Assembly Bill No. 428–Assemblymembers Flanagan, Monroe-Moreno, Roth, Anderson, Moore; Brown-May, Carter, Considine, D'Silva, González, Hunt, Jauregui, Karris, La Rue Hatch, Marzola, Miller, Nadeem, Torres-Fossett and Yeager

CHAPTER.....

AN ACT relating to insurance; requiring certain health plans to include coverage for certain procedures or services for the preservation of fertility of insureds who have been diagnosed with breast or ovarian cancer; providing certain exceptions for insurers affiliated with religious organizations; authorizing certain expenditures; making an appropriation; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires public and private policies of insurance to include certain coverage. (NRS 287.010, 287.04335, 422.2717-422.272428, 689A.04033-689A.0465, 689B.030-689B.0379, 689C.1652-689C.169, 689C.425, 695A.184-695A.1875, 695A.255-695A.265, 695B.1901-695B.1949, 695C.050, 695C.1691-695C.176, 695G.162-695G.177) Existing law also requires employers to provide certain benefits to employees, including the coverage required of health insurers, if the employer provides health benefits for its employees. (NRS 608.1555) **Sections 1, 3-9, 11 and 13-15** of this bill require public and private health plans, including Medicaid and insurance for state and local government employees, to provide coverage for certain procedures or services that are medically necessary to preserve fertility for an insured who has been diagnosed with breast or ovarian cancer if: (1) the cancer may directly or indirectly cause infertility; or (2) the insured is expected to receive medical treatment for the cancer and the treatment could directly or indirectly cause infertility. An insurer that is affiliated with a religious organization is not required to provide the coverage required by **sections 1, 3-8 and 11** if the insurer: (1) objects to providing the coverage on religious grounds; and (2) provides a written notice to insureds or prospective insureds disclosing that the insurer refuses to provide such coverage. **Section 15.5** of this bill makes an appropriation to the Division of Health Care Financing and Policy of the Department of Health and Human Services and authorizes certain expenditures for the costs associated with providing such coverage under Medicaid pursuant to **sections 9 and 15**.

Section 2 of this bill authorizes the Commissioner of Insurance to require a policy of individual health insurance issued by a domestic insurer to a person residing in another state to contain the coverage required by **section 1** in certain circumstances. **Section 12** of this bill makes a conforming change to require the Director of the Department to administer the provisions of **section 15** in the same manner as other provisions relating to Medicaid.

Section 10 of this bill authorizes the Commissioner to suspend or revoke the certificate of a health maintenance organization that fails to provide the coverage required by **section 8**. The Commissioner is also authorized to take such action against other health insurers who fail to provide the coverage required by **sections 1, 3-8 and 11**. (NRS 680A.200)

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

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

Section 1. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 4, an insurer that issues a policy of health insurance shall include in the policy coverage for any procedure or service for the preservation of fertility consistent with established medical practice or any guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, or their successor organizations, that is medically necessary to preserve fertility because the insured has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The insured is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, a medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine, or their successor organizations.

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

4. An insurer that is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of health insurance that is subject to the requirements of subsection 1 and before the renewal of such a policy, provide to the insured or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

5. A policy of health insurance that is subject to the provisions of this chapter and is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal that conflicts with the provisions of this section is void.

6. As used in this section:

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

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

Sec. 2. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~[.]~~ ***, and section 1 of this act.***

Sec. 3. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 3, an insurer that issues a policy of group health insurance shall include in the policy coverage for any procedure or service for the preservation of fertility consistent with established medical practice or any guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, or their successor organizations, that is medically necessary to preserve fertility because the insured has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The insured is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, a medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine, or their successor organizations.

3. An insurer that is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of group health insurance that is subject to the requirements of subsection 1 and before the renewal

of such a policy, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

4. A policy of group health insurance that is subject to the provisions of this chapter and is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal that conflicts with the provisions of this section is void.

