THE SEVENTY-FIFTH DAY

CARSON CITY (Friday), April 21, 2017

Assembly called to order at 12:17 p.m.
Mr. Speaker presiding.
Roll called.
All present except Assemblymen Paul Anderson, Araujo, Hambrick, and Woodbury, who were excused.
Prayer by the Chaplain, Captain Leslie Cyr.

"This is the day that the Lord has made; let us rejoice and be glad in it." Thank You, Father, for today. There is much to do, but the day is good.

I pray, Lord, that Your favor will be with the Assembly today, and that You will lead and guide it in all that is said and done in matters of this great state. I pray that Your will is sought concerning the citizens of Nevada and that the laws that come about this session will be a benefit and not a burden to the people of this state. I pray for supernatural wisdom and an openness to listen to each other and to You. Let our state be led by what unites us and binds us as a people, for united we stand and divided we fall.

In Your hands, Lord, we place this day. May we do our best and be our best; may we be inspired and uplifted. All to the glory of Jesus Christ our Lord.

AMEN.

Pledge of allegiance to the Flag.

Assemblywoman Benitez-Thompson moved that further reading of the Journal be dispensed with and the Speaker and Chief Clerk be authorized to make the necessary corrections and additions.
Motion carried.

REPORTS OF COMMITTEES

Mr. Speaker:

Your Committee on Commerce and Labor, to which was referred Assembly Bill No. 328, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

IRENE BUSTAMANTE ADAMS, *Chair*

Mr. Speaker:

Your Committee on Corrections, Parole, and Probation, to which was referred Assembly Bill No. 181, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

JAMES OHRENSCHALL, *Chair*

Mr. Speaker:

Your Committee on Education, to which were referred Assembly Bills Nos. 434, 447, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

TYRONE THOMPSON, *Chair*

Mr. Speaker:

Your Committee on Government Affairs, to which were referred Assembly Bills Nos. 258, 415, has had the same under consideration, and begs leave to report the same back with the recommendation: Do pass.

Also, your Committee on Government Affairs, to which were referred Assembly Bills Nos. 279, 301, 423, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

EDGAR FLORES, *Chair*

Mr. Speaker:

Your Committee on Health and Human Services, to which was referred Assembly Bill No. 382, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

MICHAEL C. SPRINKLE, *Chair*

Mr. Speaker:

Your Committee on Judiciary, to which were referred Assembly Bills Nos. 97, 102, 132, 276, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

Also, your Committee on Judiciary, to which were referred Assembly Bills Nos. 380, 411, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

STEVE YEAGER, *Chair*

Mr. Speaker:

Your Committee on Legislative Operations and Elections, to which was referred Assembly Bill No. 392, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

OLIVIA DIAZ, *Chair*

Mr. Speaker:

Your Committee on Natural Resources, Agriculture, and Mining, to which was referred Assembly Bill No. 16, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

Also, your Committee on Natural Resources, Agriculture, and Mining, to which was referred Assembly Bill No. 416, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

Also, your Committee on Natural Resources, Agriculture, and Mining, to which was rereferred Assembly Bill No. 391, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

HEIDI SWANK, *Chair*

Mr. Speaker:

Your Committee on Transportation, to which were referred Assembly Bills Nos. 29, 334, 335, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

RICHARD CARRILLO, *Chair*

MESSAGES FROM THE SENATE

SENATE CHAMBER, Carson City, April 20, 2017

To the Honorable the Assembly:

I have the honor to inform your honorable body that the Senate on this day passed Senate Bill No. 399.

Also, I have the honor to inform your honorable body that the Senate on this day passed, as amended, Senate Bills Nos. 10, 20, 29, 32, 210, 239, 277, 308, 371.

SHERRY RODRIGUEZ
Assistant Secretary of the Senate

MOTIONS, RESOLUTIONS AND NOTICES

NOTICE OF EXEMPTION

April 20, 2017

The Fiscal Analysis Division, pursuant to Joint Standing Rule 14.6, has determined the exemption of: Senate Bill No. 377.

