Conceptual Amendment to SB 163

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The following changes to the language of SB 163 are proposed throughout the bill, but only included once in this document for ease of reading.

1. ~~An~~ No insurer that issues a policy of health insurance shall discriminate with respect to participation and coverage under the policy, contract, plan, or agreement against any person on the basis of actual gender identity or perceived gender identity. ~~include in the policy coverage for the medically necessary treatment of conditions relating to gender dysphoria, gender incongruence and other disorders of sexual development. Such coverage must include, without limitation, coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:~~

2. Discrimination under this section includes the following:
   (1) Denying, canceling, limiting, or refusing to issue or renew an insurance policy, contract, plan, or agreement on the basis of a transgender person's or a person's transgender family member's actual gender identity or perceived gender identity;
   (2) Demanding or requiring a payment or premium that is based on a transgender person's or a person's transgender family member's actual gender identity or perceived gender identity;
   (3) Designating a transgender person's or a person's transgender family member's actual gender identity or perceived gender identity as a preexisting condition to deny, cancel, or limit coverage; and
   (4) Denying, canceling, or limiting coverage for services on the basis of actual gender identity or perceived gender identity, including but not limited to the following:
   (A) Health care services related to gender transition; provided that there is coverage under the policy, contract, plan, or agreement for the services when the services are not related to gender transition; and
   (B) Health care services that are ordinarily or exclusively available to individuals of any sex.

3. An insurer shall not apply categorical cosmetic or blanket exclusions to gender affirming treatments or procedures, or any combination of services or procedures or revisions to prior treatments, when determined to be medically necessary pursuant to section 8 of this act, only if the policy, contract, plan, or agreement also provides coverage for those services when the services are offered for purposes other than gender transition. Services indicated as medically appropriate under the World Professional Association for Transgender Health (WPATH)

EXHIBIT E Senate Committee on Commerce and Labor
Date: 3-15-2023 Total pages: 3
Exhibit begins with: E1 thru: E3

Standards of Care most recent version must be evaluated by an insurer for inclusion to treat gender dysphoria.

These services may include but are not limited to those provided by:

(a) Endocrinologists;

(b) Pediatric endocrinologists;

(c) Social workers;

(d) Psychiatrists;

(e) Psychologists;

(f) Gynecologists;

(g) Plastic surgeons;

(h) voice therapists;

(i) Primary Care Physicians;

(j) Advanced Practice Registered Nurses;

(k) Physician Assistants and

~~(h~~ i) Any other providers of medically necessary services for the treatment of gender dysphoria, gender incongruence and other disorders of sexual development.

4. An insurer that issues a policy of health insurance may prescribe requirements that must be satisfied before the insurer covers surgical treatment of conditions relating to gender dysphoria, and gender incongruence ~~and other disorders of sexual development~~ for an insured who is less than 17 years of age. Such requirements may include, without limitation, requirements that:

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

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

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

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

5. An insurer shall make a reasonable effort to 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. If, after a reasonable effort, the insurer is unable to make such benefits available through such a provider of health care, the insurer must cover the benefits when provided to an insured through a provider of health care who does not participate in the network plan of the insurer.

6. In the event of an appeal of a claim denied on the basis of medical necessity of the treatment, such appeal shall be decided in a manner consistent with applicable law and in consultation with a health care provider with experience in prescribing or delivering gender affirming treatment who shall provide input on the appropriateness of the denial of the claim

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

this section is void.

8. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) "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.

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