Sec. 4. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 4, a carrier that issues a health benefit plan shall include in the plan coverage for any procedure or service for the preservation of fertility consistent with established medical practice or any guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, or their successor organizations, that is medically necessary to preserve fertility because the insured has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The insured is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, a medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine, or their successor organizations.

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

4. A carrier that is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the carrier objects on religious grounds. Such a carrier shall, before the issuance of a health benefit plan that is subject to the requirements of subsection 1 and before the renewal of such a plan, provide to the insured or prospective insured, as applicable, written notice of the coverage that the carrier refuses to provide pursuant to this subsection.

5. A health benefit plan that is subject to the provisions of this chapter and is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the

coverage required by subsection 1, and any provision of the plan or the renewal that conflicts with the provisions of this section is void.

6. As used in this section:

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

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

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

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

Sec. 6. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 4, a society that issues a benefit contract shall include in the contract coverage for any procedure or service for the preservation of fertility consistent with established medical practice or any guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, or their successor organizations, that is medically necessary to preserve fertility because the insured has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The insured is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, a medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine, or their successor organizations.

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

4. A society that is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the society objects on religious grounds. Such a society shall, before the issuance of a benefit contract that is subject to the requirements of subsection 1 and before the renewal of such a contract, provide to the insured or prospective insured, as applicable, written notice of the coverage that the society refuses to provide pursuant to this subsection.

5. A benefit contract that is subject to the provisions of this chapter and is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal that conflicts with the provisions of this section is void.

6. As used in this section:

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

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

Sec. 7. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 4, a hospital or medical services corporation that issues a policy of health insurance shall include in the policy coverage for any procedure or service for the preservation of fertility consistent with established medical practice or any guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, or their successor organizations, that is medically necessary to preserve fertility because the insured has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The insured is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, a medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine, or their successor organizations.

3. A hospital or medical services corporation shall ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the hospital or medical services corporation.

4. A hospital or medical services corporation that is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the hospital or medical services corporation objects on religious grounds. Such a hospital or medical services corporation shall, before the issuance of a policy of health insurance that is subject to the requirements of subsection 1 and before the renewal of such a policy, provide to the insured or prospective insured, as applicable, written notice of the coverage that the hospital or medical services corporation refuses to provide pursuant to this subsection.

5. A policy of health insurance that is subject to the provisions of this chapter and is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal that conflicts with the provisions of this section is void.

6. As used in this section:

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

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

Sec. 8. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 4, a health maintenance organization that issues a health care plan shall include in the plan coverage for any procedure or service for the preservation of fertility consistent with established medical practice or any guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, or their successor organizations, that is medically necessary to preserve fertility because the enrollee has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The enrollee is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, a medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine, or their successor organizations.

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

4. A health maintenance organization that is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the health maintenance organization objects on religious grounds. Such a health maintenance organization shall, before the issuance of a health care plan that is subject to the requirements of subsection 1 and before the renewal of such a plan, provide to the enrollee or prospective enrollee, as applicable, written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection.

5. A health care plan that is subject to the provisions of this chapter and is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal that conflicts with the provisions of this section is void.

6. As used in this section:

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

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

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

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

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

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

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

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

5. The provisions of NRS 695C.16932 to 695C.1699, inclusive, 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333, 695C.17345, 695C.17347, 695C.1736 to 695C.1745, inclusive, 695C.1757 and 695C.204 ***and section 8 of this act*** apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

6. The provisions of NRS 695C.17095 do not apply to a health maintenance organization that provides health care services to members of the Public Employees' Benefits Program. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

7. The provisions of NRS 695C.1735 do not apply to a health maintenance organization that provides health care services to:

(a) The officers and employees, and the dependents of officers and employees, of the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of this State; or

(b) Members of the Public Employees' Benefits Program.

➥ This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

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

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

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

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, ***and section 8 of this act,*** 695C.204 or 695C.207;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 11. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 4, a managed care organization that issues a health care plan shall include in the plan coverage for any procedure or service for the preservation of fertility consistent with established medical practice or any guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, or their successor organizations, that is medically necessary to preserve fertility because the insured has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The insured is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, a medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine, or their successor organizations.

