
SENATE BILL NO. 394—SENATORS SPEARMAN, SEGERBLOM, DENIS,
MANENDO, PARKS; CANCELA, CANNIZZARO, FORD AND
WOODHOUSE

MARCH 20, 2017

JOINT SPONSORS: ASSEMBLYMEN NEAL;
ARAUJO, DIAZ AND THOMPSON

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to Medicaid managed care and required coverage provided by health insurers. (BDR 38-950)

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

CONTAINS UNFUNDED MANDATE (§§ 5, 6)
(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 Director of the Department of Health and Human Services to make coverage through the Medicaid managed care program available for purchase on the Silver State Health Insurance Exchange by persons who are not otherwise eligible for Medicaid under certain conditions; requiring the Director to seek any necessary waivers from the Federal Government to provide such coverage and to provide certain incentives to persons who purchase such coverage; requiring insurers to offer health insurance coverage regardless of the health status of a person; requiring insurers to provide coverage for certain essential health benefits without an annual, lifetime or other maximum limit on coverage; 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; and providing other matters properly relating thereto.



Legislative Counsel's Digest:

1 The Patient Protection and Affordable Care Act (Public Law 111-148, as
2 amended) provides a refundable federal income tax credit and cost-sharing
3 reductions to certain eligible persons who earn not more than 400 percent of the
4 federally designated poverty level in order to offset the cost of certain health care
5 plan premiums. (26 U.S.C. § 36B, 42 U.S.C. § 18071; 45 C.F.R. § 155.305) The
6 Act further requires that such credits and cost-sharing reductions only be made
7 available to purchase health insurance which is offered on a state health insurance
8 exchange, which includes, without limitation, the Silver State Health Insurance
9 Exchange established by this State in 2011. (26 U.S.C. § 36B, 42 U.S.C. § 18071;
10 NRS 695I.200) Existing federal law authorizes the Secretary of the United States
11 Department of Health and Human Services to waive certain Medicaid requirements
12 or provisions of the Act to promote state health care innovation. (42 U.S.C. §§
13 1315, 18052)

14 Existing federal law states that the purpose of the Medicaid program is to
15 promote access to health insurance for certain low-income persons. (42 U.S.C. §
16 1396) Existing law authorizes this State to enroll Medicaid recipients in a managed
17 care program provided by a health maintenance organization pursuant to a contract
18 with the Nevada Department of Health and Human Services. (42 U.S.C. § 1396u-2;
19 NRS 422.273) Existing federal law also authorizes a state to receive its Federal
20 Medical Assistance Percentage (FMAP) allotment of money from the Federal
21 Government to reimburse providers of health care for medical services which are
22 provided as part of a managed care program. (42 U.S.C. §§ 1396d, 1396u-2)
23 Existing law requires this State to develop a State Plan for Medicaid which
24 includes, without limitation, a list of the medical services provided to Medicaid
25 recipients. (42 U.S.C. § 1396a; NRS 422.063) Existing law also prohibits a state
26 from using FMAP or other federal Medicaid money to reimburse a provider of
27 health care for medical services which are provided to a person who earns more
28 than 138 percent of the federally designated poverty level or for administrative
29 expenses which are unrelated to the administration of Medicaid. (42 U.S.C. §§
30 1396a, 1396b(a)(7); 42 C.F.R. 433.15(b))

31 **Section 2** of this bill requires the Director of the Nevada Department of Health
32 and Human Services to seek any necessary waiver of certain provisions of federal
33 law to allow a Medicaid managed care program to be offered for purchase through
34 the Silver State Health Insurance Exchange to persons who are otherwise ineligible
35 for Medicaid. **Section 48** of this bill revises the definition of "qualified health plan"
36 to include the Medicaid managed care program so that it may be offered for
37 purchase in the same manner as other health plans through the Silver State Health
38 Insurance Exchange. Additionally, **section 2** of this bill requires the Director to
39 seek a federal waiver to allow persons to use the federal income tax credit and cost-
40 sharing reductions authorized by the Act to purchase coverage through a Medicaid
41 managed care program which is made available by the Silver State Health
42 Insurance Exchange.

43 To the extent allowed by federal law or if any necessary waiver is granted by
44 the Secretary of the United States Department of Health and Human Services
45 pursuant to **section 2**, **section 3** of this bill allows any person who is not otherwise
46 eligible for Medicaid to purchase coverage through the Medicaid managed care
47 program. **Section 3** requires the Director of the Nevada Department of Health and
48 Human Services to set the annual premium to be paid by a person who purchases
49 such coverage. **Section 3** further requires that the benefits offered in such a
50 Medicaid managed care program be the same as those provided to other Medicaid
51 recipients. Finally, **section 3** prohibits the Nevada Department of Health and
52 Human Services from using any federal money to offer such coverage through the
53 Medicaid managed care program.



54 Existing Nevada law provides that an insurer may not deny, limit or exclude a
 55 benefit provided by a health care plan in certain limited circumstances, including,
 56 without limitation, when a person has contracted for a blanket policy of accident or
 57 health insurance or in certain cases relating to adoption. (NRS 689B.500,
 58 689C.190, 695A.159, 695B.193, 695C.173, 695F.480) The Patient Protection and
 59 Affordable Care Act (Public Law 111-148, as amended) prohibits an insurer from
 60 establishing eligibility rules for a health care plan based on certain health status
 61 factors, including, without limitation, preexisting conditions, claims history or
 62 genetic information, and also prohibits an insurer from charging a higher premium,
 63 deductible or copay based on these health status factors. (42 U.S.C. § 300gg-4)
 64 **Sections 8, 15, 19, 24, 28, 34, 41 and 45** of this bill align Nevada law with federal
 65 law and require that all insurers offer health insurance coverage regardless of the
 66 health status of a person and prohibit an insurer from denying, limiting or excluding
 67 a benefit or requiring an insured to pay a higher premium, deductible, coinsurance
 68 or copay based on the health status of the insured or the covered spouse or
 69 dependent of the insured.

