of this act*, in the
9 same manner as an insurer that is licensed pursuant to title 57 of
10 NRS is required to comply with those provisions.

11 **Sec. 11.** Chapter 629 of NRS is hereby amended by adding
12 thereto a new section to read as follows:

13 1. *Except as otherwise provided in subsection 2, a provider of*
14 *health care shall not discriminate in providing a health care*
15 *service to a person on the basis of race, color, national origin, sex,*
16 *age, physical or mental disability, sexual orientation or gender*
17 *identity or expression.*

18 2. *A provider of health care may make distinctions in*
19 *providing health care services based on sex or gender identity or*
20 *expression if the provider has an exceedingly persuasive*
21 *justification for the distinction, which may include, without*
22 *limitation, that the distinction is substantially related to the*
23 *achievement of an important health or scientific objective.*

24 3. *A provider of health care must provide reasonable notice to*
25 *a person who receives health care services relating to the*
26 *provisions of this section.*

27 4. *A provider of health care must take reasonable steps to*
28 *ensure that a person with limited English proficiency or physical*
29 *or mental disabilities who receives health care services from the*
30 *provider has access to any assistance services which may be*
31 *needed for the person to communicate effectively with the*
32 *provider.*

33 5. *As used in this section:*

34 (a) *“Gender identity or expression” has the meaning ascribed*
35 *to it in NRS 193.0148.*

36 (b) *“Health care service” means the care and observation of*
37 *patients, the diagnosis of human diseases, the treatment and*
38 *rehabilitation of patients, or related services.*

39 (c) *“Sexual orientation” has the meaning ascribed to it in*
40 *NRS 118.093.*

41 **Sec. 12.** Chapter 679A of NRS is hereby amended by adding
42 thereto a new section to read as follows:

43 1. *Except as otherwise provided in subsection 2, an insurer*
44 *who offers a policy of health insurance shall not refuse to provide*
45 *coverage to or discriminate against a person based on race, color,*



1 national origin, sex, age, physical or mental disability, sexual
2 orientation or gender identity or expression. Such discriminatory
3 actions include, without limitation:

4 (a) Cancelling a policy;

5 (b) Refusing to provide a benefit which is available under a
6 policy to other similarly situated persons;

7 (c) Limiting coverage of a claim; or

8 (d) Imposing an additional deductible, premium, copay,
9 coinsurance or any other limitation or restriction on coverage.

10 2. An insurer may include distinctions in a policy of health
11 insurance based on sex or gender identity or expression if
12 the insurer has an exceedingly persuasive justification for the
13 distinction, which may include, without limitation, that the
14 distinction is substantially related to the achievement of an
15 important health or scientific objective.

16 3. An insurer must provide reasonable notice to an insured
17 relating to the provisions of this section.

18 4. An insurer must take reasonable steps to ensure that an
19 insured with limited English proficiency or physical or mental
20 disabilities has access to any assistance services which may be
21 needed for the insured to communicate effectively with the
22 insurer.

23 5. Nothing in this section may be construed as preventing an
24 insurer from determining whether a benefit is medically necessary
25 or whether any such benefit meets any other requirement for
26 coverage included in a policy of health insurance which is not
27 prohibited by this section or any other provision of law.

28 6. As used in this section:

29 (a) "Gender identity or expression" has the meaning ascribed
30 to it in NRS 193.0148.

31 (b) "Sexual orientation" has the meaning ascribed to it in
32 NRS 118.093.

33 **Sec. 13.** NRS 687B.225 is hereby amended to read as follows:

34 687B.225 1. Except as otherwise provided in NRS
35 689A.0405, 689A.0413, 689A.044, 689A.0445, 689B.031,
36 689B.0313, 689B.0317, 689B.0374, 695B.1912, 695B.1914,
37 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1745,
38 695C.1751, 695G.170, 695G.171 and 695G.177, **and sections 38,**
39 **39, 54, 55 and 89 of this act**, any contract for group, blanket or
40 individual health insurance or any contract by a nonprofit hospital,
41 medical or dental service corporation or organization for dental care
42 which provides for payment of a certain part of medical or dental
43 care may require the insured or member to obtain prior authorization
44 for that care from the insurer or organization. The insurer or
45 organization shall:



1 (a) File its procedure for obtaining approval of care pursuant to
2 this section for approval by the Commissioner; and

3 (b) Respond to any request for approval by the insured or
4 member pursuant to this section within 20 days after it receives the
5 request.

6 2. The procedure for prior authorization may not discriminate
7 among persons licensed to provide the covered care.

8 **Sec. 14.** Chapter 689A of NRS is hereby amended by adding
9 thereto the provisions set forth as sections 15 to 19, inclusive, of this
10 act.

11 **Sec. 15. 1.** *An insurer shall offer or issue a policy of health
12 insurance to any person regardless of the health status of the
13 person, the spouse of the person or any dependent of the person.
14 Such health status includes, without limitation:*

15 *(a) Any preexisting medical condition of the person, including,
16 without limitation, any physical or mental illness;*

17 *(b) The claims history of the person, including, without
18 limitation, any prior health care services received by the person;*

19 *(c) Genetic information relating to the person; and*

20 *(d) Any increased risk for illness, injury or any other medical
21 condition of the person, including, without limitation, any medical
22 condition caused by an act of domestic violence.*

23 2. *An insurer that offers or issues a policy of health
24 insurance shall not:*

25 *(a) Deny, limit or exclude a benefit based on the health status
26 of an insured; or*

27 *(b) Require an insured, as a condition of enrollment or
28 renewal, to pay a premium, deductible, copay or coinsurance
29 based on his or her health status which is greater than the
30 premium, deductible, copay or coinsurance charged to a similarly
31 situated insured or the covered spouse or dependent of such an
32 insured who does not have such a health status.*

33 3. *An insurer that offers or issues a policy of health
34 insurance shall not adjust a premium, deductible, copay or
35 coinsurance for any insured on the basis of genetic information
36 relating to the insured or the covered spouse or dependent of the
37 insured.*

38 **Sec. 16. 1.** *An insurer that offers or issues a policy of
39 health insurance which provides coverage for dependent children
40 shall continue to make such coverage available for an adult child
41 of an insured until such child reaches 26 years of age.*

42 2. *Nothing in this section shall be construed as requiring an
43 insurer to make coverage available for a dependent of an adult
44 child of an insured.*



1 **Sec. 17. 1. An insurer that offers or issues a policy of**
2 *health insurance shall include in the policy coverage for such*
3 *preventive health care services relating to women as the Director*
4 *of the Department of Health and Human Services requires.*

5 **2. An insurer that offers or issues a policy of health**
6 *insurance shall not:*

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

11 **(b) Refuse to issue a policy of health insurance or cancel a**
12 *policy of health insurance solely because the person applying for*
13 *or covered by the policy uses or may use a benefit provided in the*
14 *policy of health insurance pursuant to subsection 1;*

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

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

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

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

27 **3. A policy of health insurance subject to the provisions of**
28 *this chapter that is delivered, issued for delivery or renewed on or*
29 *after January 1, 2018, has the legal effect of including the*
30 *coverage required by subsection 1, and any provision of the policy*
31 *or the renewal which is in conflict with this section is void.*

32 **4. The Director of the Department of Health and Human**
33 *Services shall adopt regulations to establish the preventive health*
34 *care services which must be covered by a policy of health*
35 *insurance pursuant to subsection 1, including, without limitation:*

36 **(a) Such prenatal screenings and tests as recommended by the**
37 *American College of Obstetricians and Gynecologists or its*
38 *successor organization;*

39 **(b) Screening and counseling for interpersonal and domestic**
40 *violence;*

41 **(c) Screening, tests and counseling for such other health**
42 *conditions and diseases as recommended by the Health Resources*
43 *and Services Administration;*

44 **(d) Contraceptive drugs, devices and services;**



1 (e) Such well-woman preventive visits as recommended by the
2 Health Resources and Services Administration;

3 (f) Any supplements, drugs or devices recommended by the
4 Health Resources and Services Administration; and

5 (g) All vaccinations recommended by the Advisory Committee
6 on Immunization Practices of the Centers for Disease Control and
7 Prevention of the United States Department of Health and Human
8 Services or its successor organization.

9 5. As used in this section, "provider of health care" has the
10 meaning ascribed to it in NRS 629.031.

11 **Sec. 18. 1.** An insurer that offers or issues a policy of
12 health insurance shall include in the policy coverage for such
13 preventive health care services relating to persons 18 years of age
14 or older as the Director of the Department of Health and Human
15 Services requires.

16 2. An insurer that offers or issues a policy of health
17 insurance shall not:

18 (a) Require an insured to pay a higher deductible, any
19 copayment or coinsurance or require a longer waiting period or
20 other condition to obtain any benefit provided in the policy of
21 health insurance pursuant to subsection 1;

22 (b) Refuse to issue a policy of health insurance or cancel a
23 policy of health insurance solely because the person applying for
24 or covered by the policy uses or may use a benefit provided in the
25 policy of health insurance pursuant to subsection 1;

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

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

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

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

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

43 4. The Director of the Department of Health and Human
44 Services shall adopt regulations to establish the preventive health



1 care services which must be covered by a policy of health
2 insurance pursuant to subsection 1, including, without limitation:

3 (a) Screening, tests and counseling for such other health
4 conditions and diseases as recommended by the United States
5 Preventive Services Task Force or its successor organization;

6 (b) Counseling relating to the dietary needs of certain adults
7 who are at high-risk of chronic diseases;

8 (c) Smoking cessation programs;

9 (d) Any supplements, drugs or devices recommended by the
10 United States Preventive Services Task Force or its successor
11 organization; and

12 (e) All vaccinations recommended by the Advisory Committee
13 on Immunization Practices of the Centers for Disease Control and
14 Prevention of the United States Department of Health and Human
15 Services or its successor organization.

16 5. As used in this section, "provider of health care" has the
17 meaning ascribed to it in NRS 629.031.

18 **Sec. 19. 1.** An insurer that offers or issues a policy of
19 health insurance shall include in the policy coverage for such
20 preventive health care services relating to persons less than 18
21 years of age as the Director of the Department of Health and
22 Human Services requires.

23 2. An insurer that offers or issues a policy of health
24 insurance shall not:

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

29 (b) Refuse to issue a policy of health insurance or cancel a
30 policy of health insurance solely because the person applying for
31 or covered by the policy uses or may use a benefit provided in the
32 policy of health insurance pursuant to subsection 1;

33 (c) Offer or pay any type of material inducement or financial
34 incentive to an insured to discourage the insured from obtaining
35 any 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
40 other financial incentive to a provider of health care to deny,
41 reduce, withhold, limit or delay access to any such benefit to an
42 insured; or

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



1 3. *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 January 1, 2018, has the legal effect of including the*
4 *coverage required by subsection 1, and any provision of the policy*
5 *or the renewal which is in conflict with this section is void.*

6 4. *The Director of the Department of Health and Human*
7 *Services shall adopt regulations to establish the preventive health*
8 *care services which must be covered by a policy of health*
9 *insurance pursuant to subsection 1, including, without limitation:*

10 (a) *Screening, tests and counseling for such other health*
11 *conditions and diseases as recommended by the Health Resources*
12 *and Services Administration;*

13 (b) *Assessments relating to height, weight, body mass index*
14 *and medical history;*

15 (c) *Any supplements, drugs or devices recommended by the*
16 *Health Resources and Services Administration; and*

17 (d) *All vaccinations recommended by the Advisory Committee*
18 *on Immunization Practices of the Centers for Disease Control and*
19 *Prevention of the United States Department of Health and Human*
20 *Services or its successor organization.*

21 5. *As used in this section, "provider of health care" has the*
22 *meaning ascribed to it in NRS 629.031.*

23 **Sec. 20.** NRS 689A.0405 is hereby amended to read as
24 follows:

25 689A.0405 1. A policy of health insurance must provide
26 coverage for benefits payable for expenses incurred for:

27 (a) An annual cytologic screening test for women 18 years of
28 age or older;

29 (b) A baseline mammogram for women between the ages of 35
30 and 40; ~~and~~

31 (c) An annual mammogram for women 40 years of age or
32 older ~~+~~;

33 (d) *Counseling concerning genetic testing for breast cancer;*
34 *and*

35 (e) *Counseling concerning breast cancer chemoprevention.*

36 2. A policy of health insurance must not require an insured to
37 obtain prior authorization for any service provided pursuant to
38 subsection 1.

39 3. *An insurer that offers or issues a policy of health*
40 *insurance shall not:*

41 (a) *Require an insured to pay a higher deductible, any*
42 *copayment or coinsurance or require a longer waiting period or*
43 *other condition to obtain any benefit provided in the health benefit*
44 *plan pursuant to subsection 1;*



1 (b) Refuse to issue a policy of health insurance or cancel a
2 policy of health insurance solely because the person applying for
3 or covered by the policy uses or may use a benefit provided in the
4 policy of health insurance pursuant to subsection 1;

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

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

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

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

17 4. A policy subject to the provisions of this chapter which is
18 delivered, issued for delivery or renewed on or after ~~October 1,~~
19 ~~1989,~~ **January 1, 2018**, has the legal effect of including the
20 coverage required by subsection 1, and any provision of the policy
21 or the renewal which is in conflict with subsection 1 is void.

22 5. As used in this section, "provider of health care" has the
23 meaning ascribed to it in NRS 629.031.

24 **Sec. 21.** NRS 689A.0425 is hereby amended to read as
25 follows:

26 689A.0425 1. *An insurer that offers or issues a policy of*
27 *health insurance shall include in the policy coverage for such*
28 *health care services relating to maternal and newborn care as the*
29 *Director of the Department of Health and Human Services*
30 *requires.*

31 2. Except as otherwise provided in this subsection, an
32 individual health benefit plan issued pursuant to this chapter ~~that~~
33 ~~includes coverage for maternity care and pediatric care for newborn~~
34 ~~infants~~ may not restrict benefits for any length of stay in a hospital
35 in connection with childbirth for a mother or newborn infant
36 covered by the plan to:

37 (a) Less than 48 hours after a normal vaginal delivery; and

38 (b) Less than 96 hours after a cesarean section.

39 ↪ If a different length of stay is provided in the guidelines
40 established by the American College of Obstetricians and
41 Gynecologists, or its successor organization, and the American
42 Academy of Pediatrics, or its successor organization, the individual
43 health benefit plan may follow such guidelines in lieu of following
44 the length of stay set forth above. The provisions of this subsection
45 do not apply to any individual health benefit plan in any case in



1 which the decision to discharge the mother or newborn infant before
2 the expiration of the minimum length of stay set forth in this
3 subsection is made by the attending physician of the mother or
4 newborn infant.

5 ~~{2-}~~ 3. Nothing in this section requires a mother to:

6 (a) Deliver her baby in a hospital; or

7 (b) Stay in a hospital for a fixed period following the birth of her
8 child.

9 ~~{3-}~~ 4. An individual health benefit plan ~~{that offers coverage~~
10 ~~for maternity care and pediatric care of newborn infants}~~ may not:

11 (a) Deny a mother or her newborn infant coverage or continued
12 coverage under the terms of the plan or coverage if the sole purpose
13 of the denial of coverage or continued coverage is to avoid the
14 requirements of this section;

15 (b) Provide monetary payments or rebates to a mother to
16 encourage her to accept less than the minimum protection available
17 pursuant to this section;

18 (c) Penalize, or otherwise reduce or limit, the reimbursement of
19 an attending provider of health care because the attending provider
20 of health care provided care to a mother or newborn infant in
21 accordance with the provisions of this section;

22 (d) Provide incentives of any kind to an attending physician to
23 induce the attending physician to provide care to a mother or
24 newborn infant in a manner that is inconsistent with the provisions
25 of this section; or

26 (e) Except as otherwise provided in subsection ~~{4-}~~ 5, restrict
27 benefits for any portion of a hospital stay required pursuant to the
28 provisions of this section in a manner that is less favorable than the
29 benefits provided for any preceding portion of that stay.

30 ~~{4-}~~ 5. Nothing in this section:

31 (a) Prohibits an individual health benefit plan from imposing a
32 deductible, coinsurance or other mechanism for sharing costs
33 relating to benefits for hospital stays in connection with childbirth
34 for a mother or newborn child covered by the plan, except that such
35 coinsurance or other mechanism for sharing costs for any portion of
36 a hospital stay required by this section may not be greater than the
37 coinsurance or other mechanism for any preceding portion of that
38 stay.