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

4. A managed care organization that is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the managed care organization objects on religious grounds. Such a managed care organization shall, before the issuance of a health care plan that is subject to the requirements of subsection 1 and before the renewal of such a plan, provide to the insured or prospective insured, as applicable, written notice of the coverage that the managed care organization refuses to provide pursuant to this subsection.

5. A health care plan that is subject to the provisions of this chapter and is delivered, issued for delivery or renewed on or after January 1, 2026, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal that conflicts with the provisions of this section is void.

6. As used in this section:

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

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

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

232.320 1. The Director:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 439.581 to 439.597, inclusive, 686A.135, 687B.352, 687B.408, 687B.692, 687B.723, 687B.725, 687B.805, 689B.030 to 689B.0317, inclusive, ***and section 3 of this act,*** paragraphs (b) and (c) of subsection 1 of NRS 689B.0319, subsections 2, 4, 6 and 7 of NRS 689B.0319, 689B.033 to 689B.0369, inclusive, 689B.0375 to 689B.050, inclusive, 689B.0675, 689B.265, 689B.287 and 689B.500 apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and 689B.500 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.

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

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

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

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

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

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

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

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

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

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

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

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

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 439.581 to 439.597, inclusive, 686A.135, 687B.352, 687B.409, 687B.692, 687B.723, 687B.725, 687B.805, 689B.0353, 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.1675, 695G.170 to 695G.1712, inclusive, 695G.1714 to 695G.174, inclusive, ***and section 11 of this act,*** 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, 695G.405 and 695G.415, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 15. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

1. To the extent that federal financial participation is available, the Director shall include under Medicaid coverage for any procedure or service for the preservation of fertility consistent with established medical practice or any guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology, or their successor organizations, that is medically necessary to preserve fertility because a recipient of Medicaid has been diagnosed with breast or ovarian cancer and:

(a) The cancer may, in the judgment of a provider of health care, directly or indirectly cause infertility; or

(b) The recipient is expected to receive medical treatment for the cancer and such treatment may directly or indirectly cause infertility.

2. For the purposes of subsection 1, a medical treatment may directly or indirectly cause infertility if the treatment has a potential side effect of impaired fertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine, or their successor organizations.

3. The Department shall:

(a) Apply to the Secretary of Health and Human Services for any waiver of federal law or apply for any amendment of the State Plan for Medicaid that is necessary for the Department to receive federal funding to provide the coverage described in subsection 1.

(b) Fully cooperate in good faith with the Federal Government during the application process to satisfy the requirements of the Federal Government for obtaining a waiver or amendment pursuant to paragraph (a).

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

Sec. 15.5. 1. There is hereby appropriated from the State General Fund to the Division of Health Care Financing and Policy of the Department of Health and Human Services for the costs of providing Medicaid coverage for procedures and services for the preservation of fertility pursuant to sections 9 and 15 of this act and computer system upgrades and vendor costs associated with providing such coverage the following sums:

For the Fiscal Year 2025-2026 ..... $158,600

For the Fiscal Year 2026-2027 ..... $69,434

2. Expenditure of the following sums not appropriated from the State General Fund or the State Highway Fund is hereby authorized by the Division of Health Care Financing and Policy of the Department of Health and Human Services for the same purposes as set forth in subsection 1:

For the Fiscal Year 2025-2026 ..... $225,800

For the Fiscal Year 2026-2027 ..... $193,008

3. Any balance of the sums appropriated by subsection 1 remaining at the end of the respective fiscal years must not be committed for expenditure after June 30 of the respective fiscal years by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated

money remaining must not be spent for any purpose after September 18, 2026, and September 17, 2027, respectively, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 18, 2026, and September 17, 2027, respectively.

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

Sec. 17. 1. This section becomes effective upon passage and approval.

2. Section 15.5 of this act becomes effective on July 1, 2025.

3. Sections 1 to 15, inclusive, and 16 of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On January 1, 2027, for all other purposes.

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