70 The Patient Protection and Affordable Care Act (Public Law 111-148, as
 71 amended) prohibits an insurer from imposing an annual or lifetime limit on the
 72 monetary value of certain essential health benefits which must be covered under a
 73 health care plan, including, without limitation, outpatient services, pregnancy,
 74 maternity, and newborn care and certain contraceptive drugs, devices and services.
 75 (42 U.S.C. § 300gg-11) The Act also authorizes the Secretary of the United States
 76 Department of Health and Human Services to specify the services which must be
 77 covered as part of an essential health benefit. (42 U.S.C. § 18022(b)(2)) **Sections 9,**
 78 **13, 25, 29, 35, 42 and 46** of this bill align Nevada law with federal law in this
 79 manner, and require the Nevada Department of Health and Human Services to issue
 80 regulations that determine the services which must be covered as an essential health
 81 benefit by an insurer, including, without limitation, the services currently required
 82 to be covered under the Act.

83 The Patient Protection and Affordable Care Act (Public Law 111-148, as
 84 amended) requires all insurers to extend coverage for the covered adult child of an
 85 insured until such child reaches 26 years of age. (42 U.S.C. § 300gg-14) **Sections**
 86 **10, 14, 26, 30, 36, 43 and 47** of this bill align Nevada law with federal law in this
 87 manner.

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 and 3 of this act.

3 **Sec. 2.** *The Director shall apply to the Secretary of the*
 4 *United States Department of Health and Human Services for any*
 5 *necessary waiver pursuant to 42 U.S.C. § 1315 or § 18052, as*
 6 *applicable, to:*

7 *1. Allow the Medicaid managed care program authorized by*
 8 *NRS 422.273 to be made available to a person who is otherwise*
 9 *ineligible for Medicaid through the Silver State Health Insurance*
 10 *Exchange established by NRS 695I.200; and*

11 *2. Allow a person who is determined eligible for advance*
 12 *payments of the premium tax credit and cost-sharing reductions*



1 *pursuant to 45 C.F.R. § 155.305 to use such credits and reductions*
2 *to pay for coverage through the Medicaid managed care program.*

3 **Sec. 3.** *1. To the extent allowed by federal law or if the*
4 *Secretary of the United States Department of Health and Human*
5 *Services grants any necessary waiver described in section 2 of this*
6 *act, the Director shall make coverage through the Medicaid*
7 *managed care program available for purchase on the Silver State*
8 *Health Insurance Exchange.*

9 *2. The Director shall determine the amount to charge for the*
10 *annual premium for coverage through the Medicaid managed*
11 *care program. The annual premium must be set at an amount that*
12 *does not require any federal or state money to be used to provide*
13 *coverage.*

14 *3. A person who enrolls in a Medicaid managed care*
15 *program pursuant to this section must receive the same benefits as*
16 *those received by other recipients of Medicaid.*

17 *4. The Department must not use any federal money to carry*
18 *out the requirements of this section.*

19 *5. The Director may adopt such regulations as deemed*
20 *necessary to carry out the provisions of this section.*

21 **Sec. 4.** NRS 422.273 is hereby amended to read as follows:

22 422.273 1. For any Medicaid managed care program
23 established in the State of Nevada, the Department shall contract
24 only with a health maintenance organization that has:

25 (a) Negotiated in good faith with a federally-qualified health
26 center to provide health care services for the health maintenance
27 organization;

28 (b) Negotiated in good faith with the University Medical Center
29 of Southern Nevada to provide inpatient and ambulatory services to
30 recipients of Medicaid; and

31 (c) Negotiated in good faith with the University of Nevada
32 School of Medicine to provide health care services to recipients of
33 Medicaid.

34 ➤ Nothing in this section shall be construed as exempting a
35 federally-qualified health center, the University Medical Center of
36 Southern Nevada or the University of Nevada School of Medicine
37 from the requirements for contracting with the health maintenance
38 organization.

39 2. During the development and implementation of any
40 Medicaid managed care program, the Department shall cooperate
41 with the University of Nevada School of Medicine by assisting in
42 the provision of an adequate and diverse group of patients upon
43 which the school may base its educational programs.

44 3. The University of Nevada School of Medicine may establish
45 a nonprofit organization to assist in any research necessary for the



1 development of a Medicaid managed care program, receive and
2 accept gifts, grants and donations to support such a program and
3 assist in establishing educational services about the program for
4 recipients of Medicaid.

5 4. For the purpose of contracting with a Medicaid managed
6 care program pursuant to this section, a health maintenance
7 organization is exempt from the provisions of NRS 695C.123.

8 5. The provisions of this section apply to any managed care
9 organization, including a health maintenance organization, that
10 provides health care services to recipients of Medicaid under the
11 State Plan for Medicaid *pursuant to section 3 of this act* or
12 the Children's Health Insurance Program pursuant to a contract with
13 the Division. Such a managed care organization or health
14 maintenance organization is not required to establish a system for
15 conducting external reviews of adverse determinations in
16 accordance with chapter 695B, 695C or 695G of NRS. This
17 subsection does not exempt such a managed care organization or
18 health maintenance organization for services provided pursuant to
19 any other contract.