39 (b) Prohibits an arrangement for payment between an individual
40 health benefit plan and a provider of health care that uses capitation
41 or other financial incentives, if the arrangement is designed to
42 provide services efficiently and consistently in the best interest of
43 the mother and her newborn infant.



1 (c) Prevents an individual health benefit plan from negotiating
2 with a provider of health care concerning the level and type of
3 reimbursement to be provided in accordance with this section.

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

9 **7. The Director of the Department of Health and Human**
10 **Services shall adopt regulations to establish the health care**
11 **services which must be covered by a policy of health insurance**
12 **pursuant to subsection 1.**

13 **8. As used in this section, "provider of health care" has the**
14 **meaning ascribed to it in NRS 629.031.**

15 **Sec. 22.** NRS 689A.044 is hereby amended to read as follows:

16 689A.044 1. A policy of health insurance must provide
17 coverage for benefits payable for expenses incurred for
18 ~~administering~~ :

19 **(a) Deoxyribonucleic acid testing for high-risk strains of the**
20 **human papillomavirus; and**

21 **(b) Administering** the human papillomavirus vaccine as
22 recommended for vaccination by a competent authority, including,
23 without limitation, the Centers for Disease Control and Prevention
24 of the United States Department of Health and Human Services, the
25 Food and Drug Administration or the manufacturer of the vaccine.

26 2. A policy of health insurance must not require an insured to
27 obtain prior authorization for any service provided pursuant to
28 subsection 1.

29 **3. An insurer that offers or issues a policy of health**
30 **insurance shall not:**

31 **(a) Require an insured to pay a higher deductible, any**
32 **copayment or coinsurance or require a longer waiting period or**
33 **other condition to obtain any benefit provided in the health benefit**
34 **plan pursuant to subsection 1;**

35 **(b) Refuse to issue a policy of health insurance or cancel a**
36 **policy of health insurance solely because the person applying for**
37 **or covered by the policy uses or may use a benefit provided in the**
38 **policy of health insurance pursuant to subsection 1;**

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

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



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

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

7 **4.** A policy subject to the provisions of this chapter which is
8 delivered, issued for delivery or renewed on or after ~~July 1, 2007,~~
9 *January 1, 2018*, has the legal effect of including the coverage
10 required by subsection 1, and any provision of the policy or the
11 renewal which is in conflict with subsection 1 is void.

12 ~~4. For the purposes of this section, "human"~~

13 **5. As used in this section:**

14 *(a) "Human papillomavirus vaccine"* means the Quadrivalent
15 Human Papillomavirus Recombinant Vaccine or its successor which
16 is approved by the Food and Drug Administration for the prevention
17 of human papillomavirus infection and cervical cancer.

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

20 **Sec. 23.** NRS 689A.330 is hereby amended to read as follows:

21 689A.330 If any policy is issued by a domestic insurer for
22 delivery to a person residing in another state, and if the insurance
23 commissioner or corresponding public officer of that other state has
24 informed the Commissioner that the policy is not subject to approval
25 or disapproval by that officer, the Commissioner may by ruling
26 require that the policy meet the standards set forth in NRS 689A.030
27 to 689A.320, inclusive ~~H~~, *and sections 15 to 19, inclusive, of this*
28 *act.*

29 **Sec. 24.** Chapter 689B of NRS is hereby amended by adding
30 thereto the provisions set forth as sections 25 to 28, inclusive, of this
31 act.

32 **Sec. 25. 1.** *An insurer that offers or issues a policy of*
33 *group health insurance which provides coverage for dependent*
34 *children shall continue to make such coverage available for an*
35 *adult child of an insured until such child reaches 26 years of age.*

36 **2.** *Nothing in this section shall be construed as requiring an*
37 *insurer to make coverage available for a dependent of an adult*
38 *child of an insured.*

39 **Sec. 26. 1.** *An insurer that offers or issues a policy of*
40 *group health insurance shall include in the policy coverage for*
41 *such preventive health care services relating to women as the*
42 *Director of the Department of Health and Human Services*
43 *requires.*

44 **2.** *An insurer that offers or issues a policy of group health*
45 *insurance shall not:*



1 (a) Require an insured to pay a higher deductible, any
2 copayment or coinsurance or require a longer waiting period or
3 other condition to obtain any benefit provided in the policy of
4 group health insurance pursuant to subsection 1;

5 (b) Refuse to issue a policy of group health insurance or
6 cancel a policy of group health insurance solely because the
7 person applying for or covered by the policy uses or may use a
8 benefit provided in the policy of group health insurance pursuant
9 to subsection 1;

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

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

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

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

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

28 4. The Director of the Department of Health and Human
29 Services shall adopt regulations to establish the preventive health
30 care services which must be covered by a policy of group health
31 insurance pursuant to subsection 1, including, without limitation:

32 (a) Such prenatal screenings and tests as recommended by the
33 American College of Obstetricians and Gynecologists or its
34 successor organization;

35 (b) Screening and counseling for interpersonal and domestic
36 violence;

37 (c) Screening, tests and counseling for such other health
38 conditions and diseases as recommended by the Health Resources
39 and Services Administration;

40 (d) Contraceptive drugs, devices and services;

41 (e) Such well-woman preventive visits as recommended by the
42 Health Resources and Services Administration;

43 (f) Any supplements, drugs or devices recommended by the
44 Health Resources and Services Administration; and



1 (g) All vaccinations recommended by the Advisory Committee
2 on Immunization Practices of the Centers for Disease Control and
3 Prevention of the United States Department of Health and Human
4 Services or its successor organization.

5 5. As used in this section, "provider of health care" has the
6 meaning ascribed to it in NRS 629.031.

7 **Sec. 27. 1.** An insurer that offers or issues a policy of
8 group health insurance shall include in the policy coverage for
9 such preventive health care services relating to persons 18 years of
10 age or older as the Director of the Department of Health and
11 Human Services requires.

12 2. An insurer that offers or issues a policy of group health
13 insurance shall not:

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

18 (b) Refuse to issue a policy of group health insurance or
19 cancel a policy of group health insurance solely because the
20 person applying for or covered by the policy uses or may use a
21 benefit provided in the policy of group health insurance pursuant
22 to subsection 1;

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

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

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

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

35 3. A policy of group health insurance subject to the
36 provisions of this chapter that is delivered, issued for delivery or
37 renewed on or after January 1, 2018, has the legal effect of
38 including the coverage required by subsection 1, and any
39 provision of the policy or the renewal which is in conflict with this
40 section is void.

41 4. The Director of the Department of Health and Human
42 Services shall adopt regulations to establish the preventive health
43 care services which must be covered by a policy of group health
44 insurance pursuant to subsection 1, including, without limitation:



1 (a) Screening, tests and counseling for such other health
2 conditions and diseases as recommended by the United States
3 Preventive Services Task Force or its successor organization;

4 (b) Counseling relating to the dietary needs of certain adults
5 who are at high-risk of chronic diseases;

6 (c) Smoking cessation programs;

7 (d) Any supplements, drugs or devices recommended by the
8 United States Preventive Services Task Force or its successor
9 organization; and

10 (e) All vaccinations recommended by the Advisory Committee
11 on Immunization Practices of the Centers for Disease Control and
12 Prevention of the United States Department of Health and Human
13 Services or its successor organization.

14 5. As used in this section, "provider of health care" has the
15 meaning ascribed to it in NRS 629.031.

16 **Sec. 28.** 1. An insurer that offers or issues a policy of
17 group health insurance shall include in the policy coverage for
18 such preventive health care services relating to persons less than
19 18 years of age as the Director of the Department of Health and
20 Human Services requires.

21 2. An insurer that offers or issues a policy of group health
22 insurance shall not:

23 (a) Require an insured to pay a higher deductible, any
24 copayment or coinsurance or require a longer waiting period or
25 other condition to obtain any benefit provided in the policy of
26 group health insurance pursuant to subsection 1;

27 (b) Refuse to issue a policy of group health insurance or
28 cancel a policy of group health insurance solely because the
29 person applying for or covered by the policy uses or may use a
30 benefit provided in the policy of group health insurance pursuant
31 to subsection 1;

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

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

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

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

44 3. A policy of group health insurance subject to the
45 provisions of this chapter that is delivered, issued for delivery or



1 *renewed on or after January 1, 2018, has the legal effect of*
2 *including the coverage required by subsection 1, and any*
3 *provision of the policy or the renewal which is in conflict with this*
4 *section is void.*

5 *4. The Director of the Department of Health and Human*
6 *Services shall adopt regulations to establish the preventive health*
7 *care services which must be covered by a policy of group health*
8 *insurance pursuant to subsection 1, including, without limitation:*

9 *(a) Screening, tests and counseling for such other health*
10 *conditions and diseases as recommended by the Health Resources*
11 *and Services Administration;*

12 *(b) Assessments relating to height, weight, body mass index*
13 *and medical history;*

14 *(c) Any supplements, drugs or devices recommended by the*
15 *Health Resources and Services Administration; and*

16 *(d) All vaccinations recommended by the Advisory Committee*
17 *on Immunization Practices of the Centers for Disease Control and*
18 *Prevention of the United States Department of Health and Human*
19 *Services or its successor organization.*

20 *5. As used in this section, "provider of health care" has the*
21 *meaning ascribed to it in NRS 629.031.*

22 **Sec. 29.** NRS 689B.0313 is hereby amended to read as
23 follows:

24 689B.0313 1. A policy of group health insurance must
25 provide coverage for benefits payable for expenses incurred for
26 ~~administering~~ :

27 *(a) Deoxyribonucleic acid testing for high-risk strains of the*
28 *human papillomavirus; and*

29 *(b) Administering* the human papillomavirus vaccine as
30 recommended for vaccination by a competent authority, including,
31 without limitation, the Centers for Disease Control and Prevention
32 of the United States Department of Health and Human Services, the
33 Food and Drug Administration or the manufacturer of the vaccine.

34 2. A policy of group health insurance must not require an
35 insured to obtain prior authorization for any service provided
36 pursuant to subsection 1.

37 3. *An insurer that offers or issues a policy of group health*
38 *insurance shall not:*

39 *(a) Require an insured to pay a higher deductible, any*
40 *copayment or coinsurance or require a longer waiting period or*
41 *other condition to obtain any benefit provided in the policy of*
42 *group health insurance pursuant to subsection 1;*

43 *(b) Refuse to issue a policy of group health insurance or*
44 *cancel a policy of group health insurance solely because the*
45 *person applying for or covered by the policy uses or may use a*



1 *benefit provided in the policy of group health insurance pursuant*
2 *to subsection 1;*

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

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

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

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

15 **4.** A policy of *group health insurance* subject to the
16 provisions of this chapter which is delivered, issued for delivery or
17 renewed on or after ~~July 1, 2007,~~ **January 1, 2018**, has the legal
18 effect of including the coverage required by subsection 1, and any
19 provision of the policy or the renewal which is in conflict with
20 subsection 1 is void.

21 ~~4. For the purposes of this section, “human”~~

22 **5. As used in this section:**

23 *(a) “Human papillomavirus vaccine” means the Quadrivalent*
24 *Human Papillomavirus Recombinant Vaccine or its successor which*
25 *is approved by the Food and Drug Administration for the prevention*
26 *of human papillomavirus infection and cervical cancer.*

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

29 **Sec. 30.** NRS 689B.0374 is hereby amended to read as
30 follows:

31 689B.0374 1. A policy of group health insurance must
32 provide coverage for benefits payable for expenses incurred for:

33 (a) An annual cytologic screening test for women 18 years of
34 age or older;

35 (b) A baseline mammogram for women between the ages of 35
36 and 40; ~~and~~

37 (c) An annual mammogram for women 40 years of age or
38 older ~~;~~;

39 *(d) Counseling concerning genetic testing for breast cancer;*
40 *and*

41 *(e) Counseling concerning breast cancer chemoprevention.*

42 2. A policy of group health insurance must not require an
43 insured to obtain prior authorization for any service provided
44 pursuant to subsection 1.



1 3. *An insurer that offers or issues a policy of group health*
2 *insurance shall not:*

3 (a) *Require an insured to pay a higher deductible, any*
4 *copayment or coinsurance or require a longer waiting period or*
5 *other condition to obtain any benefit provided in the policy of*
6 *group health insurance pursuant to subsection 1;*

7 (b) *Refuse to issue a policy of group health insurance or*
8 *cancel a policy of group health insurance solely because the*
9 *person applying for or covered by the policy uses or may use a*
10 *benefit provided in the policy of group health insurance pursuant*
11 *to subsection 1;*

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

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

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

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

24 4. A policy of group health insurance subject to the
25 provisions of this chapter which is delivered, issued for delivery or
26 renewed on or after ~~{October 1, 1989,}~~ **January 1, 2018**, has the
27 legal effect of including the coverage required by subsection 1, and
28 any provision of the policy or the renewal which is in conflict with
29 subsection 1 is void.

30 5. *As used in this section, “provider of health care” has the*
31 *meaning ascribed to it in NRS 629.031.*

32 **Sec. 31.** NRS 689B.500 is hereby amended to read as follows:

33 689B.500 ~~{A carrier that issues a group health plan or coverage~~
34 ~~under blanket accident and health insurance or group health~~
35 ~~insurance shall not deny, exclude or limit a benefit for a preexisting~~
36 ~~condition.}~~

37 1. *An insurer shall offer or issue a policy of group health*
38 *insurance to any person regardless of the health status of the*
39 *person, the spouse of the person or any dependent of the person.*
40 *Such health status includes, without limitation:*

41 (a) *Any preexisting medical condition of the person, including,*
42 *without limitation, any physical or mental illness;*

43 (b) *The claims history of the person, including, without*
44 *limitation, any prior health care services received by the person;*

45 (c) *Genetic information relating to the person; and*



1 (d) Any increased risk for illness, injury or any other medical
2 condition of the person, including, without limitation, any medical
3 condition caused by an act of domestic violence.

4 2. An insurer that offers or issues a policy of group health
5 insurance shall not:

6 (a) Deny, limit or exclude a benefit based on the health status
7 of an insured; or

8 (b) Require an insured, as a condition of enrollment or
9 renewal, to pay a premium, deductible, copay or coinsurance
10 based on his or her health status which is greater than the
11 premium, deductible, copay or coinsurance charged to a similarly
12 situated insured or the covered spouse or dependent of such an
13 insured who does not have such a health status.

14 3. An insurer that offers or issues a policy of group health
15 insurance shall not adjust a premium, deductible, copay or
16 coinsurance for any insured on the basis of genetic information
17 relating to the insured or the covered spouse or dependent of the
18 insured.

19 **Sec. 32.** NRS 689B.520 is hereby amended to read as follows:

20 689B.520 1. An insurer that offers or issues a policy of
21 group health insurance shall include in the policy coverage for
22 such health care services relating to maternal and newborn care
23 as the Director of the Department of Health and Human Services
24 requires.

25 2. Except as otherwise provided in this subsection, a group
26 health plan or coverage offered under group health insurance issued
27 pursuant to this chapter ~~{that includes coverage for maternity care~~
28 ~~and pediatric care for newborn infants}~~ may not restrict benefits for
29 any length of stay in a hospital in connection with childbirth for a
30 mother or newborn infant covered by the plan or coverage to:

31 (a) Less than 48 hours after a normal vaginal delivery; and

32 (b) Less than 96 hours after a cesarean section.

33 ↪ If a different length of stay is provided in the guidelines
34 established by the American College of Obstetricians and
35 Gynecologists, or its successor organization, and the American
36 Academy of Pediatrics, or its successor organization, the group
37 health plan or health insurance coverage may follow such guidelines
38 in lieu of following the length of stay set forth above. The
39 provisions of this subsection do not apply to any group health plan
40 or health insurance coverage in any case in which the decision to
41 discharge the mother or newborn infant before the expiration of the
42 minimum length of stay set forth in this subsection is made by the
43 attending physician of the mother or newborn infant.

44 ~~{2}~~ 3. Nothing in this section requires a mother to:

45 (a) Deliver her baby in a hospital; or



1 (b) Stay in a hospital for a fixed period following the birth of her
2 child.