MARK KRMPOTIC
Fiscal Analysis Division

INTRODUCTION, FIRST READING AND REFERENCE

Senate Bill No. 10.
Assemblywoman Benitez-Thompson moved that the bill be referred to the Committee on Government Affairs.
Motion carried.

Senate Bill No. 20.
Assemblywoman Benitez-Thompson moved that the bill be referred to the Committee on Education.
Motion carried.

Senate Bill No. 29.
Assemblywoman Benitez-Thompson moved that the bill be referred to the Committee on Judiciary.
Motion carried.

Senate Bill No. 32.
Assemblywoman Benitez-Thompson moved that the bill be referred to the Committee on Judiciary.
Motion carried.

Senate Bill No. 210.
Assemblywoman Benitez-Thompson moved that the bill be referred to the Committee on Commerce and Labor.
Motion carried.

Senate Bill No. 239.
Assemblywoman Benitez-Thompson moved that the bill be referred to the Committee on Judiciary.
Motion carried.

Senate Bill No. 277.
Assemblywoman Benitez-Thompson moved that the bill be referred to the Committee on Judiciary.
Motion carried.

Senate Bill No. 308.
Assemblywoman Benitez-Thompson moved that the bill be referred to the Committee on Transportation.
Motion carried.

Senate Bill No. 371.

Assemblywoman Benitez-Thompson moved that the bill be referred to the Committee on Natural Resources, Agriculture, and Mining.

Motion carried.

Senate Bill No. 399.

Assemblywoman Benitez-Thompson moved that the bill be referred to the Committee on Government Affairs.

Motion carried.

SECOND READING AND AMENDMENT

Assembly Bill No. 120.

Bill read second time.

The following amendment was proposed by the Committee on Government Affairs:

Amendment No. 570.

AN ACT relating to school construction; revising provisions governing the imposition of a residential construction tax; revising provisions relating to the purchase of certain property for school construction; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Under existing law, the board of trustees of a school district whose population is less than 55,000 (currently counties other than Clark and Washoe Counties and Carson City) are authorized to request the board of county commissioners of the county to impose a tax on certain residential construction in the school district. The amount of the tax is limited to $1,600 per unit of certain new construction or development and the proceeds are required to be used to construct, remodel and make additions to school buildings. (NRS 387.331) **Section 1** of this bill requires the board of trustees **of a school district in any county** to provide to the board of county commissioners a statement of the impact on the school district of the proposed construction or development of an apartment house, five or more residential dwelling units or five or more lots for mobile homes within the school district. **Section 1** also extends the authority to request the imposition of the tax to all school districts and requires the board of county commissioners to approve such a request unless the board finds that the request was not justified. ~~[Finally,]~~ **Additionally, section 1 : (1)** expands the purposes for which the proceeds of the residential construction tax may be used to include modernization of school buildings ~~[and the acquisition of furniture, fixtures, equipment]~~ and necessary appurtenances ~~[and incidentals.]~~ **; (2) restricts the area or areas in which proceeds are authorized to be used to only those areas specified in the request for the imposition of the tax; and (3) specifies a deadline for the collection of the tax. Finally, section 1 exempts the construction or development of certain low-income**

housing from the residential construction tax and the requirement of an impact statement.