20 6. As used in this section, unless the context otherwise
21 requires:

22 (a) "Federally-qualified health center" has the meaning ascribed
23 to it in 42 U.S.C. § 1396d(1)(2)(B).

24 (b) "Health maintenance organization" has the meaning ascribed
25 to it in NRS 695C.030.

26 (c) "Managed care organization" has the meaning ascribed to it
27 in NRS 695G.050.

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

29 287.010 1. The governing body of any county, school
30 district, municipal corporation, political subdivision, public
31 corporation or other local governmental agency of the State of
32 Nevada may:

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

40 (b) Purchase group policies of life, accident or health insurance,
41 or any combination thereof, for the benefit of such officers and
42 employees, and the dependents of such officers and employees, as
43 have authorized the purchase, from insurance companies authorized
44 to transact the business of such insurance in the State of Nevada,
45 and, where necessary, deduct from the compensation of officers and



1 employees the premiums upon insurance and pay the deductions
2 upon the premiums.

3 (c) Provide group life, accident or health coverage through a
4 self-insurance reserve fund and, where necessary, deduct
5 contributions to the maintenance of the fund from the compensation
6 of officers and employees and pay the deductions into the fund. The
7 money accumulated for this purpose through deductions from the
8 compensation of officers and employees and contributions of the
9 governing body must be maintained as an internal service fund as
10 defined by NRS 354.543. The money must be deposited in a state or
11 national bank or credit union authorized to transact business in the
12 State of Nevada. Any independent administrator of a fund created
13 under this section is subject to the licensing requirements of chapter
14 683A of NRS, and must be a resident of this State. Any contract
15 with an independent administrator must be approved by the
16 Commissioner of Insurance as to the reasonableness of
17 administrative charges in relation to contributions collected and
18 benefits provided. The provisions of NRS 687B.408, 689B.030 to
19 689B.050, inclusive, *and sections 13 and 14 of this act* and
20 689B.287 apply to coverage provided pursuant to this paragraph.

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

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

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



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

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

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

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

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

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

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

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

22 **Sec. 6.** NRS 287.04335 is hereby amended to read as follows:

23 287.04335 If the Board provides health insurance through a
24 plan of self-insurance, it shall comply with the provisions of NRS
25 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645,
26 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177,
27 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive,
28 and 695G.405, *and sections 45, 46 and 47 of this act* in the same
29 manner as an insurer that is licensed pursuant to title 57 of NRS is
30 required to comply with those provisions.

31 **Sec. 7.** Chapter 689A of NRS is hereby amended by adding
32 thereto the provisions set forth as sections 8, 9 and 10 of this act.

33 **Sec. 8. 1. *An insurer shall offer or issue a policy of health
34 insurance to any person regardless of the health status of the
35 person, the spouse of the person or any dependent of the person.
36 Such health status includes, without limitation:***

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

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

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

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



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

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

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

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

16 **Sec. 9. 1.** *An insurer that offers or issues a policy of health*
17 *insurance shall include in each policy coverage for all essential*
18 *health benefits and shall not place an annual, lifetime or other*
19 *maximum limit on coverage for such essential health benefits.*

20 2. *The Department of Health and Human Services shall, by*
21 *regulation, determine the essential health benefits that must be*
22 *covered by an insurer pursuant to subsection 1. Such essential*
23 *health benefits must include, without limitation:*

24 (i) *Outpatient services;*

25 (ii) *Emergency care;*

26 (iii) *Hospitalization;*

27 (iv) *Pregnancy, maternity and newborn care;*

28 (v) *Services relating to mental health and substance use*
29 *disorders, including, without limitation, treatment for behavioral*
30 *health and inpatient services for behavioral and mental health;*

31 (vi) *Prescription drugs;*

32 (vii) *Rehabilitative and habilitative services and devices;*

33 (viii) *Laboratory services;*

34 (ix) *Preventive and wellness services and management of*
35 *chronic diseases;*

36 (x) *Pediatric services, including, without limitation, oral and*
37 *vision care for children;*

38 (xi) *Contraceptive drugs, devices and services; and*

39 (xii) *Breastfeeding support, counseling and supplies.*

40 **Sec. 10. 1.** *An insurer that offers or issues a policy of*
41 *health insurance which provides coverage for dependent children*
42 *shall continue to make such coverage available for an adult child*
43 *of an insured until such child reaches 26 years of age.*



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

4 **Sec. 11.** NRS 689A.330 is hereby amended to read as follows:

5 689A.330 If any policy is issued by a domestic insurer for
6 delivery to a person residing in another state, and if the insurance
7 commissioner or corresponding public officer of that other state has
8 informed the Commissioner that the policy is not subject to approval
9 or disapproval by that officer, the Commissioner may by ruling
10 require that the policy meet the standards set forth in NRS 689A.030
11 to 689A.320, inclusive **†**, **and sections 8, 9 and 10 of this act.**

12 **Sec. 12.** Chapter 689B of NRS is hereby amended by adding
13 thereto the provisions set forth as sections 13 and 14 of this act.