3 ~~3-1~~ 4. A group health plan or coverage under group health
4 insurance ~~{that offers coverage for maternity care and pediatric care~~
5 ~~of newborn infants}~~ may not:

6 (a) Deny a mother or her newborn infant coverage or continued
7 coverage under the terms of the plan or coverage if the sole purpose
8 of the denial of coverage or continued coverage is to avoid the
9 requirements of this section;

10 (b) Provide monetary payments or rebates to a mother to
11 encourage her to accept less than the minimum protection available
12 pursuant to this section;

13 (c) Penalize, or otherwise reduce or limit, the reimbursement of
14 an attending provider of health care because the attending provider
15 of health care provided care to a mother or newborn infant in
16 accordance with the provisions of this section;

17 (d) Provide incentives of any kind to an attending physician to
18 induce the attending physician to provide care to a mother or
19 newborn infant in a manner that is inconsistent with the provisions
20 of this section; or

21 (e) Except as otherwise provided in subsection ~~4-1~~ 5, restrict
22 benefits for any portion of a hospital stay required pursuant to the
23 provisions of this section in a manner that is less favorable than the
24 benefits provided for any preceding portion of that stay.

25 ~~4-1~~ 5. Nothing in this section:

26 (a) Prohibits a group health plan or carrier from imposing a
27 deductible, coinsurance or other mechanism for sharing costs
28 relating to benefits for hospital stays in connection with childbirth
29 for a mother or newborn child covered by the plan, except that such
30 coinsurance or other mechanism for sharing costs for any portion of
31 a hospital stay required by this section may not be greater than the
32 coinsurance or other mechanism for any preceding portion of that
33 stay.

34 (b) Prohibits an arrangement for payment between a group
35 health plan or carrier and a provider of health care that uses
36 capitation or other financial incentives, if the arrangement is
37 designed to provide services efficiently and consistently in the best
38 interest of the mother and her newborn infant.

39 (c) Prevents a group health plan or carrier from negotiating with
40 a provider of health care concerning the level and type of
41 reimbursement to be provided in accordance with this section.

42 *6. A policy of group health insurance subject to the*
43 *provisions of this chapter that is delivered, issued for delivery or*
44 *renewed on or after January 1, 2018, has the legal effect of*
45 *including the coverage required by subsection 1, and any*



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

3 *7. The Director of the Department of Health and Human*
4 *Services shall adopt regulations to establish the health care*
5 *services which must be covered by a policy of group health*
6 *insurance pursuant to subsection 1.*

7 *8. As used in this section, "provider of health care" has the*
8 *meaning ascribed to it in NRS 629.031.*

9 **Sec. 33.** Chapter 689C of NRS is hereby amended by adding
10 thereto the provisions set forth as sections 34 to 39, inclusive, of this
11 act.

12 **Sec. 34.** *1. A carrier that offers or issues a health benefit*
13 *plan which provides coverage for dependent children shall*
14 *continue to make such coverage available for an adult child of an*
15 *insured until such child reaches 26 years of age.*

16 *2. Nothing in this section shall be construed as requiring a*
17 *carrier to make coverage available for a dependent of an adult*
18 *child of an insured.*

19 **Sec. 35.** *1. A carrier that offers or issues a health benefit*
20 *plan shall include in the plan coverage for such preventive health*
21 *care services relating to women as the Director of the Department*
22 *of Health and Human Services requires.*

23 *2. A carrier that offers or issues a health benefit plan shall*
24 *not:*

25 *(a) Require an insured to pay a higher deductible, any*
26 *copayment or coinsurance or require a longer waiting period or*
27 *other condition to obtain any benefit provided in the health benefit*
28 *plan pursuant to subsection 1;*

29 *(b) Refuse to issue a health benefit plan or cancel a health*
30 *benefit plan solely because the person applying for or covered by*
31 *the plan uses or may use a benefit provided in the health benefit*
32 *plan pursuant to subsection 1;*

33 *(c) Offer or pay any type of material inducement or financial*
34 *incentive to an insured to discourage the insured from obtaining*
35 *any 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*
40 *other financial incentive to a provider of health care to deny,*
41 *reduce, withhold, limit or delay access to any such benefit to an*
42 *insured; or*

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



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

6 4. *The Director of the Department of Health and Human*
7 *Services shall adopt regulations to establish the preventive health*
8 *care services which must be covered by a health benefit plan*
9 *pursuant to subsection 1, including, without limitation:*

10 (a) *Such prenatal screenings and tests as recommended by the*
11 *American College of Obstetricians and Gynecologists or its*
12 *successor organization;*

13 (b) *Screening and counseling for interpersonal and domestic*
14 *violence;*

15 (c) *Screening, tests and counseling for such other health*
16 *conditions and diseases as recommended by the Health Resources*
17 *and Services Administration;*

18 (d) *Contraceptive drugs, devices and services;*

19 (e) *Such well-woman preventive visits as recommended by the*
20 *Health Resources and Services Administration;*

21 (f) *Any supplements, drugs or devices recommended by the*
22 *Health Resources and Services Administration; and*

23 (g) *All vaccinations recommended by the Advisory Committee*
24 *on Immunization Practices of the Centers for Disease Control and*
25 *Prevention of the United States Department of Health and Human*
26 *Services or its successor organization.*

27 5. *As used in this section, "provider of health care" has the*
28 *meaning ascribed to it in NRS 629.031.*

29 **Sec. 36. 1.** *A carrier that offers or issues a health benefit*
30 *plan shall include in the plan coverage for such preventive health*
31 *care services relating to persons 18 years of age or older as the*
32 *Director of the Department of Health and Human Services*
33 *requires.*

34 2. *A carrier that offers or issues a health benefit plan shall*
35 *not:*

36 (a) *Require an insured to pay a higher deductible, any*
37 *copayment or coinsurance or require a longer waiting period or*
38 *other condition to obtain any benefit provided in the health benefit*
39 *plan pursuant to subsection 1;*

40 (b) *Refuse to issue a health benefit plan or cancel a health*
41 *benefit plan solely because the person applying for or covered by*
42 *the plan uses or may use a benefit provided in the health benefit*
43 *plan pursuant to subsection 1;*



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

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

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

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

13 3. A health benefit plan subject to the provisions of this
14 chapter that is delivered, issued for delivery or renewed on or after
15 January 1, 2018, has the legal effect of including the coverage
16 required by subsection 1, and any provision of the plan or the
17 renewal which is in conflict with this section is void.

18 4. The Director of the Department of Health and Human
19 Services shall adopt regulations to establish the preventive health
20 care services which must be covered by a health benefit plan
21 pursuant to subsection 1, including, without limitation:

22 (a) Screening, tests and counseling for such other health
23 conditions and diseases as recommended by the United States
24 Preventive Services Task Force or its successor organization;

25 (b) Counseling relating to the dietary needs of certain adults
26 who are at high-risk of chronic diseases;

27 (c) Smoking cessation programs;

28 (d) Any supplements, drugs or devices recommended by the
29 United States Preventive Services Task Force or its successor
30 organization; and

31 (e) All vaccinations recommended by the Advisory Committee
32 on Immunization Practices of the Centers for Disease Control and
33 Prevention of the United States Department of Health and Human
34 Services or its successor organization.

35 5. As used in this section, "provider of health care" has the
36 meaning ascribed to it in NRS 629.031.

37 **Sec. 37. 1.** A carrier that offers or issues a health benefit
38 plan shall include in the plan coverage for such preventive health
39 care services relating to persons less than 18 years of age as the
40 Director of the Department of Health and Human Services
41 requires.

42 2. A carrier that offers or issues a health benefit plan shall
43 not:

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



1 *other condition to obtain any benefit provided in the health benefit*
2 *plan pursuant to subsection 1;*

3 *(b) Refuse to issue a health benefit plan or cancel a health*
4 *benefit plan solely because the person applying for or covered by*
5 *the plan uses or may use a benefit provided in the health benefit*
6 *plan pursuant to subsection 1;*

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

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

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

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

19 *3. A health benefit plan subject to the provisions of this*
20 *chapter that is delivered, issued for delivery or renewed on or after*
21 *January 1, 2018, has the legal effect of including the coverage*
22 *required by subsection 1, and any provision of the plan or the*
23 *renewal which is in conflict with this section is void.*

24 *4. The Director of the Department of Health and Human*
25 *Services shall adopt regulations to establish the preventive health*
26 *care services which must be covered by a health benefit plan*
27 *pursuant to subsection 1, including, without limitation:*

28 *(a) Screening, tests and counseling for such other health*
29 *conditions and diseases as recommended by the Health Resources*
30 *and Services Administration;*

31 *(b) Assessments relating to height, weight, body mass index*
32 *and medical history;*

33 *(c) Any supplements, drugs or devices recommended by the*
34 *Health Resources and Services Administration; and*

35 *(d) All vaccinations recommended by the Advisory Committee*
36 *on Immunization Practices of the Centers for Disease Control and*
37 *Prevention of the United States Department of Health and Human*
38 *Services or its successor organization.*

39 *5. As used in this section, "provider of health care" has the*
40 *meaning ascribed to it in NRS 629.031.*

41 **Sec. 38. 1. A health benefit plan must provide coverage for**
42 **benefits payable for expenses incurred for:**

43 *(a) Deoxyribonucleic acid testing for high-risk strains of the*
44 *human papillomavirus; and*



1 *(b) Administering the human papillomavirus vaccine as*
2 *recommended for vaccination by a competent authority, including,*
3 *without limitation, the Centers for Disease Control and Prevention*
4 *of the United States Department of Health and Human Services,*
5 *the Food and Drug Administration or the manufacturer of the*
6 *vaccine.*

7 2. *A health benefit plan must not require an insured to obtain*
8 *prior authorization for any service provided pursuant to*
9 *subsection 1.*

10 3. *A carrier that offers or issues a health benefit plan shall*
11 *not:*

12 (a) *Require an insured to pay a higher deductible, any*
13 *copayment or coinsurance or require a longer waiting period or*
14 *other condition to obtain any benefit provided in the health benefit*
15 *plan pursuant to subsection 1;*

16 (b) *Refuse to issue a health benefit plan or cancel a health*
17 *benefit plan solely because the person applying for or covered by*
18 *the plan uses or may use a benefit provided in the health benefit*
19 *plan pursuant to subsection 1;*

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

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

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

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

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

37 5. *As used in this section:*

38 (a) *“Human papillomavirus vaccine” means the Quadrivalent*
39 *Human Papillomavirus Recombinant Vaccine or its successor*
40 *which is approved by the Food and Drug Administration for the*
41 *prevention of human papillomavirus infection and cervical*
42 *cancer.*

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



1 **Sec. 39. 1. A health benefit plan must provide coverage for**
2 **benefits payable for expenses incurred for:**

3 **(a) An annual cytologic screening test for women 18 years of**
4 **age or older;**

5 **(b) A baseline mammogram for women between the ages of 35**
6 **and 40 years;**

7 **(c) An annual mammogram for women 40 years of age or**
8 **older;**

9 **(d) Counseling concerning genetic testing for breast cancer;**
10 **and**

11 **(e) Counseling concerning breast cancer chemoprevention.**

12 **2. A health benefit plan must not require an insured to obtain**
13 **prior authorization for any service provided pursuant to**
14 **subsection 1.**

15 **3. A carrier that offers or issues a health benefit plan shall**
16 **not:**

17 **(a) Require an insured to pay a higher deductible, any**
18 **copayment or coinsurance or require a longer waiting period or**
19 **other condition to obtain any benefit provided in the health benefit**
20 **plan pursuant to subsection 1;**

21 **(b) Refuse to issue a health benefit plan or cancel a health**
22 **benefit plan solely because the person applying for or covered by**
23 **the plan uses or may use a benefit provided in the health benefit**
24 **plan pursuant to subsection 1;**

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

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

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

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

37 **4. A health benefit plan subject to the provisions of this**
38 **chapter which is delivered, issued for delivery or renewed on or**
39 **after January 1, 2018, has the legal effect of including the**
40 **coverage required by subsection 1, and any provision of the plan**
41 **or the renewal which is in conflict with subsection 1 is void.**

42 **5. As used in this section, "provider of health care" has the**
43 **meaning ascribed to it in NRS 629.031.**



1 **Sec. 40.** NRS 689C.159 is hereby amended to read as follows:

2 689C.159 The provisions of NRS 689C.156 ~~and 689C.190~~ do
3 not apply to health benefit plans offered by a carrier if the carrier
4 makes the health benefit plan available in the small employer
5 market only through a bona fide association.

6 **Sec. 41.** NRS 689C.190 is hereby amended to read as follows:

7 689C.190 ~~[A carrier serving small employers that issues a~~
8 ~~health benefit plan shall not deny, exclude or limit a benefit for a~~
9 ~~preexisting condition.]~~

10 1. *A carrier shall offer or issue a health benefit plan to any*
11 *person regardless of the health status of the person, the spouse of*
12 *the person or any dependent of the person. Such health status*
13 *includes, without limitation:*

14 (a) *Any preexisting medical condition of the person, including,*
15 *without limitation, any physical or mental illness;*

16 (b) *The claims history of the person, including, without*
17 *limitation, any prior health care services received by the person;*

18 (c) *Genetic information relating to the person; and*

19 (d) *Any increased risk for illness, injury or any other medical*
20 *condition of the person, including, without limitation, any medical*
21 *condition caused by an act of domestic violence.*

22 2. *A carrier that offers or issues a health benefit plan shall*
23 *not:*

24 (a) *Deny, limit or exclude a benefit based on the health status*
25 *of an insured; or*

26 (b) *Require an insured, as a condition of enrollment or*
27 *renewal, to pay a premium, deductible, copay or coinsurance*
28 *based on his or her health status which is greater than the*
29 *premium, deductible, copay or coinsurance charged to a similarly*
30 *situated insured or the covered spouse or dependent of such an*
31 *insured who does not have such a health status.*

32 3. *A carrier that offers or issues a health benefit plan shall*
33 *not adjust a premium, deductible, copay or coinsurance for any*
34 *insured on the basis of genetic information relating to the insured*
35 *or the covered spouse or dependent of the insured.*

36 **Sec. 42.** NRS 689C.193 is hereby amended to read as follows:

37 689C.193 1. A carrier shall not place any restriction on a
38 small employer or an eligible employee or a dependent of the
39 eligible employee as a condition of being a participant in or a
40 beneficiary of a health benefit plan that is inconsistent with NRS
41 689C.015 to 689C.355, inclusive ~~H~~, *and sections 34 to 39,*
42 *inclusive, of this act.*

43 2. A carrier that offers health insurance coverage to small
44 employers pursuant to this chapter shall not establish rules of
45 eligibility, including, but not limited to, rules which define



1 applicable waiting periods, for the initial or continued enrollment
2 under a health benefit plan offered by the carrier that are based on
3 the following factors relating to the eligible employee or a
4 dependent of the eligible employee:

5 (a) Health status.

6 (b) Medical condition, including physical and mental illnesses,
7 or both.

8 (c) Claims experience.

9 (d) Receipt of health care.

10 (e) Medical history.

11 (f) Genetic information.

12 (g) Evidence of insurability, including conditions which arise
13 out of acts of domestic violence.

14 (h) Disability.

15 3. Except as otherwise provided in NRS 689C.190, the
16 provisions of subsection 1 do not require a carrier to provide
17 particular benefits other than those that would otherwise be provided
18 under the terms of the health benefit plan or coverage.

19 4. As a condition of enrollment or continued enrollment under
20 a health benefit plan, a carrier shall not require any person to pay a
21 premium or contribution that is greater than the premium or
22 contribution for a similarly situated person covered by similar
23 coverage on the basis of any factor described in subsection 2 in
24 relation to the person or a dependent of the person.

25 5. Nothing in this section:

26 (a) Restricts the amount that a small employer may be charged
27 for coverage by a carrier;

28 (b) Prevents a carrier from establishing premium discounts or
29 rebates or from modifying otherwise applicable copayments or
30 deductibles in return for adherence by the insured person to
31 programs of health promotion and disease prevention; or

32 (c) Precludes a carrier from establishing rules relating to
33 employer contribution or group participation when offering health
34 insurance coverage to small employers in this State.

35 6. As used in this section:

36 (a) "Contribution" means the minimum employer contribution
37 toward the premium for enrollment of participants and beneficiaries
38 in a health benefit plan.

39 (b) "Group participation" means the minimum number of
40 participants or beneficiaries that must be enrolled in a health benefit
41 plan in relation to a specified percentage or number of eligible
42 persons or employees of the employer.