With certain exceptions, a person who wishes to subdivide land is required under existing law to prepare and file a tentative map with the planning commission of the city or county, as applicable, or its designated representative or, if there is no planning commission, with the clerk of the governing body of the city or the board of county commissioners, as applicable. (NRS 278.330) Within 10 days after such filing, a copy of the tentative map must be forwarded to the board of trustees of the school district within which the proposed subdivision is located. Within 15 days after receipt of the tentative map, the board of trustees is required to notify the planning commission or the governing body of the city or the board of county commissioners, as applicable, if a site for a school is needed within the area of the proposed subdivision. If the board of trustees requests a school site, the subdivider is required under existing law to set aside a site of the size determined by the board of trustees and negotiate the price with the board of trustees. (NRS 278.346) **Section 2** of this bill **requires the subdivider to consult with the planning commission or other applicable representative of the county or city with respect to the setting aside of a site. Section 2** imposes additional qualifications for such a school site, namely that: (1) the location be within the proposed subdivision and appropriate for a school based on public safety and convenience; [and] (2) the physical characteristics are suitable for use as a school site and for construction of a school in a manner that is economically sound and feasible [.] **; and (3) the site is compatible with the adjoining neighborhoods and applicable land use plans and regulations. Section 2** also requires the board of trustees and the subdivider to negotiate over the share of the costs of infrastructure required for the development of a school on the site that benefit the other tracts in the subdivision, which are required to be paid by the subdivider.

In a county whose population is 100,000 or more but less than 700,000 (currently Washoe County), if the school district has not purchased land for a school site from a subdivider within 5 years after the final map that shows the school site is approved, the subdivider is no longer required under existing law to set aside the land for the school district. **Section 2** extends this period for setting aside the land to [10] **8** years.

Under existing law, if land purchased by a school district from a subdivider has not been placed in use as a school site within 10 years after the date of purchase, the land is required to be offered for sale to the subdivider or the successor in interest of the subdivider. (NRS 278.346) **Section 2** extends this period for placing land in use as a school site to [20] **15** years.

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

Section 1. NRS 387.331 is hereby amended to read as follows:

387.331 1. The tax on residential construction authorized by this section is a specified amount which must be the same for each:

(a) Lot for a mobile home;

(b) Residential dwelling unit; and

(c) Suite in an apartment house,

➥ imposed on the privilege of constructing apartment houses and residential dwelling units and developing lots for mobile homes.

2. [The] ***Whenever an apartment house or a project involving five or more residential dwelling units or five or more lots for mobile homes is proposed to be constructed or developed, the planning commission of the city or county in which the construction or development is proposed or its designated representative or, if there is no planning commission, the clerk or other designated representative of the city or county, as applicable, shall, within [30] 10 days after the filing of an initial application for a permit or other authorization for the proposed construction or development, notify, in writing, the*** board of trustees of [any] ***the*** school district [whose population is less than 55,000] ***within which the proposed construction or development is located. The board of trustees shall, after receipt of the notification, submit to the board of county commissioners a written statement regarding the impact of the proposed construction or development on the school district.***

3. The board of trustees may request ***, in writing,*** that the board of county commissioners of the county in which the school district is located impose a tax on residential construction in the school district to construct, remodel ***, modernize*** and make additions to school buildings [.] ***and [to acquire furniture, fixtures, equipment and] for any appurtenance [or incidental] deemed necessary by the board of trustees for school buildings.*** [Whenever the board of trustees takes that action, it shall notify the board of county commissioners and shall] ***Such a request must*** specify the ***area or*** areas of the county to be served by the buildings to be erected ***, remodeled , modernized*** or enlarged [.

3.] ***and include, without limitation, a map showing the area or areas of the county to be served and a list of any existing schools that may be affected. The board of county commissioners shall approve a request made by the board of trustees pursuant to this subsection unless the board of county commissioners makes a finding that the request is not justified.***

4. If the board of county commissioners decides that the tax should be imposed, it shall notify the Nevada Tax Commission. If the Commission approves, the board of county commissioners may then impose the tax, whose specified amount must not exceed $1,600.

[4.] ***5.*** [The] ***Before the time at which a certificate of occupancy or other final authorization for the construction or development is issued or at such other time as is specified in the ordinance imposing the tax, the*** board ***of county commissioners*** shall collect the tax so imposed, in the areas of the county to which it applies, and may require that administrative costs, not to exceed 1 percent, be paid from the amount collected.