14 **Sec. 13. 1. An insurer that offers or issues a policy of**
15 **group health insurance shall include in each policy coverage for**
16 **all essential health benefits and shall not place an annual, lifetime**
17 **or other maximum limit on coverage for such essential health**
18 **benefits.**

19 **2. The Department of Health and Human Services shall, by**
20 **regulation, determine the essential health benefits that must be**
21 **covered by an insurer pursuant to subsection 1. Such essential**
22 **health benefits must include, without limitation:**

- 23 **(a) Outpatient services;**
- 24 **(b) Emergency care;**
- 25 **(c) Hospitalization;**
- 26 **(d) Pregnancy, maternity and newborn care;**
- 27 **(e) Services relating to mental health and substance use**
28 **disorders, including, without limitation, treatment for behavioral**
29 **health and inpatient services for behavioral and mental health;**
- 30 **(f) Prescription drugs;**
- 31 **(g) Rehabilitative and habilitative services and devices;**
- 32 **(h) Laboratory services;**
- 33 **(i) Preventive and wellness services and management of**
34 **chronic diseases;**
- 35 **(j) Pediatric services, including, without limitation, oral and**
36 **vision care for children;**
- 37 **(k) Contraceptive drugs, devices and services; and**
- 38 **(l) Breastfeeding support, counseling and supplies.**

39 **Sec. 14. 1. An insurer that offers or issues a policy of**
40 **group health insurance which provides coverage for dependent**
41 **children shall continue to make such coverage available for an**
42 **adult child of an insured until such child reaches 26 years of age.**

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



1 **Sec. 15.** NRS 689B.500 is hereby amended to read as follows:

2 689B.500 ~~{A carrier that issues a group health plan or coverage~~
3 ~~under blanket accident and health insurance or group health~~
4 ~~insurance shall not deny, exclude or limit a benefit for a preexisting~~
5 ~~condition.}~~

6 *1. An insurer shall offer or issue a policy of group health*
7 *insurance to any person regardless of the health status of the*
8 *person, the spouse of the person or any dependent of the person.*
9 *Such health status includes, without limitation:*

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

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

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

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

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

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

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

28 *3. An insurer that offers or issues a policy of group health*
29 *insurance shall not adjust a premium, deductible, copay or*
30 *coinsurance for any insured on the basis of genetic information*
31 *relating to the insured or the covered spouse or dependent of the*
32 *insured.*

33 **Sec. 16.** Chapter 689C of NRS is hereby amended by adding
34 thereto the provisions set forth as sections 17 and 18 of this act.

35 **Sec. 17.** *1. A carrier that offers or issues a health benefit*
36 *plan shall include in each plan coverage for all essential health*
37 *benefits and shall not place an annual, lifetime or other maximum*
38 *limit on coverage for such essential health benefits.*

39 *2. The Department of Health and Human Services shall, by*
40 *regulation, determine the essential health benefits that must be*
41 *covered by a carrier pursuant to subsection 1. Such essential*
42 *health benefits must include, without limitation:*

43 *(a) Outpatient services;*

44 *(b) Emergency care;*

45 *(c) Hospitalization;*



- 1 (d) *Pregnancy, maternity and newborn care;*
- 2 (e) *Services relating to mental health and substance use*
- 3 *disorders, including, without limitation, treatment for behavioral*
- 4 *health and inpatient services for behavioral and mental health;*
- 5 (f) *Prescription drugs;*
- 6 (g) *Rehabilitative and habilitative services and devices;*
- 7 (h) *Laboratory services;*
- 8 (i) *Preventive and wellness services and management of*
- 9 *chronic diseases;*
- 10 (j) *Pediatric services, including, without limitation, oral and*
- 11 *vision care for children;*
- 12 (k) *Contraceptive drugs, devices and services; and*
- 13 (l) *Breastfeeding support, counseling and supplies.*

14 **Sec. 18.** 1. *A carrier that offers or issues a health benefit*

15 *plan which provides coverage for dependent children shall*

16 *continue to make such coverage available for an adult child of an*

17 *insured until such child reaches 26 years of age.*

18 2. *Nothing in this section shall be construed as requiring a*

19 *carrier to make coverage available for a dependent of an adult*

20 *child of an insured.*

21 **Sec. 19.** NRS 689C.190 is hereby amended to read as follows:

22 689C.190 ~~{A carrier serving small employers that issues a~~

23 ~~health benefit plan shall not deny, exclude or limit a benefit for a~~

24 ~~preexisting condition.}~~

25 1. *A carrier shall offer or issue a health benefit plan to any*

26 *person regardless of the health status of the person, the spouse of*

27 *the person or any dependent of the person. Such health status*

28 *includes, without limitation:*

29 (a) *Any preexisting medical condition of the person, including,*

30 *without limitation, any physical or mental illness;*

31 (b) *The claims history of the person, including, without*

32 *limitation, any prior health care services received by the person;*

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

34 (d) *Any increased risk for illness, injury or any other medical*

35 *condition of the person, including, without limitation, any medical*

36 *condition caused by an act of domestic violence.*

37 2. *A carrier that offers or issues a health benefit plan shall*

38 *not:*

39 (a) *Deny, limit or exclude a benefit based on the health status*

40 *of an insured; or*

41 (b) *Require an insured, as a condition of enrollment or*

42 *renewal, to pay a premium, deductible, copay or coinsurance*

43 *based on his or her health status which is greater than the*

44 *premium, deductible, copay or coinsurance charged to a similarly*



1 *situated insured or the covered spouse or dependent of such an*
2 *insured who does not have such a health status.*

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

7 **Sec. 20.** NRS 689C.270 is hereby amended to read as follows:

8 689C.270 1. The Commissioner shall adopt regulations
9 which require a carrier to file with the Commissioner, for approval
10 by the Commissioner, a disclosure offered by the carrier to a small
11 employer. The disclosure must include:

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

14 (b) Any restrictions on payments for emergency care, including,
15 without limitation, related definitions of an emergency and medical
16 necessity;

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

20 (d) The provisions relating to renewability of policies and
21 contracts; *and*

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

23 ~~—(f)~~ Any other information that the Commissioner finds
24 necessary to provide for full and fair disclosure of the provisions of
25 a policy or contract of insurance issued pursuant to this chapter.