43 **Sec. 43.** NRS 689C.194 is hereby amended to read as follows:

44 689C.194 1. *A carrier that offers or issues a health benefit*
45 *plan shall include in the plan coverage for such health care*



1 *services relating to maternal and newborn care as the Director of*
2 *the Department of Health and Human Services requires.*

3 2. Except as otherwise provided in this subsection, a health
4 benefit plan issued pursuant to this chapter ~~that includes coverage~~
5 ~~for maternity care and pediatric care for newborn infants~~ may not
6 restrict benefits for any length of stay in a hospital in connection
7 with childbirth for a mother or newborn infant covered by the plan
8 to:

9 (a) Less than 48 hours after a normal vaginal delivery; and

10 (b) Less than 96 hours after a cesarean section.

11 ➔ If a different length of stay is provided in the guidelines
12 established by the American College of Obstetricians and
13 Gynecologists, or its successor organization, and the American
14 Academy of Pediatrics, or its successor organization, the health
15 benefit plan may follow such guidelines in lieu of following the
16 length of stay set forth above. The provisions of this subsection do
17 not apply to any health benefit plan in any case in which the
18 decision to discharge the mother or newborn infant before the
19 expiration of the minimum length of stay set forth in this subsection
20 is made by the attending physician of the mother or newborn infant.

21 ~~2.~~ 3. Nothing in this section requires a mother to:

22 (a) Deliver her baby in a hospital; or

23 (b) Stay in a hospital for a fixed period following the birth of her
24 child.

25 ~~3.~~ 4. A health benefit plan ~~that offers coverage for maternity~~
26 ~~care and pediatric care of newborn infants~~ may not:

27 (a) Deny a mother or her newborn infant coverage or continued
28 coverage under the terms of the plan if the sole purpose of the denial
29 of coverage or continued coverage is to avoid the requirements of
30 this section;

31 (b) Provide monetary payments or rebates to a mother to
32 encourage her to accept less than the minimum protection available
33 pursuant to this section;

34 (c) Penalize, or otherwise reduce or limit, the reimbursement of
35 an attending provider of health care because the attending provider
36 of health care provided care to a mother or newborn infant in
37 accordance with the provisions of this section;

38 (d) Provide incentives of any kind to an attending physician to
39 induce the attending physician to provide care to a mother or
40 newborn infant in a manner that is inconsistent with the provisions
41 of this section; or

42 (e) Except as otherwise provided in subsection ~~4.~~ 5, restrict
43 benefits for any portion of a hospital stay required pursuant to the
44 provisions of this section in a manner that is less favorable than the
45 benefits provided for any preceding portion of that stay.



1 ~~44~~ 5. Nothing in this section:

2 (a) Prohibits a health benefit plan or carrier from imposing a
3 deductible, coinsurance or other mechanism for sharing costs
4 relating to benefits for hospital stays in connection with childbirth
5 for a mother or newborn child covered by the plan, except that such
6 coinsurance or other mechanism for sharing costs for any portion of
7 a hospital stay required by this section may not be greater than the
8 coinsurance or other mechanism for any preceding portion of that
9 stay.

10 (b) Prohibits an arrangement for payment between a health
11 benefit plan or carrier and a provider of health care that uses
12 capitation or other financial incentives, if the arrangement is
13 designed to provide services efficiently and consistently in the best
14 interest of the mother and her newborn infant.

15 (c) Prevents a health benefit plan or carrier from negotiating
16 with a provider of health care concerning the level and type of
17 reimbursement to be provided in accordance with this section.

18 *6. A health benefit plan subject to the provisions of this*
19 *chapter that is delivered, issued for delivery or renewed on or after*
20 *January 1, 2018, has the legal effect of including the coverage*
21 *required by subsection 1, and any provision of the plan or the*
22 *renewal which is in conflict with this section is void.*

23 *7. The Director of the Department of Health and Human*
24 *Services shall adopt regulations to establish the health care*
25 *services which must be covered by a health benefit plan pursuant*
26 *to subsection 1.*

27 *8. As used in this section, "provider of health care" has the*
28 *meaning ascribed to it in NRS 629.031.*

29 **Sec. 44.** NRS 689C.270 is hereby amended to read as follows:

30 689C.270 1. The Commissioner shall adopt regulations
31 which require a carrier to file with the Commissioner, for approval
32 by the Commissioner, a disclosure offered by the carrier to a small
33 employer. The disclosure must include:

34 (a) Any significant exception, reduction or limitation that
35 applies to the policy;

36 (b) Any restrictions on payments for emergency care, including,
37 without limitation, related definitions of an emergency and medical
38 necessity;

39 (c) The provision of the health benefit plan concerning the
40 carrier's right to change premium rates and the characteristics, other
41 than claim experience, that affect changes in premium rates;

42 (d) The provisions relating to renewability of policies and
43 contracts; *and*

44 (e) ~~The provisions relating to any preexisting condition; and~~



1 ~~(F)~~ Any other information that the Commissioner finds
2 necessary to provide for full and fair disclosure of the provisions of
3 a policy or contract of insurance issued pursuant to this chapter.

4 2. The disclosure must be written in language which is easily
5 understood and must include a statement that the disclosure is a
6 summary of the policy only, and that the policy itself should be read
7 to determine the governing contractual provisions.

8 3. The Commissioner shall not approve any proposed
9 disclosure submitted to the Commissioner pursuant to this section
10 which does not comply with the requirements of this section and the
11 applicable regulations.

12 4. The carrier shall make available to a small employer or a
13 producer acting on behalf of a small employer, upon request, a copy
14 of the disclosure approved by the Commissioner pursuant to this
15 section for policies of health insurance for which that employer may
16 be eligible.

17 **Sec. 45.** NRS 689C.425 is hereby amended to read as follows:

18 689C.425 A voluntary purchasing group and any contract
19 issued to such a group pursuant to NRS 689C.360 to 689C.600,
20 inclusive, are subject to the provisions of NRS 689C.015 to
21 689C.355, inclusive, *and sections 34 to 39, inclusive, of this act*, to
22 the extent applicable and not in conflict with the express provisions
23 of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

24 **Sec. 46.** NRS 689C.440 is hereby amended to read as follows:

25 689C.440 1. The Commissioner shall adopt regulations
26 which require a carrier to file with the Commissioner, for approval
27 by the Commissioner, a disclosure offered by the carrier to a
28 voluntary purchasing group. The disclosure must include:

29 (a) Any significant exception, prior authorization, reduction or
30 limitation that applies to a contract;

31 (b) Any restrictions on payments for emergency care, including,
32 without limitation, related definitions of an emergency and medical
33 necessity;

34 (c) Any provision of a contract concerning the carrier's right to
35 change premium rates and the characteristics, other than claim
36 experience, that affect changes in premium rates;

37 (d) The provisions relating to renewability of contracts; *and*

38 (e) ~~The provisions relating to any preexisting condition; and~~

39 ~~(F)~~ Any other information that the Commissioner finds
40 necessary to provide for full and fair disclosure of the provisions of
41 a contract.

42 2. The disclosure must be written in a language which is easily
43 understood and must include a statement that the disclosure is a
44 summary of the contract only, and that the contract itself should be
45 read to determine the governing contractual provisions.



1 3. The Commissioner shall not approve any proposed
2 disclosure submitted to the Commissioner pursuant to this section
3 which does not comply with the requirements of this section and the
4 applicable regulations.

5 **Sec. 47.** Chapter 695A of NRS is hereby amended by adding
6 thereto the provisions set forth as sections 48 to 55, inclusive, of this
7 act.

8 **Sec. 48. 1.** *A society shall offer or issue a benefit contract*
9 *to any person regardless of the health status of the person, the*
10 *spouse of the person or any dependent of the person. Such health*
11 *status includes, without limitation:*

- 12 (a) *Any preexisting medical condition of the person, including,*
13 *without limitation, any physical or mental illness;*
14 (b) *The claims history of the person, including, without*
15 *limitation, any prior health care services received by the person;*
16 (c) *Genetic information relating to the person; and*
17 (d) *Any increased risk for illness, injury or any other medical*
18 *condition of the person, including, without limitation, any medical*
19 *condition caused by an act of domestic violence.*

20 2. *A society that offers or issues a benefit contract shall not:*

- 21 (a) *Deny, limit or exclude a benefit based on the health status*
22 *of an insured; or*
23 (b) *Require an insured, as a condition of enrollment or*
24 *renewal, to pay a premium, deductible, copay or coinsurance*
25 *based on his or her health status which is greater than the*
26 *premium, deductible, copay or coinsurance charged to a similarly*
27 *situated insured or the covered spouse or dependent of such an*
28 *insured who does not have such a health status.*

29 3. *A society that offers or issues a benefit contract shall not*
30 *adjust a premium, deductible, copay or coinsurance for any*
31 *insured on the basis of genetic information relating to the insured*
32 *or the covered spouse or dependent of the insured.*

33 **Sec. 49. 1.** *A society that offers or issues a benefit contract*
34 *which provides coverage for dependent children shall continue to*
35 *make such coverage available for an adult child of an insured*
36 *until such child reaches 26 years of age.*

37 2. *Nothing in this section shall be construed as requiring a*
38 *society to make coverage available for a dependent of an adult*
39 *child of an insured.*

40 **Sec. 50. 1.** *A society that offers or issues a benefit contract*
41 *shall include in the contract coverage for such preventive health*
42 *care services relating to women as the Director of the Department*
43 *of Health and Human Services requires.*

44 2. *A society that offers or issues a benefit contract shall not:*



1 (a) Require an insured to pay a higher deductible, any
2 copayment or coinsurance or require a longer waiting period or
3 other condition to obtain any benefit provided in the benefit
4 contract pursuant to subsection 1;

5 (b) Refuse to issue a benefit contract or cancel a benefit
6 contract solely because the person applying for or covered by the
7 contract uses or may use a benefit provided in the benefit contract
8 pursuant to subsection 1;

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

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

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

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

21 3. A benefit contract subject to the provisions of this chapter
22 that is delivered, issued for delivery or renewed on or after
23 January 1, 2018, has the legal effect of including the coverage
24 required by subsection 1, and any provision of the contract or the
25 renewal which is in conflict with this section is void.

26 4. The Director of the Department of Health and Human
27 Services shall adopt regulations to establish the preventive health
28 care services which must be covered by a benefit contract pursuant
29 to subsection 1, including, without limitation:

30 (a) Such prenatal screenings and tests as recommended by the
31 American College of Obstetricians and Gynecologists or its
32 successor organization;

33 (b) Screening and counseling for interpersonal and domestic
34 violence;

35 (c) Screening, tests and counseling for such other health
36 conditions and diseases as recommended by the Health Resources
37 and Services Administration;

38 (d) Contraceptive drugs, devices and services;

39 (e) Such well-woman preventive visits as recommended by the
40 Health Resources and Services Administration;

41 (f) Any supplements, drugs or devices recommended by the
42 Health Resources and Services Administration; and

43 (g) All vaccinations recommended by the Advisory Committee
44 on Immunization Practices of the Centers for Disease Control and



1 *Prevention of the United States Department of Health and Human*
2 *Services or its successor organization.*

3 5. *As used in this section, “provider of health care” has the*
4 *meaning ascribed to it in NRS 629.031.*

5 **Sec. 51. 1.** *A society that offers or issues a benefit contract*
6 *shall include in the contract coverage for such preventive health*
7 *care services relating to persons 18 years of age or older as the*
8 *Director of the Department of Health and Human Services*
9 *requires.*

10 2. *A society that offers or issues a benefit contract shall not:*

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

15 (b) *Refuse to issue a benefit contract or cancel a benefit*
16 *contract solely because the person applying for or covered by the*
17 *contract uses or may use a benefit provided in the benefit contract*
18 *pursuant to subsection 1;*

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

22 (d) *Penalize a provider of health care who provides any such*
23 *benefit to an insured, 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*
26 *other financial incentive to a provider of health care to deny,*
27 *reduce, withhold, limit or delay access to any such benefit to an*
28 *insured; or*

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

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

36 4. *The Director of the Department of Health and Human*
37 *Services shall adopt regulations to establish the preventive health*
38 *care services which must be covered by a benefit contract pursuant*
39 *to subsection 1, including, without limitation:*

40 (a) *Screening, tests and counseling for such other health*
41 *conditions and diseases as recommended by the United States*
42 *Preventive Services Task Force or its successor organization;*

43 (b) *Counseling relating to the dietary needs of certain adults*
44 *who are at high-risk of chronic diseases;*

45 (c) *Smoking cessation programs;*



1 (d) Any supplements, drugs or devices recommended by the
2 United States Preventive Services Task Force or its successor
3 organization; and

4 (e) All vaccinations recommended by the Advisory Committee
5 on Immunization Practices of the Centers for Disease Control and
6 Prevention of the United States Department of Health and Human
7 Services or its successor organization.

8 5. As used in this section, “provider of health care” has the
9 meaning ascribed to it in NRS 629.031.

10 **Sec. 52. 1.** A society that offers or issues a benefit contract
11 shall include in the contract coverage for such preventive health
12 care services relating to persons less than 18 years of age as the
13 Director of the Department of Health and Human Services
14 requires.

15 2. A society that offers or issues a benefit contract shall not:

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

20 (b) Refuse to issue a benefit contract or cancel a benefit
21 contract solely because the person applying for or covered by the
22 contract uses or may use a benefit provided in the benefit contract
23 pursuant to subsection 1;

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

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

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

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

36 3. A benefit contract subject to the provisions of this chapter
37 that is delivered, issued for delivery or renewed on or after
38 January 1, 2018, has the legal effect of including the coverage
39 required by subsection 1, and any provision of the contract or the
40 renewal which is in conflict with this section is void.

41 4. The Director of the Department of Health and Human
42 Services shall adopt regulations to establish the preventive health
43 care services which must be covered by a benefit contract pursuant
44 to subsection 1, including, without limitation:



1 (a) Screening, tests and counseling for such other health
2 conditions and diseases as recommended by the Health Resources
3 and Services Administration;

4 (b) Assessments relating to height, weight, body mass index
5 and medical history;

6 (c) Any supplements, drugs or devices recommended by the
7 Health Resources and Services Administration; and

8 (d) All vaccinations recommended by the Advisory Committee
9 on Immunization Practices of the Centers for Disease Control and
10 Prevention of the United States Department of Health and Human
11 Services or its successor organization.

12 5. As used in this section, "provider of health care" has the
13 meaning ascribed to it in NRS 629.031.

14 **Sec. 53. 1.** A society that offers or issues a benefit contract
15 shall include in the contract coverage for such health care services
16 relating to maternal and newborn care as the Director of the
17 Department of Health and Human Services requires.

18 2. Except as otherwise provided in this subsection, a benefit
19 contract issued pursuant to this chapter may not restrict benefits
20 for any length of stay in a hospital in connection with childbirth
21 for a mother or newborn infant covered by the contract to:

22 (a) Less than 48 hours after a normal vaginal delivery; and

23 (b) Less than 96 hours after a cesarean section.

24 ↪ If a different length of stay is provided in the guidelines
25 established by the American College of Obstetricians and
26 Gynecologists, or its successor organization, and the American
27 Academy of Pediatrics, or its successor organization, the benefit
28 contract may follow such guidelines in lieu of following the length
29 of stay set forth above. The provisions of this subsection do not
30 apply to any benefit contract in any case in which the decision to
31 discharge the mother or newborn infant before the expiration of
32 the minimum length of stay set forth in this subsection is made by
33 the attending physician of the mother or newborn infant.

34 3. Nothing in this section requires a mother to:

35 (a) Deliver her baby in a hospital; or

36 (b) Stay in a hospital for a fixed period following the birth of
37 her child.

38 4. A benefit contract may not:

39 (a) Deny a mother or her newborn infant coverage or
40 continued coverage under the terms of the contract or coverage if
41 the sole purpose of the denial of coverage or continued coverage is
42 to avoid the requirements of this section;

43 (b) Provide monetary payments or rebates to a mother to
44 encourage her to accept less than the minimum protection
45 available pursuant to this section;



1 (c) Penalize, or otherwise reduce or limit, the reimbursement
2 of an attending provider of health care because the attending
3 provider of health care provided care to a mother or newborn
4 infant in accordance with the provisions of this section;

5 (d) Provide incentives of any kind to an attending physician to
6 induce the attending physician to provide care to a mother or
7 newborn infant in a manner that is inconsistent with the
8 provisions of this section; or

9 (e) Except as otherwise provided in subsection 5, restrict
10 benefits for any portion of a hospital stay required pursuant to the
11 provisions of this section in a manner that is less favorable than
12 the benefits provided for any preceding portion of that stay.

13 5. Nothing in this section:

14 (a) Prohibits a benefit contract from imposing a deductible,
15 coinsurance or other mechanism for sharing costs relating to
16 benefits for hospital stays in connection with childbirth for a
17 mother or newborn child covered by the contract, except that such
18 coinsurance or other mechanism for sharing costs for any portion
19 of a hospital stay required by this section may not be greater than
20 the coinsurance or other mechanism for any preceding portion of
21 that stay.

22 (b) Prohibits an arrangement for payment between a benefit
23 contract or society and a provider of health care that uses
24 capitation or other financial incentives, if the arrangement is
25 designed to provide services efficiently and consistently in the best
26 interest of the mother and her newborn infant.

27 (c) Prevents a benefit contract or society from negotiating with
28 a provider of health care concerning the level and type of
29 reimbursement to be provided in accordance with this section.

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

35 7. The Director of the Department of Health and Human
36 Services shall adopt regulations to establish the health care
37 services which must be covered by a benefit contract pursuant to
38 subsection 1.

39 8. As used in this section, "provider of health care" has the
40 meaning ascribed to it in NRS 629.031.

41 **Sec. 54. 1.** A benefit contract must provide coverage for
42 benefits payable for expenses incurred for:

43 (a) Deoxyribonucleic acid testing for high-risk strains of the
44 human papillomavirus; and



1 ***(b) Administering the human papillomavirus vaccine as***
2 ***recommended for vaccination by a competent authority, including,***
3 ***without limitation, the Centers for Disease Control and Prevention***
4 ***of the United States Department of Health and Human Services,***
5 ***the Food and Drug Administration or the manufacturer of the***
6 ***vaccine.***

7 ***2. A benefit contract must not require an insured to obtain***
8 ***prior authorization for any service provided pursuant to***
9 ***subsection 1.***

10 ***3. A society that offers or issues a benefit contract shall not:***

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

15 ***(b) Refuse to issue a benefit contract or cancel a benefit***
16 ***contract solely because the person applying for or covered by the***
17 ***contract uses or may use a benefit provided in the benefit contract***
18 ***pursuant to subsection 1;***

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

22 ***(d) Penalize a provider of health care who provides any such***
23 ***benefit to an insured, 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***
26 ***other financial incentive to a provider of health care to deny,***
27 ***reduce, withhold, limit or delay access to any such benefit to an***
28 ***insured; or***

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

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

36 ***5. As used in this section:***

37 ***(a) "Human papillomavirus vaccine" means the Quadrivalent***
38 ***Human Papillomavirus Recombinant Vaccine or its successor***
39 ***which is approved by the Food and Drug Administration for the***
40 ***prevention of human papillomavirus infection and cervical***
41 ***cancer.***

42 ***(b) "Provider of health care" has the meaning ascribed to it in***
43 ***NRS 629.031.***

44 ***Sec. 55. 1. A benefit contract must provide coverage for***
45 ***benefits payable for expenses incurred for:***



1 (a) *An annual cytologic screening test for women 18 years of*
2 *age or older;*

3 (b) *A baseline mammogram for women between the ages of 35*
4 *and 40 years;*

5 (c) *An annual mammogram for women 40 years of age or*
6 *older;*

7 (d) *Counseling concerning genetic testing for breast cancer;*
8 *and*

9 (e) *Counseling concerning breast cancer chemoprevention.*

10 2. *A benefit contract must not require an insured to obtain*
11 *prior authorization for any service provided pursuant to*
12 *subsection 1.*

13 3. *A society that offers or issues a benefit contract shall not:*

14 (a) *Require an insured to pay a higher deductible, any*
15 *copayment or coinsurance or require a longer waiting period or*
16 *other condition to obtain any benefit provided in the benefit*
17 *contract pursuant to subsection 1;*

18 (b) *Refuse to issue a benefit contract or cancel a benefit*
19 *contract solely because the person applying for or covered by the*
20 *contract uses or may use a benefit provided in the benefit contract*
21 *pursuant to subsection 1;*

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 benefit contract subject to the provisions of this chapter*
35 *which is delivered, issued for delivery or renewed on or after*
36 *January 1, 2018, has the legal effect of including the coverage*
37 *required by subsection 1, and any provision of the contract or the*
38 *renewal which is in conflict with subsection 1 is void.*

39 5. *As used in this section, "provider of health care" has the*
40 *meaning ascribed to it in NRS 629.031.*

41 **Sec. 56.** Chapter 695B of NRS is hereby amended by adding
42 thereto the provisions set forth as sections 57 to 62, inclusive, of this
43 act.

44 **Sec. 57. 1.** *An insurer shall offer or issue a contract for*
45 *hospital or medical service to any person regardless of the health*



1 *status of the person, the spouse of the person or any dependent of*
2 *the person. Such health status includes, without limitation:*

3 (a) *Any preexisting medical condition of the person, including,*
4 *without limitation, any physical or mental illness;*

5 (b) *The claims history of the person, including, without*
6 *limitation, any prior health care services received by the person;*

7 (c) *Genetic information relating to the person; and*

8 (d) *Any increased risk for illness, injury or any other medical*
9 *condition of the person, including, without limitation, any medical*
10 *condition caused by an act of domestic violence.*

11 2. *An insurer that offers or issues a contract for hospital or*
12 *medical service shall not:*

13 (a) *Deny, limit or exclude a benefit based on the health status*
14 *of an insured; or*

15 (b) *Require an insured, as a condition of enrollment or*
16 *renewal, to pay a premium, deductible, copay or coinsurance*
17 *based on his or her health status which is greater than the*
18 *premium, deductible, copay or coinsurance charged to a similarly*
19 *situated insured or the covered spouse or dependent of such an*
20 *insured who does not have such a health status.*

21 3. *An insurer that offers or issues a contract for hospital or*
22 *medical service shall not adjust a premium, deductible, copay or*
23 *coinsurance for any insured on the basis of genetic information*
24 *relating to the insured or the covered spouse or dependent of the*
25 *insured.*

26 **Sec. 58.** 1. *An insurer that offers or issues a contract for*
27 *hospital or medical service which provides coverage for dependent*
28 *children shall continue to make such coverage available for an*
29 *adult child of an insured until such child reaches 26 years of age.*

30 2. *Nothing in this section shall be construed as requiring a*
31 *hospital or medical service corporation to make coverage available*
32 *for a dependent of an adult child of an insured.*

33 **Sec. 59.** 1. *An insurer that offers or issues a contract for*
34 *hospital or medical service shall include in the contract coverage*
35 *for such preventive health care services relating to women as the*
36 *Director of the Department of Health and Human Services*
37 *requires.*

38 2. *An insurer that offers or issues a contract for hospital or*
39 *medical service shall not:*

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

44 (b) *Refuse to issue a contract for hospital or medical service or*
45 *cancel a contract for hospital or medical service solely because the*



1 *person applying for or covered by the contract uses or may use a*
2 *benefit provided in the contract for hospital or medical service*
3 *pursuant to subsection 1;*

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

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

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

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

16 *3. A contract for hospital or medical service subject to the*
17 *provisions of this chapter that is delivered, issued for delivery or*
18 *renewed on or after January 1, 2018, has the legal effect of*
19 *including the coverage required by subsection 1, and any*
20 *provision of the contract or the renewal which is in conflict with*
21 *this section is void.*

22 *4. The Director of the Department of Health and Human*
23 *Services shall adopt regulations to establish the preventive health*
24 *care services which must be covered by a contract for hospital or*
25 *medical service pursuant to subsection 1, including, without*
26 *limitation:*

27 *(a) Such prenatal screenings and tests as recommended by the*
28 *American College of Obstetricians and Gynecologists or its*
29 *successor organization;*

30 *(b) Screening and counseling for interpersonal and domestic*
31 *violence;*

32 *(c) Screening, tests and counseling for such other health*
33 *conditions and diseases as recommended by the Health Resources*
34 *and Services Administration;*

35 *(d) Contraceptive drugs, devices and services;*

36 *(e) Such well-woman preventive visits as recommended by the*
37 *Health Resources and Services Administration;*

38 *(f) Any supplements, drugs or devices recommended by the*
39 *Health Resources and Services Administration; and*

40 *(g) All vaccinations recommended by the Advisory Committee*
41 *on Immunization Practices of the Centers for Disease Control and*
42 *Prevention of the United States Department of Health and Human*
43 *Services or its successor organization.*

44 *5. As used in this section, "provider of health care" has the*
45 *meaning ascribed to it in NRS 629.031.*



1 **Sec. 60. 1. An insurer that offers or issues a contract for**
2 *hospital or medical service shall include in the contract coverage*
3 *for such preventive health care services relating to persons 18*
4 *years of age or older as the Director of the Department of Health*
5 *and Human Services requires.*

6 **2. An insurer that offers or issues a contract for hospital or**
7 *medical service shall not:*

8 **(a) Require an insured to pay a higher deductible, any**
9 *copayment or coinsurance or require a longer waiting period or*
10 *other condition to obtain any benefit provided in the contract for*
11 *hospital or medical service pursuant to subsection 1;*

12 **(b) Refuse to issue a contract for hospital or medical service or**
13 *cancel a contract for hospital or medical service solely because the*
14 *person applying for or covered by the contract uses or may use a*
15 *benefit provided in the contract for hospital or medical service*
16 *pursuant to subsection 1;*

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

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

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

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

29 **3. A contract for hospital or medical service subject to the**
30 *provisions of this chapter that is delivered, issued for delivery or*
31 *renewed on or after January 1, 2018, has the legal effect of*
32 *including the coverage required by subsection 1, and any*
33 *provision of the contract or the renewal which is in conflict with*
34 *this section is void.*

35 **4. The Director of the Department of Health and Human**
36 *Services shall adopt regulations to establish the preventive health*
37 *care services which must be covered by a contract for hospital or*
38 *medical service pursuant to subsection 1, including, without*
39 *limitation:*

40 **(a) Screening, tests and counseling for such other health**
41 *conditions and diseases as recommended by the United States*
42 *Preventive Services Task Force or its successor organization;*

43 **(b) Counseling relating to the dietary needs of certain adults**
44 *who are at high-risk of chronic diseases;*

45 **(c) Smoking cessation programs;**



1 (d) Any supplements, drugs or devices recommended by the
2 United States Preventive Services Task Force or its successor
3 organization; and

4 (e) All vaccinations recommended by the Advisory Committee
5 on Immunization Practices of the Centers for Disease Control and
6 Prevention of the United States Department of Health and Human
7 Services or its successor organization.

8 5. As used in this section, “provider of health care” has the
9 meaning ascribed to it in NRS 629.031.

10 **Sec. 61.** 1. An insurer that offers or issues a contract for
11 hospital or medical service shall include in the contract coverage
12 for such preventive health care services relating to persons less
13 than 18 years of age as the Director of the Department of Health
14 and Human Services requires.

15 2. An insurer that offers or issues a contract for hospital or
16 medical service shall not:

17 (a) Require an insured to pay a higher deductible, any
18 copayment or coinsurance or require a longer waiting period or
19 other condition to obtain any benefit provided in the contract for
20 hospital or medical service pursuant to subsection 1;

21 (b) Refuse to issue a contract for hospital or medical service or
22 cancel a contract for hospital or medical service solely because the
23 person applying for or covered by the contract uses or may use a
24 benefit provided in the contract for hospital or medical service
25 pursuant to subsection 1;

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

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

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

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

38 3. A contract for hospital or medical service subject to the
39 provisions of this chapter that is delivered, issued for delivery or
40 renewed on or after January 1, 2018, has the legal effect of
41 including the coverage required by subsection 1, and any
42 provision of the contract or the renewal which is in conflict with
43 this section is void.

44 4. The Director of the Department of Health and Human
45 Services shall adopt regulations to establish the preventive health



1 *care services which must be covered by a contract for hospital or*
2 *medical service pursuant to subsection 1, including, without*
3 *limitation:*

4 (a) *Screening, tests and counseling for such other health*
5 *conditions and diseases as recommended by the Health Resources*
6 *and Services Administration;*

7 (b) *Assessments relating to height, weight, body mass index*
8 *and medical history;*

9 (c) *Any supplements, drugs or devices recommended by the*
10 *Health Resources and Services Administration; and*

11 (d) *All vaccinations recommended by the Advisory Committee*
12 *on Immunization Practices of the Centers for Disease Control and*
13 *Prevention of the United States Department of Health and Human*
14 *Services or its successor organization.*

15 5. *As used in this section, "provider of health care" has the*
16 *meaning ascribed to it in NRS 629.031.*

17 **Sec. 62. 1.** *An insurer that offers or issues a contract for*
18 *hospital or medical service shall include in the contract coverage*
19 *for such health care services relating to maternal and newborn*
20 *care as the Director of the Department of Health and Human*
21 *Services requires.*

22 2. *Except as otherwise provided in this subsection, a contract*
23 *for hospital or medical service issued pursuant to this chapter may*
24 *not restrict benefits for any length of stay in a hospital in*
25 *connection with childbirth for a mother or newborn infant covered*
26 *by the contract to:*

27 (a) *Less than 48 hours after a normal vaginal delivery; and*

28 (b) *Less than 96 hours after a cesarean section.*

29 ↪ *If a different length of stay is provided in the guidelines*
30 *established by the American College of Obstetricians and*
31 *Gynecologists, or its successor organization, and the American*
32 *Academy of Pediatrics, or its successor organization, the contract*
33 *for hospital or medical service may follow such guidelines in lieu*
34 *of following the length of stay set forth above. The provisions of*
35 *this subsection do not apply to any contract for hospital or medical*
36 *service in any case in which the decision to discharge the mother*
37 *or newborn infant before the expiration of the minimum length of*
38 *stay set forth in this subsection is made by the attending physician*
39 *of the mother or newborn infant.*

40 3. *Nothing in this section requires a mother to:*

41 (a) *Deliver her baby in a hospital; or*

42 (b) *Stay in a hospital for a fixed period following the birth of*
43 *her child.*

44 4. *A contract for hospital or medical service may not:*



1 (a) Deny a mother or her newborn infant coverage or
2 continued coverage under the terms of the contract or coverage if
3 the sole purpose of the denial of coverage or continued coverage is
4 to avoid the requirements of this section;

5 (b) Provide monetary payments or rebates to a mother to
6 encourage her to accept less than the minimum protection
7 available pursuant to this section;

8 (c) Penalize, or otherwise reduce or limit, the reimbursement
9 of an attending provider of health care because the attending
10 provider of health care provided care to a mother or newborn
11 infant in accordance with the provisions of this section;

12 (d) Provide incentives of any kind to an attending physician to
13 induce the attending physician to provide care to a mother or
14 newborn infant in a manner that is inconsistent with the
15 provisions of this section; or

16 (e) Except as otherwise provided in subsection 5, restrict
17 benefits for any portion of a hospital stay required pursuant to the
18 provisions of this section in a manner that is less favorable than
19 the benefits provided for any preceding portion of that stay.

20 5. Nothing in this section:

21 (a) Prohibits a contract for hospital or medical service from
22 imposing a deductible, coinsurance or other mechanism for
23 sharing costs relating to benefits for hospital stays in connection
24 with childbirth for a mother or newborn child covered by the
25 contract, except that such coinsurance or other mechanism for
26 sharing costs for any portion of a hospital stay required by this
27 section may not be greater than the coinsurance or other
28 mechanism for any preceding portion of that stay.

29 (b) Prohibits an arrangement for payment between an insurer
30 and a provider of health care that uses capitation or other
31 financial incentives, if the arrangement is designed to provide
32 services efficiently and consistently in the best interest of the
33 mother and her newborn infant.

34 (c) Prevents an insurer from negotiating with a provider of
35 health care concerning the level and type of reimbursement to be
36 provided in accordance with this section.

37 6. A contract for hospital or medical service subject to the
38 provisions of this chapter that is delivered, issued for delivery or
39 renewed on or after January 1, 2018, has the legal effect of
40 including the coverage required by subsection 1, and any
41 provision of the contract or the renewal which is in conflict with
42 this section is void.