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

30 3. The Commissioner shall not approve any proposed
31 disclosure submitted to the Commissioner pursuant to this section
32 which does not comply with the requirements of this section and the
33 applicable regulations.

34 4. The carrier shall make available to a small employer or a
35 producer acting on behalf of a small employer, upon request, a copy
36 of the disclosure approved by the Commissioner pursuant to this
37 section for policies of health insurance for which that employer may
38 be eligible.

39 **Sec. 21.** NRS 689C.425 is hereby amended to read as follows:

40 689C.425 A voluntary purchasing group and any contract
41 issued to such a group pursuant to NRS 689C.360 to 689C.600,
42 inclusive, are subject to the provisions of NRS 689C.015 to
43 689C.355, inclusive, *and sections 17 and 18 of this act* to the extent
44 applicable and not in conflict with the express provisions of NRS
45 687B.408 and 689C.360 to 689C.600, inclusive.



1 **Sec. 22.** NRS 689C.440 is hereby amended to read as follows:

2 689C.440 1. The Commissioner shall adopt regulations
3 which require a carrier to file with the Commissioner, for approval
4 by the Commissioner, a disclosure offered by the carrier to a
5 voluntary purchasing group. The disclosure must include:

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

8 (b) Any restrictions on payments for emergency care, including,
9 without limitation, related definitions of an emergency and medical
10 necessity;

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

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

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

16 ~~—(f)~~ Any other information that the Commissioner finds
17 necessary to provide for full and fair disclosure of the provisions of
18 a contract.

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

23 3. The Commissioner shall not approve any proposed
24 disclosure submitted to the Commissioner pursuant to this section
25 which does not comply with the requirements of this section and the
26 applicable regulations.

27 **Sec. 23.** Chapter 695A of NRS is hereby amended by adding
28 thereto the provisions set forth as sections 24, 25 and 26 of this act.

29 **Sec. 24. 1.** *A society shall offer or issue a benefit contract
30 to any person regardless of the health status of the person, the
31 spouse of the person or any dependent of the person. Such health
32 status includes, without limitation:*

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

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

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

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

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

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

44 (b) *Require an insured, as a condition of enrollment or
45 renewal, to pay a premium, deductible, copay or coinsurance*



1 *based on his or her health status which is greater than the*
2 *premium, deductible, copay or coinsurance charged to a similarly*
3 *situated insured or the covered spouse or dependent of such an*
4 *insured who does not have such a health status.*

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

9 **Sec. 25.** *1. A society that offers or issues a benefit contract*
10 *shall include in each contract coverage for all essential health*
11 *benefits and shall not place an annual, lifetime or other maximum*
12 *limit on coverage for such essential health benefits.*

13 *2. The Department of Health and Human Services shall, by*
14 *regulation, determine the essential health benefits that must be*
15 *covered by a society pursuant to subsection 1. Such essential*
16 *health benefits must include, without limitation:*

17 *(a) Outpatient services;*

18 *(b) Emergency care;*

19 *(c) Hospitalization;*

20 *(d) Pregnancy, maternity and newborn care;*

21 *(e) Services relating to mental health and substance use*
22 *disorders, including, without limitation, treatment for behavioral*
23 *health and inpatient services for behavioral and mental health;*

24 *(f) Prescription drugs;*

25 *(g) Rehabilitative and habilitative services and devices;*

26 *(h) Laboratory services;*

27 *(i) Preventive and wellness services and management of*
28 *chronic diseases;*

29 *(j) Pediatric services, including, without limitation, oral and*
30 *vision care for children;*

31 *(k) Contraceptive drugs, devices and services; and*

32 *(l) Breastfeeding support, counseling and supplies.*

33 **Sec. 26.** *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. 27.** Chapter 695B of NRS is hereby amended by adding
41 thereto the provisions set forth as sections 28, 29 and 30 of this act.

42 **Sec. 28.** *1. A hospital or medical service corporation shall*
43 *offer or issue a contract for hospital or medical service to any*
44 *person regardless of the health status of the person, the spouse of*



1 *the person or any dependent of the person. Such health status*
2 *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. A hospital or medical service corporation that offers or*
12 *issues a contract for hospital or 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. A hospital or medical service corporation that offers or*
22 *issues a contract for hospital or medical service shall not adjust a*
23 *premium, deductible, copay or coinsurance for any insured on the*
24 *basis of genetic information relating to the insured or the covered*
25 *spouse or dependent of the insured.*

26 **Sec. 29. 1.** *A hospital or medical service corporation that*
27 *offers or issues a contract for hospital or medical service shall*
28 *include in each contract coverage for all essential health benefits*
29 *and shall not place an annual, lifetime or other maximum limit on*
30 *coverage for such essential health benefits.*

31 *2. The Department of Health and Human Services shall, by*
32 *regulation, determine the essential health benefits that must be*
33 *covered by a hospital or medical service corporation pursuant to*
34 *subsection 1. Such essential health benefits must include, without*
35 *limitation:*

36 *(a) Outpatient services;*

37 *(b) Emergency care;*

38 *(c) Hospitalization;*

39 *(d) Pregnancy, maternity and newborn care;*

40 *(e) Services relating to mental health and substance use*
41 *disorders, including, without limitation, treatment for behavioral*
42 *health and inpatient services for behavioral and mental health;*

43 *(f) Prescription drugs;*

44 *(g) Rehabilitative and habilitative services and devices;*

45 *(h) Laboratory services;*



1 (i) Preventive and wellness services and management of
2 chronic diseases;

3 (j) Pediatric services, including, without limitation, oral and
4 vision care for children;

5 (k) Contraceptive drugs, devices and services; and

6 (l) Breastfeeding support, counseling and supplies.