43 7. The Director of the Department of Health and Human
44 Services shall adopt regulations to establish the health care



1 *services which must be covered by a contract for hospital or*
2 *medical service pursuant to subsection 1.*

3 *8. As used in this section, "provider of health care" has the*
4 *meaning ascribed to it in NRS 629.031.*

5 **Sec. 63.** NRS 695B.1912 is hereby amended to read as
6 follows:

7 695B.1912 1. A ~~policy of health insurance~~ *contract for*
8 *hospital or medical service* issued by a hospital or medical service
9 corporation must provide coverage for benefits payable for expenses
10 incurred for:

11 (a) An annual cytologic screening test for women 18 years of
12 age or older;

13 (b) A baseline mammogram for women between the ages of 35
14 and 40; ~~and~~

15 (c) An annual mammogram for women 40 years of age or
16 older ~~;~~;

17 (d) *Counseling concerning genetic testing for breast cancer;*
18 *and*

19 (e) *Counseling concerning breast cancer chemoprevention.*

20 2. A ~~policy of health insurance~~ *contract for hospital or*
21 *medical service* issued by a hospital or medical service corporation
22 must not require an insured to obtain prior authorization for any
23 service provided pursuant to subsection 1.

24 3. *An insurer that offers or issues a contract for hospital or*
25 *medical service shall not:*

26 (a) *Require an insured to pay a higher deductible, any*
27 *copayment or coinsurance or require a longer waiting period or*
28 *other condition to obtain any benefit provided in the contract for*
29 *hospital or medical service pursuant to subsection 1;*

30 (b) *Refuse to issue a contract for hospital or medical service or*
31 *cancel a contract for hospital or medical service solely because the*
32 *person applying for or covered by the contract uses or may use a*
33 *benefit provided in the contract for hospital or medical service*
34 *pursuant to subsection 1;*

35 (c) *Offer or pay any type of material inducement or financial*
36 *incentive to an insured to discourage the insured from obtaining*
37 *any 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*
42 *other financial incentive to a provider of health care to deny,*
43 *reduce, withhold, limit or delay access to any such benefit to an*
44 *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}~~ *contract for hospital or medical service* subject
4 to the provisions of this chapter which is delivered, issued for
5 delivery or renewed on or after ~~{October 1, 1989,}~~ *January 1, 2018,*
6 has the legal effect of including the coverage required by subsection
7 1, and any provision of the ~~{policy}~~ *contract* or the renewal which is
8 in conflict with subsection 1 is void.

9 5. *As used in this section, “provider of health care” has the*
10 *meaning ascribed to it in NRS 629.031.*

11 **Sec. 64.** NRS 695B.1925 is hereby amended to read as
12 follows:

13 695B.1925 1. A ~~{policy of health insurance}~~ *contract for*
14 *hospital or medical service* issued by a hospital or medical service
15 corporation must provide coverage for benefits payable for expenses
16 incurred for ~~{administering}~~ :

17 (a) *Deoxyribonucleic acid testing for high-risk strains of the*
18 *human papillomavirus; and*

19 (b) *Administering* the human papillomavirus vaccine to women
20 and girls at such ages as recommended for vaccination by a
21 competent authority, including, without limitation, the Centers for
22 Disease Control and Prevention of the United States Department of
23 Health and Human Services, the Food and Drug Administration or
24 the manufacturer of the vaccine.

25 2. A ~~{policy of health insurance}~~ *contract for hospital or*
26 *medical service* issued by a hospital or medical service corporation
27 must not require an insured to obtain prior authorization for any
28 service provided pursuant to subsection 1.

29 3. *An insurer that offers or issues a contract for hospital or*
30 *medical service shall not:*

31 (a) *Require an insured to pay a higher deductible, any*
32 *copayment or coinsurance or require a longer waiting period or*
33 *other condition to obtain any benefit provided in the contract for*
34 *hospital or medical service pursuant to subsection 1;*

35 (b) *Refuse to issue a contract for hospital or medical service or*
36 *cancel a contract for hospital or medical service solely because the*
37 *person applying for or covered by the contract uses or may use a*
38 *benefit provided in the contract for hospital or medical service*
39 *pursuant to subsection 1;*

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

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



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

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

7 4. A ~~policy~~ contract for hospital or medical service subject
8 to the provisions of this chapter which is delivered, issued for
9 delivery or renewed on or after ~~July 1, 2007,~~ January 1, 2018, has
10 the legal effect of including the coverage required by subsection 1,
11 and any provision of the policy or the renewal which is in conflict
12 with subsection 1 is void.

13 ~~4. For the purposes of this section, "human~~

14 5. As used in this section:

15 (a) "Human papillomavirus vaccine" means the Quadrivalent
16 Human Papillomavirus Recombinant Vaccine or its successor which
17 is approved by the Food and Drug Administration for the prevention
18 of human papillomavirus infection and cervical cancer.

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

21 Sec. 65. NRS 695B.193 is hereby amended to read as follows:

22 695B.193 1. All individual and group service or indemnity-
23 type contracts issued by a nonprofit corporation which provide
24 coverage for a family member of the subscriber must as to such
25 coverage provide that the health benefits applicable for children are
26 payable with respect to:

27 (a) A newly born child of the subscriber from the moment of
28 birth;

29 (b) An adopted child from the date the adoption becomes
30 effective, if the child was not placed in the home before adoption;
31 and

32 (c) A child placed with the subscriber for the purpose of
33 adoption from the moment of placement as certified by the public or
34 private agency making the placement. The coverage of such a child
35 ceases if the adoption proceedings are terminated as certified by the
36 public or private agency making the placement.

37 ↪ The contracts must provide the coverage specified in subsection
38 3, and must not exclude premature births.

39 2. The contract may require that notification of:

40 (a) The birth of a newly born child;

41 (b) The effective date of adoption of a child; or

42 (c) The date of placement of a child for adoption,

43 ↪ and payments of the required fees, if any, must be furnished to
44 the nonprofit service corporation within 31 days after the date of



1 birth, adoption or placement for adoption in order to have the
2 coverage continue beyond the 31-day period.

3 3. The coverage for newly born and adopted children and
4 children placed for adoption consists of coverage of injury or
5 sickness, including the necessary care and treatment of medically
6 diagnosed congenital defects and birth abnormalities and, within the
7 limits of the policy, necessary transportation costs from place of
8 birth to the nearest specialized treatment center under major medical
9 policies, and with respect to basic policies to the extent such costs
10 are charged by the treatment center.

11 4. ~~¶A corporation shall not restrict the coverage of a dependent~~
12 ~~child adopted or placed for adoption solely because of a preexisting~~
13 ~~condition the child has at the time the child would otherwise become~~
14 ~~eligible for coverage pursuant to that contract. Any provision~~
15 ~~relating to an exclusion for a preexisting condition must comply~~
16 ~~with NRS 689C.190.~~

17 ~~—5.†~~ For covered services provided to the child, the corporation
18 shall reimburse noncontracted providers of health care to an amount
19 equal to the average amount of payment for which the organization
20 has agreements, contracts or arrangements for those covered
21 services.

22 **Sec. 66.** NRS 695B.2555 is hereby amended to read as
23 follows:

24 695B.2555 A ~~¶converted contract must not exclude a~~
25 ~~preexisting condition not excluded by the group contract, but a†~~
26 converted contract may provide that any hospital, surgical or
27 medical benefits payable under it may be reduced by the amount of
28 any benefits payable under the group contract after his or her
29 termination. A converted contract may provide that during the first
30 contract year the benefits payable under it, together with the benefits
31 payable under the group contract, must not exceed those that would
32 have been payable if the subscriber's coverage under the group
33 contract had remained in effect.

34 **Sec. 67.** Chapter 695C of NRS is hereby amended by adding
35 thereto the provisions set forth as sections 68 to 73, inclusive, of this
36 act.

37 **Sec. 68. 1. A health maintenance organization shall offer**
38 **or issue a health care plan to any person regardless of the health**
39 **status of the person, the spouse of the person or any dependent of**
40 **the person. Such health status includes, without limitation:**

41 **(a) Any preexisting medical condition of the person, including,**
42 **without limitation, any physical or mental illness;**

43 **(b) The claims history of the person, including, without**
44 **limitation, any prior health care services received by the person;**

45 **(c) Genetic information relating to the person; and**



1 *(d) Any increased risk for illness, injury or any other medical*
2 *condition of the person, including, without limitation, any medical*
3 *condition caused by an act of domestic violence.*

4 *2. A health maintenance organization that offers or issues a*
5 *health care plan shall not:*

6 *(a) Deny, limit or exclude a benefit based on the health status*
7 *of an enrollee; or*

8 *(b) Require an enrollee, as a condition of enrollment or*
9 *renewal, to pay a premium, deductible, copay or coinsurance*
10 *based on his or her health status which is greater than the*
11 *premium, deductible, copay or coinsurance charged to a similarly*
12 *situated enrollee or the covered spouse or dependent of such an*
13 *enrollee who does not have such a health status.*

14 *3. A health maintenance organization that offers or issues a*
15 *health care plan shall not adjust a premium, deductible, copay or*
16 *coinsurance for any enrollee on the basis of genetic information*
17 *relating to the enrollee or the covered spouse or dependent of the*
18 *enrollee.*

19 **Sec. 69. 1.** *A health maintenance organization that offers*
20 *or issues a health care plan which provides coverage for*
21 *dependent children shall continue to make such coverage*
22 *available for an adult child of an enrollee until such child reaches*
23 *26 years of age.*

24 *2. Nothing in this section shall be construed as requiring a*
25 *health maintenance organization to make coverage available for a*
26 *dependent of an adult child of an enrollee.*

27 **Sec. 70. 1.** *A health maintenance organization that offers*
28 *or issues a health care plan shall include in the plan coverage for*
29 *such preventive health care services relating to women as the*
30 *Director of the Department of Health and Human Services*
31 *requires.*

32 *2. A health maintenance organization that offers or issues a*
33 *health care plan shall not:*

34 *(a) Require an enrollee to pay a higher deductible, any*
35 *copayment or coinsurance or require a longer waiting period or*
36 *other condition to obtain any benefit provided in the health care*
37 *plan pursuant to subsection 1;*

38 *(b) Refuse to issue a health care plan or cancel a health care*
39 *plan solely because the person applying for or covered by the plan*
40 *uses or may use a benefit provided in the health care plan*
41 *pursuant to subsection 1;*

42 *(c) Offer or pay any type of material inducement or financial*
43 *incentive to an enrollee to discourage the enrollee from obtaining*
44 *any such benefit;*



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

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

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

10 3. An evidence of coverage subject to the provisions of this
11 chapter that is delivered, issued for delivery or renewed on or after
12 January 1, 2018, has the legal effect of including the coverage
13 required by subsection 1, and any provision of the evidence of
14 coverage or the renewal which is in conflict with this section is
15 void.

16 4. The Director of the Department of Health and Human
17 Services shall adopt regulations to establish the preventive health
18 care services which must be covered by a health care plan
19 pursuant to subsection 1, including, without limitation:

20 (a) Such prenatal screenings and tests as recommended by the
21 American College of Obstetricians and Gynecologists or its
22 successor organization;

23 (b) Screening and counseling for interpersonal and domestic
24 violence;

25 (c) Screening, tests and counseling for such other health
26 conditions and diseases as recommended by the Health Resources
27 and Services Administration;

28 (d) Contraceptive drugs, devices and services;

29 (e) Such well-woman preventive visits as recommended by the
30 Health Resources and Services Administration;

31 (f) Any supplements, drugs or devices recommended by the
32 Health Resources and Services Administration; and

33 (g) All vaccinations recommended by the Advisory Committee
34 on Immunization Practices of the Centers for Disease Control and
35 Prevention of the United States Department of Health and Human
36 Services or its successor organization.

37 5. As used in this section, "provider of health care" has the
38 meaning ascribed to it in NRS 629.031.

39 **Sec. 71. 1.** A health maintenance organization that offers
40 or issues a health care plan shall include in the plan coverage for
41 such preventive health care services relating to persons 18 years of
42 age or older as the Director of the Department of Health and
43 Human Services requires.

44 2. A health maintenance organization that offers or issues a
45 health care plan shall not:



1 (a) Require an enrollee to pay a higher deductible, any
2 copayment or coinsurance or require a longer waiting period or
3 other condition to obtain any benefit provided in the health care
4 plan pursuant to subsection 1;

5 (b) Refuse to issue a health care plan or cancel a health care
6 plan solely because the person applying for or covered by the plan
7 uses or may use a benefit provided in the health care plan
8 pursuant to subsection 1;

9 (c) Offer or pay any type of material inducement or financial
10 incentive to an enrollee to discourage the enrollee from obtaining
11 any such benefit;

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

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

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

21 3. An evidence of coverage subject to the provisions of this
22 chapter that is delivered, issued for delivery or renewed on or after
23 January 1, 2018, has the legal effect of including the coverage
24 required by subsection 1, and any provision of the evidence of
25 coverage or the renewal which is in conflict with this section is
26 void.

27 4. The Director of the Department of Health and Human
28 Services shall adopt regulations to establish the preventive health
29 care services which must be covered by a health care plan
30 pursuant to subsection 1, including, without limitation:

31 (a) Screening, tests and counseling for such other health
32 conditions and diseases as recommended by the United States
33 Preventive Services Task Force or its successor organization;

34 (b) Counseling relating to the dietary needs of certain adults
35 who are at high-risk of chronic diseases;

36 (c) Smoking cessation programs;

37 (d) Any supplements, drugs or devices recommended by the
38 United States Preventive Services Task Force or its successor
39 organization; and

40 (e) All vaccinations recommended by the Advisory Committee
41 on Immunization Practices of the Centers for Disease Control and
42 Prevention of the United States Department of Health and Human
43 Services or its successor organization.

44 5. As used in this section, "provider of health care" has the
45 meaning ascribed to it in NRS 629.031.



1 **Sec. 72. 1. A health maintenance organization that offers**
2 *or issues a health care plan shall include in the plan coverage for*
3 *such preventive health care services relating to persons less than*
4 *18 years of age as the Director of the Department of Health and*
5 *Human Services requires.*

6 **2. A health maintenance organization that offers or issues a**
7 *health care plan shall not:*

8 **(a) Require an enrollee to pay a higher deductible, any**
9 *copayment or coinsurance or require a longer waiting period or*
10 *other condition to obtain any benefit provided in the health care*
11 *plan pursuant to subsection 1;*

12 **(b) Refuse to issue a health care plan or cancel a health care**
13 *plan solely because the person applying for or covered by the plan*
14 *uses or may use a benefit provided in the health care plan*
15 *pursuant to subsection 1;*

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

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

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

26 **(f) Impose any other restrictions or delays on the access of an**
27 *enrollee to any such benefit.*

28 **3. An evidence of coverage subject to the provisions of this**
29 *chapter that is delivered, issued for delivery or renewed on or after*
30 *January 1, 2018, has the legal effect of including the coverage*
31 *required by subsection 1, and any provision of the evidence of*
32 *coverage or the renewal which is in conflict with this section is*
33 *void.*

34 **4. The Director of the Department of Health and Human**
35 *Services shall adopt regulations to establish the preventive health*
36 *care services which must be covered by a health care plan*
37 *pursuant to subsection 1, including, without limitation:*

38 **(a) Screening, tests and counseling for such other health**
39 *conditions and diseases as recommended by the Health Resources*
40 *and Services Administration;*

41 **(b) Assessments relating to height, weight, body mass index**
42 *and medical history;*

43 **(c) Any supplements, drugs or devices recommended by the**
44 *Health Resources and Services Administration; and*



1 (d) All vaccinations recommended by the Advisory Committee
2 on Immunization Practices of the Centers for Disease Control and
3 Prevention of the United States Department of Health and Human
4 Services or its successor organization.

5 5. As used in this section, "provider of health care" has the
6 meaning ascribed to it in NRS 629.031.

7 **Sec. 73. 1.** A health maintenance organization that offers
8 or issues a health care plan shall include in the plan coverage for
9 such health care services relating to maternal and newborn care as
10 the Director of the Department of Health and Human Services
11 requires.

12 2. Except as otherwise provided in this subsection, an
13 evidence of coverage issued pursuant to this chapter may not
14 restrict benefits for any length of stay in a hospital in connection
15 with childbirth for a mother or newborn infant covered by the
16 health care plan to:

17 (a) Less than 48 hours after a normal vaginal delivery; and

18 (b) Less than 96 hours after a cesarean section.

19 ↪ If a different length of stay is provided in the guidelines
20 established by the American College of Obstetricians and
21 Gynecologists, or its successor organization, and the American
22 Academy of Pediatrics, or its successor organization, the health
23 care plan may follow such guidelines in lieu of following the
24 length of stay set forth above. The provisions of this subsection do
25 not apply to any health care plan in any case in which the decision
26 to discharge the mother or newborn infant before the expiration of
27 the minimum length of stay set forth in this subsection is made by
28 the attending physician of the mother or newborn infant.

29 3. Nothing in this section requires a mother to:

30 (a) Deliver her baby in a hospital; or

31 (b) Stay in a hospital for a fixed period following the birth of
32 her child.

33 4. A health care plan may not:

34 (a) Deny a mother or her newborn infant coverage or
35 continued coverage under the terms of the plan or coverage if the
36 sole purpose of the denial of coverage or continued coverage is to
37 avoid the requirements of this section;

38 (b) Provide monetary payments or rebates to a mother to
39 encourage her to accept less than the minimum protection
40 available pursuant to this section;

41 (c) Penalize, or otherwise reduce or limit, the reimbursement
42 of an attending provider of health care because the attending
43 provider of health care provided care to a mother or newborn
44 infant in accordance with the provisions of this section;



1 (d) Provide incentives of any kind to an attending physician to
2 induce the attending physician to provide care to a mother or
3 newborn infant in a manner that is inconsistent with the
4 provisions of this section; or

5 (e) Except as otherwise provided in subsection 5, restrict
6 benefits for any portion of a hospital stay required pursuant to the
7 provisions of this section in a manner that is less favorable than
8 the benefits provided for any preceding portion of that stay.

9 5. Nothing in this section:

10 (a) Prohibits a health care plan from imposing a deductible,
11 coinsurance or other mechanism for sharing costs relating to
12 benefits for hospital stays in connection with childbirth for a
13 mother or newborn child covered by the plan, except that such
14 coinsurance or other mechanism for sharing costs for any portion
15 of a hospital stay required by this section may not be greater than
16 the coinsurance or other mechanism for any preceding portion of
17 that stay.

18 (b) Prohibits an arrangement for payment between a health
19 maintenance organization and a provider of health care that uses
20 capitation or other financial incentives, if the arrangement is
21 designed to provide services efficiently and consistently in the best
22 interest of the mother and her newborn infant.

23 (c) Prevents a health maintenance organization from
24 negotiating with a provider of health care concerning the level and
25 type of reimbursement to be provided in accordance with this
26 section.

27 6. An evidence of coverage subject to the provisions of this
28 chapter that is delivered, issued for delivery or renewed on or after
29 January 1, 2018, has the legal effect of including the coverage
30 required by subsection 1, and any provision of the evidence of
31 coverage or the renewal which is in conflict with this section is
32 void.

33 7. The Director of the Department of Health and Human
34 Services shall adopt regulations to establish the health care
35 services which must be covered by a health care plan pursuant to
36 subsection 1.

37 8. As used in this section, "provider of health care" has the
38 meaning ascribed to it in NRS 629.031.

39 **Sec. 74.** NRS 695C.050 is hereby amended to read as follows:

40 695C.050 1. Except as otherwise provided in this chapter or
41 in specific provisions of this title, the provisions of this title are not
42 applicable to any health maintenance organization granted a
43 certificate of authority under this chapter. This provision does not
44 apply to an insurer licensed and regulated pursuant to this title



1 except with respect to its activities as a health maintenance
2 organization authorized and regulated pursuant to this chapter.

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

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

10 4. The provisions of NRS 695C.110, 695C.125, 695C.1691,
11 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to
12 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734,
13 ~~695C.1735 to~~ 695C.1751, 695C.1755, ~~inclusive,~~ 695C.176 to
14 695C.200, inclusive, and 695C.265 do not apply to a health
15 maintenance organization that provides health care services through
16 managed care to recipients of Medicaid under the State Plan for
17 Medicaid or insurance pursuant to the Children's Health Insurance
18 Program pursuant to a contract with the Division of Health Care
19 Financing and Policy of the Department of Health and Human
20 Services. This subsection does not exempt a health maintenance
21 organization from any provision of this chapter for services
22 provided pursuant to any other contract.

23 5. The provisions of NRS 695C.1694, 695C.1695, 695C.1708,
24 695C.1731, 695C.17345 ~~and~~ , 695C.1735, 695C.1745 and
25 695C.1757 *and sections 68 to 73, inclusive, of this act* apply to a
26 health maintenance organization that provides health care services
27 through managed care to recipients of Medicaid under the State Plan
28 for Medicaid.

29 **Sec. 75.** NRS 695C.173 is hereby amended to read as follows:

30 695C.173 1. All individual and group health care plans which
31 provide coverage for a family member of the enrollee must as to
32 such coverage provide that the health care services applicable for
33 children are payable with respect to:

34 (a) A newly born child of the enrollee from the moment of birth;

35 (b) An adopted child from the date the adoption becomes
36 effective, if the child was not placed in the home before adoption;
37 and

38 (c) A child placed with the enrollee for the purpose of adoption
39 from the moment of placement as certified by the public or private
40 agency making the placement. The coverage of such a child ceases
41 if the adoption proceedings are terminated as certified by the public
42 or private agency making the placement.

43 ➤ The plans must provide the coverage specified in subsection 3,
44 and must not exclude premature births.

45 2. The evidence of coverage may require that notification of:



- 1 (a) The birth of a newly born child;
- 2 (b) The effective date of adoption of a child; or
- 3 (c) The date of placement of a child for adoption,
- 4 ↪ and payments of the required charge, if any, must be furnished to
- 5 the health maintenance organization within 31 days after the date of
- 6 birth, adoption or placement for adoption in order to have the
- 7 coverage continue beyond the 31-day period.

8 3. The coverage for newly born and adopted children and
9 children placed for adoption consists of preventive health care
10 services as well as coverage of injury or sickness, including the
11 necessary care and treatment of medically diagnosed congenital
12 defects and birth abnormalities and, within the limits of the policy,
13 necessary transportation costs from place of birth to the nearest
14 specialized treatment center under major medical policies, and with
15 respect to basic policies to the extent such costs are charged by the
16 treatment center.

17 4. ~~¶ A health maintenance organization shall not restrict the~~
18 ~~coverage of a dependent child adopted or placed for adoption solely~~
19 ~~because of a preexisting condition the child has at the time the child~~
20 ~~would otherwise become eligible for coverage pursuant to that plan.~~
21 ~~Any provision relating to an exclusion for a preexisting condition~~
22 ~~must comply with NRS 689B.500 or 689C.190, as appropriate.~~

23 —5.¶ For covered services provided to the child, the health
24 maintenance organization shall reimburse noncontracted providers
25 of health care to an amount equal to the average amount of payment
26 for which the organization has agreements, contracts or
27 arrangements for those covered services.

28 **Sec. 76.** NRS 695C.1735 is hereby amended to read as
29 follows:

30 695C.1735 1. A health maintenance *organization which*
31 *offers or issues a health care* plan must provide coverage for
32 benefits payable for expenses incurred for:

33 (a) An annual cytologic screening test for women 18 years of
34 age or older;

35 (b) A baseline mammogram for women between the ages of 35
36 and 40; ~~and~~

37 (c) An annual mammogram for women 40 years of age or
38 older ~~¶~~;

39 *(d) Counseling concerning genetic testing for breast cancer;*
40 *and*

41 *(e) Counseling concerning breast cancer chemoprevention.*

42 2. A health ~~maintenance~~ *care* plan must not require an
43 insured to obtain prior authorization for any service provided
44 pursuant to subsection 1.



1 3. *A health maintenance organization that offers or issues a*
2 *health care plan shall not:*

3 (a) *Require an enrollee to pay a higher deductible, any*
4 *copayment or coinsurance or require a longer waiting period or*
5 *other condition to obtain any benefit provided in the health care*
6 *plan pursuant to subsection 1;*

7 (b) *Refuse to issue a health care plan or cancel a health care*
8 *plan solely because the person applying for or covered by the plan*
9 *uses or may use a benefit provided in the health care plan*
10 *pursuant to subsection 1;*

11 (c) *Offer or pay any type of material inducement or financial*
12 *incentive to an enrollee to discourage the enrollee from obtaining*
13 *any such benefit;*

14 (d) *Penalize a provider of health care who provides any such*
15 *benefit to an enrollee, including, without limitation, reducing the*
16 *reimbursement of the provider of health care;*

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

21 (f) *Impose any other restrictions or delays on the access of an*
22 *enrollee to any such benefit.*

23 4. ~~{A-policy}~~ *An evidence of coverage* subject to the provisions
24 of this chapter which is delivered, issued for delivery or renewed on
25 or after ~~{October 1, 1989,}~~ *January 1, 2018*, has the legal effect of
26 including the coverage required by subsection 1, and any provision
27 of the ~~{policy}~~ *evidence of coverage* or the renewal which is in
28 conflict with subsection 1 is void.

29 5. *As used in this section, “provider of health care” has the*
30 *meaning ascribed to it in NRS 629.031.*

31 **Sec. 77.** NRS 695C.1745 is hereby amended to read as
32 follows:

33 695C.1745 1. A health care plan of a health maintenance
34 organization must provide coverage for benefits payable for
35 expenses incurred for ~~{administering}~~ :

36 (a) *Deoxyribonucleic acid testing for high-risk strains of the*
37 *human papillomavirus; and*

38 (b) *Administering* the human papillomavirus vaccine as
39 recommended for vaccination by a competent authority, including,
40 without limitation, the Centers for Disease Control and Prevention
41 of the United States Department of Health and Human Services, the
42 Food and Drug Administration or the manufacturer of the vaccine.

43 2. A health care plan of a health maintenance organization
44 must not require an insured to obtain prior authorization for any
45 service provided pursuant to subsection 1.



1 3. *A health maintenance organization that offers or issues a*
2 *health care plan shall not:*

3 (a) *Require an enrollee to pay a higher deductible, any*
4 *copayment or coinsurance or require a longer waiting period or*
5 *other condition to obtain any benefit provided in the health care*
6 *plan pursuant to subsection 1;*

7 (b) *Refuse to issue a health care plan or cancel a health care*
8 *plan solely because the person applying for or covered by the plan*
9 *uses or may use a benefit provided in the health care plan*
10 *pursuant to subsection 1;*

11 (c) *Offer or pay any type of material inducement or financial*
12 *incentive to an enrollee to discourage the enrollee from obtaining*
13 *any such benefit;*

14 (d) *Penalize a provider of health care who provides any such*
15 *benefit to an enrollee, including, without limitation, reducing the*
16 *reimbursement of the provider of health care;*

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

21 (f) *Impose any other restrictions or delays on the access of an*
22 *enrollee to any such benefit.*

23 4. Any evidence of coverage subject to the provisions of this
24 chapter which is delivered, issued for delivery or renewed on or
25 after ~~July 1, 2007,~~ **January 1, 2018**, has the legal effect of
26 including the coverage required by subsection 1, and any provision
27 of the evidence of coverage or the renewal which is in conflict with
28 subsection 1 is void.

29 ~~4. For the purposes of this section, "human~~

30 5. *As used in this section:*

31 (a) *"Human papillomavirus vaccine"* means the Quadrivalent
32 Human Papillomavirus Recombinant Vaccine or its successor which
33 is approved by the Food and Drug Administration for the prevention
34 of human papillomavirus infection and cervical cancer.

35 (b) *"Provider of health care" has the meaning ascribed to it in*
36 *NRS 629.031.*

37 **Sec. 78.** NRS 695C.330 is hereby amended to read as follows:

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

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



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

4 (b) The health maintenance organization issues evidence of
5 coverage or uses a schedule of charges for health care services
6 which do not comply with the requirements of NRS 695C.1691 to
7 695C.200, inclusive, *and sections 68 to 73, inclusive, of this act* or
8 695C.207;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

14 **Sec. 79.** Chapter 695F of NRS is hereby amended by adding
15 thereto the provisions set forth as sections 80 and 81 of this act.

16 **Sec. 80. 1. A prepaid limited health service organization**
17 **shall offer or issue evidence of coverage to any person regardless**
18 **of the health status of the person, the spouse of the person or any**
19 **dependent of the person. Such health status includes, without**
20 **limitation:**

21 (a) *Any preexisting medical condition of the person, including,*
22 *without limitation, any physical or mental illness;*

23 (b) *The claims history of the person, including, without*
24 *limitation, any prior health care services received by the person;*

25 (c) *Genetic information relating to the person; and*

26 (d) *Any increased risk for illness, injury or any other medical*
27 *condition of the person, including, without limitation, any medical*
28 *condition caused by an act of domestic violence.*

29 2. *A prepaid limited health service organization that offers or*
30 *issues evidence of coverage shall not:*

31 (a) *Deny, limit or exclude a benefit based on the health status*
32 *of an enrollee; or*

33 (b) *Require an enrollee, as a condition of enrollment or*
34 *renewal, to pay a premium, deductible, copay or coinsurance*
35 *based on his or her health status which is greater than the*
36 *premium, deductible, copay or coinsurance charged to a similarly*
37 *situated enrollee or the covered spouse or dependent of such an*
38 *enrollee who does not have such a health status.*

39 3. *A prepaid limited health service organization that offers or*
40 *issues evidence of coverage shall not adjust a premium,*
41 *deductible, copay or coinsurance for any enrollee on the basis of*
42 *genetic information relating to the enrollee or the covered spouse*
43 *or dependent of the enrollee.*

44 **Sec. 81. 1. A prepaid limited health service organization**
45 **that offers or issues evidence of coverage which provides coverage**



1 *for dependent children shall continue to make such coverage*
2 *available for an adult child of an enrollee until such child reaches*
3 *26 years of age.*

4 *2. Nothing in this section shall be construed as requiring a*
5 *prepaid limited health service organization to make coverage*
6 *available for a dependent of an adult child of an enrollee.*

7 **Sec. 82.** Chapter 695G of NRS is hereby amended by adding
8 thereto the provisions set forth as sections 83 to 89, inclusive, of this
9 act.

10 **Sec. 83.** *1. A managed care organization shall offer or*
11 *issue a health care plan to any person regardless of the health*
12 *status of the person, the spouse of the person or any dependent of*
13 *the person. Such health status includes, without limitation:*

14 *(a) Any preexisting medical condition of the person, including,*
15 *without limitation, any physical or mental illness;*

16 *(b) The claims history of the person, including, without*
17 *limitation, any prior health care services received by the person;*

18 *(c) Genetic information relating to the person; and*

19 *(d) Any increased risk for illness, injury or any other medical*
20 *condition of the person, including, without limitation, any medical*
21 *condition caused by an act of domestic violence.*

22 *2. A managed care organization that offers or issues a health*
23 *care plan shall not:*

24 *(a) Deny, limit or exclude a benefit based on the health status*
25 *of an insured; or*

26 *(b) Require an insured, as a condition of enrollment or*
27 *renewal, to pay a premium, deductible, copay or coinsurance*
28 *based on his or her health status which is greater than the*
29 *premium, deductible, copay or coinsurance charged to a similarly*
30 *situated insured or the covered spouse or dependent of such an*
31 *insured who does not have such a health status.*

32 *3. A managed care organization that offers or issues a health*
33 *care plan shall not adjust a premium, deductible, copay or*
34 *coinsurance for any insured on the basis of genetic information*
35 *relating to the insured or the covered spouse or dependent of the*
36 *insured.*

37 **Sec. 84.** *1. A managed care organization that offers or*
38 *issues a health care plan which provides coverage for dependent*
39 *children shall continue to make such coverage available for an*
40 *adult child of an insured until such child reaches 26 years of age.*

41 *2. Nothing in this section shall be construed as requiring a*
42 *managed care organization to make coverage available for a*
43 *dependent of an adult child of an insured.*

44 **Sec. 85.** *1. A managed care organization that offers or*
45 *issues a health care plan shall include in the plan coverage for*



1 *such preventive health care services relating to women as the*
2 *Director of the Department of Health and Human Services*
3 *requires.*

4 *2. A managed care organization that offers or issues a health*
5 *care plan shall not:*

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

10 *(b) Refuse to issue a health care plan or cancel a health care*
11 *plan solely because the person applying for or covered by the plan*
12 *uses or may use a benefit provided in the health care plan*
13 *pursuant to subsection 1;*

14 *(c) Offer or pay any type of material inducement or financial*
15 *incentive to an insured to discourage the insured from obtaining*
16 *any 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*
21 *other financial incentive to a provider of health care to deny,*
22 *reduce, withhold, limit or delay access to any such benefit to an*
23 *insured; or*

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

26 *3. An evidence of coverage subject to the provisions of this*
27 *chapter that is delivered, issued for delivery or renewed on or after*
28 *January 1, 2018, has the legal effect of including the coverage*
29 *required by subsection 1, and any provision of the evidence of*
30 *coverage or the renewal which is in conflict with this section is*
31 *void.*

32 *4. The Director of the Department of Health and Human*
33 *Services shall adopt regulations to establish the preventive health*
34 *care services which must be covered by a health care plan*
35 *pursuant to subsection 1, including, without limitation:*

36 *(a) Such prenatal screenings and tests as recommended by the*
37 *American College of Obstetricians and Gynecologists or its*
38 *successor organization;*

39 *(b) Screening and counseling for interpersonal and domestic*
40 *violence;*

41 *(c) Screening, tests and counseling for such other health*
42 *conditions and diseases as recommended by the Health Resources*
43 *and Services Administration;*

44 *(d) Contraceptive drugs, devices and services;*



1 (e) Such well-woman preventive visits as recommended by the
2 Health Resources and Services Administration;

3 (f) Any supplements, drugs or devices recommended by the
4 Health Resources and Services Administration; and

5 (g) All vaccinations recommended by the Advisory Committee
6 on Immunization Practices of the Centers for Disease Control and
7 Prevention of the United States Department of Health and Human
8 Services or its successor organization.