7 **Sec. 30.** 1. A hospital or medical service corporation that
8 offers or issues a contract for hospital or medical service which
9 provides coverage for dependent children shall continue to make
10 such coverage available for an adult child of an insured until such
11 child reaches 26 years of age.

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

15 **Sec. 31.** NRS 695B.193 is hereby amended to read as follows:

16 695B.193 1. All individual and group service or indemnity-
17 type contracts issued by a nonprofit corporation which provide
18 coverage for a family member of the subscriber must as to such
19 coverage provide that the health benefits applicable for children are
20 payable with respect to:

21 (a) A newly born child of the subscriber from the moment of
22 birth;

23 (b) An adopted child from the date the adoption becomes
24 effective, if the child was not placed in the home before adoption;
25 and

26 (c) A child placed with the subscriber for the purpose of
27 adoption from the moment of placement as certified by the public or
28 private agency making the placement. The coverage of such a child
29 ceases if the adoption proceedings are terminated as certified by the
30 public or private agency making the placement.

31 ➤ The contracts must provide the coverage specified in subsection
32 3, and must not exclude premature births.

33 2. The contract may require that notification of:

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

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

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

37 ➤ and payments of the required fees, if any, must be furnished to
38 the nonprofit service corporation within 31 days after the date of
39 birth, adoption or placement for adoption in order to have the
40 coverage continue beyond the 31-day period.

41 3. The coverage for newly born and adopted children and
42 children placed for adoption consists of coverage of injury or
43 sickness, including the necessary care and treatment of medically
44 diagnosed congenital defects and birth abnormalities and, within the
45 limits of the policy, necessary transportation costs from place of



1 birth to the nearest specialized treatment center under major medical
2 policies, and with respect to basic policies to the extent such costs
3 are charged by the treatment center.

4 4. ~~{A corporation shall not restrict the coverage of a dependent
5 child adopted or placed for adoption solely because of a preexisting
6 condition the child has at the time the child would otherwise become
7 eligible for coverage pursuant to that contract. Any provision
8 relating to an exclusion for a preexisting condition must comply
9 with NRS 689C.190.~~

10 ~~—5.}~~ For covered services provided to the child, the corporation
11 shall reimburse noncontracted providers of health care to an amount
12 equal to the average amount of payment for which the organization
13 has agreements, contracts or arrangements for those covered
14 services.

15 **Sec. 32.** NRS 695B.2555 is hereby amended to read as
16 follows:

17 695B.2555 A ~~{converted contract must not exclude a
18 preexisting condition not excluded by the group contract, but a}~~
19 converted contract may provide that any hospital, surgical or
20 medical benefits payable under it may be reduced by the amount of
21 any benefits payable under the group contract after his or her
22 termination. A converted contract may provide that during the first
23 contract year the benefits payable under it, together with the benefits
24 payable under the group contract, must not exceed those that would
25 have been payable if the subscriber's coverage under the group
26 contract had remained in effect.

27 **Sec. 33.** Chapter 695C of NRS is hereby amended by adding
28 thereto the provisions set forth as sections 34, 35 and 36 of this act.

29 **Sec. 34. 1.** *A health maintenance organization shall offer
30 or issue a health care plan to any person regardless of the health
31 status of the person, the spouse of the person or any dependent of
32 the person. Such health status includes, without limitation:*

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

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

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

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

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

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



1 (b) Require an enrollee, as a condition of enrollment or
2 renewal, to pay a premium, deductible, copay or coinsurance
3 based on his or her health status which is greater than the
4 premium, deductible, copay or coinsurance charged to a similarly
5 situated enrollee or the covered spouse or dependent of such an
6 enrollee who does not have such a health status.

7 3. A health maintenance organization that offers or issues a
8 health care plan shall not adjust a premium, deductible, copay or
9 coinsurance for any enrollee on the basis of genetic information
10 relating to the enrollee or the covered spouse or dependent of the
11 enrollee.

12 **Sec. 35. 1.** A health maintenance organization that offers
13 or issues a health care plan shall include in each plan coverage
14 for all essential health benefits and shall not place an annual,
15 lifetime or other maximum limit on coverage for such essential
16 health benefits.

17 2. The Department of Health and Human Services shall, by
18 regulation, determine the essential health benefits that must be
19 covered by a health maintenance organization pursuant to
20 subsection 1. Such essential health benefits must include, without
21 limitation:

- 22 (a) Outpatient services;
- 23 (b) Emergency care;
- 24 (c) Hospitalization;
- 25 (d) Pregnancy, maternity and newborn care;
- 26 (e) Services relating to mental health and substance use
27 disorders, including, without limitation, treatment for behavioral
28 health and inpatient services for behavioral and mental health;
- 29 (f) Prescription drugs;
- 30 (g) Rehabilitative and habilitative services and devices;
- 31 (h) Laboratory services;
- 32 (i) Preventive and wellness services and management of
33 chronic diseases;
- 34 (j) Pediatric services, including, without limitation, oral and
35 vision care for children;
- 36 (k) Contraceptive drugs, devices and services; and
- 37 (l) Breastfeeding support, counseling and supplies.

38 **Sec. 36. 1.** A health maintenance organization that offers
39 or issues a health care plan which provides coverage for
40 dependent children shall continue to make such coverage
41 available for an adult child of an enrollee until such child reaches
42 26 years of age.

43 2. Nothing in this section shall be construed as requiring a
44 health maintenance organization to make coverage available for a
45 dependent of an adult child of an enrollee.



1 **Sec. 37.** NRS 695C.050 is hereby amended to read as follows:

2 695C.050 1. Except as otherwise provided in this chapter or
3 in specific provisions of this title, the provisions of this title are not
4 applicable to any health maintenance organization granted a
5 certificate of authority under this chapter. This provision does not
6 apply to an insurer licensed and regulated pursuant to this title
7 except with respect to its activities as a health maintenance
8 organization authorized and regulated pursuant to this chapter.

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

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

16 4. The provisions of NRS 695C.110, 695C.125, 695C.1691,
17 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to
18 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734,
19 695C.1735 to 695C.1755, inclusive, 695C.176 to 695C.200,
20 inclusive, and 695C.265 do not apply to a health maintenance
21 organization that provides health care services through managed
22 care to recipients of Medicaid under the State Plan for Medicaid or
23 insurance pursuant to the Children's Health Insurance Program
24 pursuant to a contract with the Division of Health Care Financing
25 and Policy of the Department of Health and Human Services. This
26 subsection does not exempt a health maintenance organization from
27 any provision of this chapter for services provided pursuant to any
28 other contract.

29 5. The provisions of NRS 695C.1694, 695C.1695, 695C.1708,
30 695C.1731, 695C.17345 and 695C.1757 *and sections 34, 35 and 36*
31 *of this act* apply to a health maintenance organization that provides
32 health care services through managed care to recipients of Medicaid
33 under the State Plan for Medicaid.

34 **Sec. 38.** NRS 695C.173 is hereby amended to read as follows:

35 695C.173 1. All individual and group health care plans which
36 provide coverage for a family member of the enrollee must as to
37 such coverage provide that the health care services applicable for
38 children are payable with respect to:

39 (a) A newly born child of the enrollee from the moment of birth;

40 (b) An adopted child from the date the adoption becomes
41 effective, if the child was not placed in the home before adoption;
42 and

43 (c) A child placed with the enrollee for the purpose of adoption
44 from the moment of placement as certified by the public or private
45 agency making the placement. The coverage of such a child ceases



1 if the adoption proceedings are terminated as certified by the public
2 or private agency making the placement.

3 ↪ The plans must provide the coverage specified in subsection 3,
4 and must not exclude premature births.

5 2. The evidence of coverage may require that notification of:

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

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

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

9 ↪ and payments of the required charge, if any, must be furnished to
10 the health maintenance organization within 31 days after the date of
11 birth, adoption or placement for adoption in order to have the
12 coverage continue beyond the 31-day period.

13 3. The coverage for newly born and adopted children and
14 children placed for adoption consists of preventive health care
15 services as well as coverage of injury or sickness, including the
16 necessary care and treatment of medically diagnosed congenital
17 defects and birth abnormalities and, within the limits of the policy,
18 necessary transportation costs from place of birth to the nearest
19 specialized treatment center under major medical policies, and with
20 respect to basic policies to the extent such costs are charged by the
21 treatment center.

22 4. ~~1A health maintenance organization shall not restrict the~~
23 ~~coverage of a dependent child adopted or placed for adoption solely~~
24 ~~because of a preexisting condition the child has at the time the child~~
25 ~~would otherwise become eligible for coverage pursuant to that plan.~~
26 ~~Any provision relating to an exclusion for a preexisting condition~~
27 ~~must comply with NRS 689B.500 or 689C.190, as appropriate.~~

28 ~~—5.1~~ For covered services provided to the child, the health
29 maintenance organization shall reimburse noncontracted providers
30 of health care to an amount equal to the average amount of payment
31 for which the organization has agreements, contracts or
32 arrangements for those covered services.

33 **Sec. 39.** NRS 695C.330 is hereby amended to read as follows:

34 695C.330 1. The Commissioner may suspend or revoke any
35 certificate of authority issued to a health maintenance organization
36 pursuant to the provisions of this chapter if the Commissioner finds
37 that any of the following conditions exist:

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



1 (b) The health maintenance organization issues evidence of
2 coverage or uses a schedule of charges for health care services
3 which do not comply with the requirements of NRS 695C.1691 to
4 695C.200, inclusive, or 695C.207 ~~†~~ *or sections 34, 35 and 36 of*
5 *this act;*

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

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

10 (1) Does not meet the requirements of subsection 1 of NRS
11 695C.080; or

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

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

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

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

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

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

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

31 (i) The continued operation of the health maintenance
32 organization would be hazardous to its enrollees;

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

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

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

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

44 4. If the certificate of authority of a health maintenance
45 organization is revoked, the organization shall proceed, immediately



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

10 **Sec. 40.** Chapter 695F of NRS is hereby amended by adding
11 thereto the provisions set forth as sections 41, 42 and 43 of this act.