9 5. As used in this section, "provider of health care" has the
10 meaning ascribed to it in NRS 629.031.

11 **Sec. 86. 1.** A managed care organization that offers or
12 issues a health care plan shall include in the plan coverage for
13 such preventive health care services relating to persons 18 years of
14 age or older as the Director of the Department of Health and
15 Human Services requires.

16 2. A managed care organization that offers or issues a health
17 care plan shall not:

18 (a) Require an insured to pay a higher deductible, any
19 copayment or coinsurance or require a longer waiting period or
20 other condition to obtain any benefit provided in the health care
21 plan pursuant to subsection 1;

22 (b) Refuse to issue a health care plan or cancel a health care
23 plan solely because the person applying for or covered by the plan
24 uses or may use a benefit provided in the health care plan
25 pursuant to subsection 1;

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

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

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

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

38 3. An evidence of coverage subject to the provisions of this
39 chapter that is delivered, issued for delivery or renewed on or after
40 January 1, 2018, has the legal effect of including the coverage
41 required by subsection 1, and any provision of the evidence of
42 coverage or the renewal which is in conflict with this section is
43 void.

44 4. The Director of the Department of Health and Human
45 Services shall adopt regulations to establish the preventive health



1 *care services which must be covered by a health care plan*
2 *pursuant to subsection 1, including, without limitation:*

3 (a) *Screening, tests and counseling for such other health*
4 *conditions and diseases as recommended by the United States*
5 *Preventive Services Task Force or its successor organization;*

6 (b) *Counseling relating to the dietary needs of certain adults*
7 *who are at high-risk of chronic diseases;*

8 (c) *Smoking cessation programs;*

9 (d) *Any supplements, drugs or devices recommended by the*
10 *United States Preventive Services Task Force or its successor*
11 *organization; and*

12 (e) *All vaccinations recommended by the Advisory Committee*
13 *on Immunization Practices of the Centers for Disease Control and*
14 *Prevention of the United States Department of Health and Human*
15 *Services or its successor organization.*

16 5. *As used in this section, "provider of health care" has the*
17 *meaning ascribed to it in NRS 629.031.*

18 **Sec. 87. 1.** *A managed care organization that offers or*
19 *issues a health care plan shall include in the plan coverage for*
20 *such preventive health care services relating to persons less than*
21 *18 years of age as the Director of the Department of Health and*
22 *Human Services requires.*

23 2. *A managed care organization that offers or issues a health*
24 *care plan shall not:*

25 (a) *Require an insured to pay a higher deductible, any*
26 *copayment or coinsurance or require a longer waiting period or*
27 *other condition to obtain any benefit provided in the health care*
28 *plan pursuant to subsection 1;*

29 (b) *Refuse to issue a health care plan or cancel a health care*
30 *plan solely because the person applying for or covered by the plan*
31 *uses or may use a benefit provided in the health care plan*
32 *pursuant to subsection 1;*

33 (c) *Offer or pay any type of material inducement or financial*
34 *incentive to an insured to discourage the insured from obtaining*
35 *any 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*
40 *other financial incentive to a provider of health care to deny,*
41 *reduce, withhold, limit or delay access to any such benefit to an*
42 *insured; or*

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



1 3. *An evidence of coverage subject to the provisions of this*
2 *chapter that is delivered, issued for delivery or renewed on or after*
3 *January 1, 2018, has the legal effect of including the coverage*
4 *required by subsection 1, and any provision of the evidence of*
5 *coverage or the renewal which is in conflict with this section is*
6 *void.*

7 4. *The Director of the Department of Health and Human*
8 *Services shall adopt regulations to establish the preventive health*
9 *care services which must be covered by a health care plan*
10 *pursuant to subsection 1, including, without limitation:*

11 (a) *Screening, tests and counseling for such other health*
12 *conditions and diseases as recommended by the Health Resources*
13 *and Services Administration;*

14 (b) *Assessments relating to height, weight, body mass index*
15 *and medical history;*

16 (c) *Any supplements, drugs or devices recommended by the*
17 *Health Resources and Services Administration; and*

18 (d) *All vaccinations recommended by the Advisory Committee*
19 *on Immunization Practices of the Centers for Disease Control and*
20 *Prevention of the United States Department of Health and Human*
21 *Services or its successor organization.*

22 5. *As used in this section, "provider of health care" has the*
23 *meaning ascribed to it in NRS 629.031.*

24 **Sec. 88. 1.** *A managed care organization that offers or*
25 *issues a health care plan shall include in the plan coverage for*
26 *such health care services relating to maternal and newborn care*
27 *as the Director of the Department of Health and Human Services*
28 *requires.*

29 2. *Except as otherwise provided in this subsection, an*
30 *evidence of coverage issued pursuant to this chapter may not*
31 *restrict benefits for any length of stay in a hospital in connection*
32 *with childbirth for a mother or newborn infant covered by the*
33 *health care plan to:*

34 (a) *Less than 48 hours after a normal vaginal delivery; and*

35 (b) *Less than 96 hours after a cesarean section.*

36 ↪ *If a different length of stay is provided in the guidelines*
37 *established by the American College of Obstetricians and*
38 *Gynecologists, or its successor organization, and the American*
39 *Academy of Pediatrics, or its successor organization, the health*
40 *care plan may follow such guidelines in lieu of following the*
41 *length of stay set forth above. The provisions of this subsection do*
42 *not apply to any health care plan in any case in which the decision*
43 *to discharge the mother or newborn infant before the expiration of*
44 *the minimum length of stay set forth in this subsection is made by*
45 *the attending physician of the mother or newborn infant.*



1 3. *Nothing in this section requires a mother to:*

2 (a) *Deliver her baby in a hospital; or*

3 (b) *Stay in a hospital for a fixed period following the birth of*
4 *her child.*

5 4. *A health care plan may not:*

6 (a) *Deny a mother or her newborn infant coverage or*
7 *continued coverage under the terms of the plan or coverage if the*
8 *sole purpose of the denial of coverage or continued coverage is to*
9 *avoid the requirements of this section;*

10 (b) *Provide monetary payments or rebates to a mother to*
11 *encourage her to accept less than the minimum protection*
12 *available pursuant to this section;*

13 (c) *Penalize, or otherwise reduce or limit, the reimbursement*
14 *of an attending provider of health care because the attending*
15 *provider of health care provided care to a mother or newborn*
16 *infant in accordance with the provisions of this section;*

17 (d) *Provide incentives of any kind to an attending physician to*
18 *induce the attending physician to provide care to a mother or*
19 *newborn infant in a manner that is inconsistent with the*
20 *provisions of this section; or*

21 (e) *Except as otherwise provided in subsection 5, restrict*
22 *benefits for any portion of a hospital stay required pursuant to the*
23 *provisions of this section in a manner that is less favorable than*
24 *the benefits provided for any preceding portion of that stay.*

25 5. *Nothing in this section:*

26 (a) *Prohibits a health care plan from imposing a deductible,*
27 *coinsurance or other mechanism for sharing costs relating to*
28 *benefits for hospital stays in connection with childbirth for a*
29 *mother or newborn child covered by the plan, except that such*
30 *coinsurance or other mechanism for sharing costs for any portion*
31 *of a hospital stay required by this section may not be greater than*
32 *the coinsurance or other mechanism for any preceding portion of*
33 *that stay.*

34 (b) *Prohibits an arrangement for payment between a managed*
35 *care organization and a provider of health care that uses*
36 *capitation or other financial incentives, if the arrangement is*
37 *designed to provide services efficiently and consistently in the best*
38 *interest of the mother and her newborn infant.*

39 (c) *Prevents a managed care organization from negotiating*
40 *with a provider of health care concerning the level and type of*
41 *reimbursement to be provided in accordance with this section.*

42 6. *An evidence of coverage subject to the provisions of this*
43 *chapter that is delivered, issued for delivery or renewed on or after*
44 *January 1, 2018, has the legal effect of including the coverage*
45 *required by subsection 1, and any provision of the evidence of*



1 coverage or the renewal which is in conflict with this section is
2 void.

3 7. The Director of the Department of Health and Human
4 Services shall adopt regulations to establish the health care
5 services which must be covered by a health care plan pursuant to
6 subsection 1.

7 8. As used in this section, "provider of health care" has the
8 meaning ascribed to it in NRS 629.031.

9 **Sec. 89. 1.** A managed care organization which offers or
10 issues a health care plan must provide coverage for benefits
11 payable for expenses incurred for:

12 (a) An annual cytologic screening test for women 18 years of
13 age or older;

14 (b) A baseline mammogram for women between the ages of 35
15 and 40 years;

16 (c) An annual mammogram for women 40 years of age or
17 older;

18 (d) Counseling concerning genetic testing for breast cancer;
19 and

20 (e) Counseling concerning breast cancer chemoprevention.

21 2. A health care plan must not require an insured to obtain
22 prior authorization for any service provided pursuant to
23 subsection 1.

24 3. A managed care organization that offers or issues a health
25 care plan shall not:

26 (a) Require an insured to pay a higher deductible, any
27 copayment or coinsurance or require a longer waiting period or
28 other condition to obtain any benefit provided in the health care
29 plan pursuant to subsection 1;

30 (b) Refuse to issue a health care plan or cancel a health care
31 plan solely because the person applying for or covered by the plan
32 uses or may use a benefit provided in the health care plan
33 pursuant to subsection 1;

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

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

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

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



1 4. *An evidence of coverage subject to the provisions of this*
2 *chapter which is delivered, issued for delivery or renewed on or*
3 *after January 1, 2018, has the legal effect of including the*
4 *coverage required by subsection 1, and any provision of the*
5 *evidence of coverage or the renewal which is in conflict with*
6 *subsection 1 is void.*

7 5. *As used in this section, "provider of health care" has the*
8 *meaning ascribed to it in NRS 629.031.*

9 **Sec. 90.** NRS 695G.171 is hereby amended to read as follows:

10 695G.171 1. A health care plan issued by a managed care
11 organization must provide coverage for benefits payable for
12 expenses incurred for ~~administering~~ :

13 (a) *Deoxyribonucleic acid testing for high-risk strains of the*
14 *human papillomavirus; and*

15 (b) *Administering* the human papillomavirus vaccine as
16 recommended for vaccination by a competent authority, including,
17 without limitation, the Centers for Disease Control and Prevention
18 of the United States Department of Health and Human Services, the
19 Food and Drug Administration or the manufacturer of the vaccine.

20 2. A health care plan must not require an insured to
21 obtain prior authorization for any service provided pursuant to
22 subsection 1.

23 3. *A managed care organization that offers or issues a health*
24 *care plan shall not:*

25 (a) *Require an insured to pay a higher deductible, any*
26 *copayment or coinsurance or require a longer waiting period or*
27 *other condition to obtain any benefit provided in the health care*
28 *plan pursuant to subsection 1;*

29 (b) *Refuse to issue a health care plan or cancel a health care*
30 *plan solely because the person applying for or covered by the plan*
31 *uses or may use a benefit provided in the health care plan*
32 *pursuant to subsection 1;*

33 (c) *Offer or pay any type of material inducement or financial*
34 *incentive to an insured to discourage the insured from obtaining*
35 *any 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*
40 *other financial incentive to a provider of health care to deny,*
41 *reduce, withhold, limit or delay access to any such benefit to an*
42 *insured; or*

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



1 4. An evidence of coverage for a health care plan subject to the
2 provisions of this chapter which is delivered, issued for delivery or
3 renewed on or after ~~July 1, 2007,~~ **January 1, 2018**, has the legal
4 effect of including the coverage required by subsection 1, and any
5 provision of the evidence of coverage or the renewal thereof which
6 is in conflict with subsection 1 is void.

7 ~~{4. For the purposes of this section, "human}~~

8 5. *As used in this section:*

9 (a) *"Human papillomavirus vaccine"* means the Quadrivalent
10 Human Papillomavirus Recombinant Vaccine or its successor which
11 is approved by the Food and Drug Administration for the prevention
12 of human papillomavirus infection and cervical cancer.

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

15 **Sec. 91.** Chapter 695I of NRS is hereby amended by adding
16 thereto a new section to read as follows:

17 1. *Except as otherwise provided in subsection 2, the*
18 *Exchange shall not discriminate against a person on the basis of*
19 *race, color, national origin, sex, age, physical or mental disability,*
20 *sexual orientation or gender identity or expression, including,*
21 *without limitation, offering qualified health plans that*
22 *discriminate in such a manner.*

23 2. *The Exchange may make distinctions based on sex or*
24 *gender identity or expression, if the Exchange has an exceedingly*
25 *persuasive justification for the distinction, which may include,*
26 *without limitation, that the distinction is substantially related to*
27 *the achievement of an important health or scientific objective.*

28 3. *The Exchange must provide reasonable notice to a person*
29 *relating to the provisions of this section.*

30 4. *The Exchange must take reasonable steps to ensure that a*
31 *person with limited English proficiency or physical or mental*
32 *disabilities has access to any assistance services which may be*
33 *needed for the person to transact business with the Exchange.*

34 5. *As used in this section:*

35 (a) *"Gender identity or expression" has the meaning ascribed*
36 *to it in NRS 193.0148.*

37 (b) *"Sexual orientation" has the meaning ascribed to it in*
38 *NRS 118.093.*

39 **Sec. 92.** The provisions of NRS 354.599 do not apply to any
40 additional expenses of a local government that are related to the
41 provisions of this act.

42 **Sec. 93.** 1. The Director of the Department of Health and
43 Human Services shall adopt regulations as soon as possible after the
44 effective date of this act which establish the health care services
45 which must be covered by a policy of health insurance, policy of



1 group health insurance, health benefit plan, benefit contract, contract
2 for hospital or medical service or health care plan pursuant to
3 sections 2 to 5, inclusive, 17, 18, 19, 21, 26, 27, 28, 32, 35, 36, 37,
4 43, 50 to 53, inclusive, 59 to 62, inclusive, 70 to 73, inclusive, and
5 85 to 88, inclusive, of this act.

6 2. The regulations adopted pursuant to subsection 1 must
7 include, without limitation, the health care services which are
8 required to be covered pursuant to 45 C.F.R. § 147.130 and the
9 Patient Protection and Affordable Care Act, Pub. L. 111-148, as
10 amended.

11 **Sec. 94.** NRS 689A.523, 689A.585, 689B.450, 689C.082,
12 695A.159 and 695F.480 are hereby repealed.

13 **Sec. 95.** This act becomes effective:

14 1. Upon passage and approval for the purposes of adopting any
15 regulations and performing any other preparatory administrative
16 tasks that are necessary to carry out the provisions of this act; and

17 2. On January 1, 2018, for all other purposes.

LEADLINES OF REPEALED SECTIONS

689A.523 “Exclusion for a preexisting condition” defined.

689A.585 “Preexisting condition” defined.

689B.450 “Preexisting condition” defined.

689C.082 “Preexisting condition” defined.

695A.159 Society prohibited from restricting coverage of
child based on preexisting condition when person who is eligible
for group coverage adopts or assumes legal obligation for child.

695F.480 Organization prohibited from restricting
coverage of child based on preexisting condition if person who is
eligible for group coverage adopts or assumes legal obligation
for child.