12 **Sec. 41. 1.** *A prepaid limited health service organization*
13 *shall offer or issue evidence of coverage to any person regardless*
14 *of the health status of the person, the spouse of the person or any*
15 *dependent of the person. Such health status includes, without*
16 *limitation:*

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

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

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

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

25 **2.** *A prepaid limited health service organization that offers or*
26 *issues evidence of coverage shall not:*

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

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

35 **3.** *A prepaid limited health service organization that offers or*
36 *issues evidence of coverage shall not adjust a premium,*
37 *deductible, copay or coinsurance for any enrollee on the basis of*
38 *genetic information relating to the enrollee or the covered spouse*
39 *or dependent of the enrollee.*

40 **Sec. 42. 1.** *A prepaid limited health service organization*
41 *that offers or issues evidence of coverage shall include coverage*
42 *for all essential health benefits and shall not place an annual,*
43 *lifetime or other maximum limit on coverage for such essential*
44 *health benefits.*



1 2. *The Department of Health and Human Services shall, by*
2 *regulation, determine the essential health benefits that must be*
3 *covered by a prepaid limited health service organization pursuant*
4 *to subsection 1. Such essential health benefits must include,*
5 *without limitation:*

6 (i) *Outpatient services;*

7 (ii) *Emergency care;*

8 (iii) *Hospitalization;*

9 (iv) *Pregnancy, maternity and newborn care;*

10 (v) *Services relating to mental health and substance use*
11 *disorders, including, without limitation, treatment for behavioral*
12 *health and inpatient services for behavioral and mental health;*

13 (vi) *Prescription drugs;*

14 (vii) *Rehabilitative and habilitative services and devices;*

15 (viii) *Laboratory services;*

16 (ix) *Preventive and wellness services and management of*
17 *chronic diseases;*

18 (x) *Pediatric services, including, without limitation, oral and*
19 *vision care for children;*

20 (xi) *Contraceptive drugs, devices and services; and*

21 (xii) *Breastfeeding support, counseling and supplies.*

22 **Sec. 43.** *1. A prepaid limited health service organization*
23 *that offers or issues evidence of coverage which provides coverage*
24 *for dependent children shall continue to make such coverage*
25 *available for an adult child of an enrollee until such child reaches*
26 *26 years of age.*

27 2. *Nothing in this section shall be construed as requiring a*
28 *prepaid limited health service organization to make coverage*
29 *available for a dependent of an adult child of an enrollee.*

30 **Sec. 44.** Chapter 695G of NRS is hereby amended by adding
31 thereto the provisions set forth as sections 45, 46 and 47 of this act.

32 **Sec. 45.** *1. A managed care organization shall offer or*
33 *issue a health care plan to any person regardless of the health*
34 *status of the person, the spouse of the person or any dependent of*
35 *the person. Such health status includes, without limitation:*

36 (i) *Any preexisting medical condition of the person, including,*
37 *without limitation, any physical or mental illness;*

38 (ii) *The claims history of the person, including, without*
39 *limitation, any prior health care services received by the person;*

40 (iii) *Genetic information relating to the person; and*

41 (iv) *Any increased risk for illness, injury or any other medical*
42 *condition of the person, including, without limitation, any medical*
43 *condition caused by an act of domestic violence.*

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



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

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

9 3. A managed care organization that offers or issues a health
10 care plan shall not adjust a premium, deductible, copay or
11 coinsurance for any insured on the basis of genetic information
12 relating to the insured or the covered spouse or dependent of the
13 insured.

14 **Sec. 46. 1.** A managed care organization that offers or
15 issues a health care plan shall include in each plan coverage for
16 all essential health benefits and shall not place an annual, lifetime
17 or other maximum limit on coverage for such essential health
18 benefits.

19 2. The Department of Health and Human Services shall, by
20 regulation, determine the essential health benefits that must be
21 covered by a managed care organization pursuant to subsection 1.
22 Such essential health benefits must include, without limitation:

23 (a) Outpatient services;

24 (b) Emergency care;

25 (c) Hospitalization;

26 (d) Pregnancy, maternity and newborn care;

27 (e) Services relating to mental health and substance use
28 disorders, including, without limitation, treatment for behavioral
29 health and inpatient services for behavioral and mental health;

30 (f) Prescription drugs;

31 (g) Rehabilitative and habilitative services and devices;

32 (h) Laboratory services;

33 (i) Preventive and wellness services and management of
34 chronic diseases;

35 (j) Pediatric services, including, without limitation, oral and
36 vision care for children;

37 (k) Contraceptive drugs, devices and services; and

38 (l) Breastfeeding support, counseling and supplies.

39 **Sec. 47. 1.** A managed care organization that offers or
40 issues a health care plan which provides coverage for dependent
41 children shall continue to make such coverage available for an
42 adult child of an insured until such child reaches 26 years of age.

43 2. Nothing in this section shall be construed as requiring a
44 managed care organization to make coverage available for a
45 dependent of an adult child of an insured.



1 **Sec. 48.** NRS 695I.080 is hereby amended to read as follows:
2 695I.080 Except as otherwise provided in NRS 695I.370,
3 “qualified health plan” ~~has the meaning ascribed to it in~~ *means:*

4 1. *A health plan which meets the requirements of* § 1301 of
5 the Federal Act ~~†~~; *or*

6 2. *The Medicaid managed care program to the extent that it is*
7 *made available as described in section 3 of this act.*

8 **Sec. 49.** The amendatory provisions of sections 5 to 48,
9 inclusive, of this act only apply to a policy of health insurance,
10 policy of group health insurance, health benefit plan, benefit
11 contract, contract for hospital or medical service, health care plan or
12 evidence of coverage which is issued or renewed on or after
13 January 1, 2018.

14 **Sec. 50.** NRS 689A.523, 689A.585, 689B.450, 689C.082,
15 695A.159 and 695F.480 are hereby repealed.

16 **Sec. 51.** The provisions of NRS 354.599 do not apply to any
17 additional expenses of a local government that are related to the
18 provisions of this act.

19 **Sec. 52.** 1. This section and sections 1 and 2 of this act
20 become effective upon passage and approval.

21 2. Sections 3 to 51, inclusive, of this act become effective upon
22 passage and approval for the purpose of adopting any regulations
23 and performing any other preparatory administrative tasks that are
24 necessary to carry out the provisions of this act and on January 1,
25 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.