[5.] ***6.*** The money collected ***pursuant to subsection 5*** must be [deposited with] ***submitted to*** the county treasurer [in the school district's fund for capital projects to be held and expended in the same manner as other money deposited in that fund. ***and]*** ***for transfer to the county school district. Any money received by the county school district pursuant to this section must be*** ***accounted for separately*** ***[in the county general fund.]*** ***by the county school district.*** ***The money may only be used to construct, remodel, modernize and make additions to school buildings and*** ***[to acquire furniture, fixtures, equipment and]*** ***for*** ***any appurtenance*** ***[or incidental]*** ***deemed necessary by the board of trustees for school buildings*** ***[.]*** ***within the area or areas of the county specified in the request submitted by the board of trustees to the board of county commissioners pursuant to subsection 3.***

7. Nothing in this section shall be construed to prevent the planning commission of the city or county in which the construction or development is proposed or its designated representative or, if there is no planning commission, the clerk or other designated representative of the city or county, as applicable, from issuing permits or other authorization for the construction or development during the period in which the determination of whether to impose the tax and, if so, the amount of the tax to be made.

8. The provisions of this section do not apply to the construction or development of residential housing that is affordable to persons of low income on property which is subject to a covenant, condition or restriction contained in a deed, contract or other legal instrument which:

(a) Restricts the property to use for low-income housing for not less than 20 years;

(b) Restricts the amount of rent that may be charged to a tenant who occupies a unit of the residential housing; and

(c) Prohibits the sale, transfer or other conveyance of the property during the term of the covenant, condition or restriction unless the covenant, condition or restriction is binding upon the person to whom the property is conveyed.

Sec. 2. NRS 278.346 is hereby amended to read as follows:

278.346 1. The planning commission or its designated representative or, if there is no planning commission, the clerk or other designated representative of the governing body shall, not more than 10 days after the tentative map is filed pursuant to the provisions of subsection 2 of NRS 278.330, forward a copy of the tentative map to the board of trustees of the school district within which the proposed subdivision is located. Within 15

days after receipt of the copy, the board of trustees or its designee shall, if a school site is needed within the area, notify the commission or governing body that a site is requested.

2. If the board of trustees requests a site:

(a) The subdivider ***, in consultation with the planning commission of the city or county in which the proposed subdivision is located or its designated representative or, if there is no planning commission, the clerk or other designated representative of the city or county, as applicable,*** shall, except as otherwise provided in subsection 8, set aside a site ~~[of]~~ ***within the proposed subdivision:***

(1) Of the size which is determined by the board ~~[.]~~ ***of trustees;***

(2) Which is an appropriate location for a school based on considerations of public safety and convenience; ~~***[and]***~~

(3) The physical characteristics of which are suitable for use as a school site and for construction of a school in a manner that is economically sound and feasible ~~***[.]***~~ ***; and***

(4) Which is compatible with the adjoining neighborhoods and land use plans and regulations applicable to the area.

➥ ***If the board of trustees objects to the site set aside by the subdivider, the planning commission or its designated representative or, if there is no planning commission, the clerk or other designated representative of the governing body shall cause an independent third party with expertise in school facilities to make a determination of the suitability of the site for a school. Such a determination is binding on the board of trustees and subdivider. The cost of the independent third party must be paid by the board of trustees.***

(b) The subdivider and the board of trustees shall, except as otherwise provided in subsections 7 and 8, negotiate for ~~[the]~~ ***:***

(1) The price of the site ~~[,]~~ ***to be paid by the board of trustees,*** which must not exceed the fair market value of the land as determined by an independent appraisal paid for by the board ~~[.]~~ ***of trustees.***

(2) The share of the costs to be paid by the subdivider of any infrastructure required for the development of a school on the site, which must be proportional to the benefits from the infrastructure derived by the other tracts in the subdivision. If the board of trustees and the subdivider cannot reach an agreement on such costs, the planning commission or its designated representative or, if there is no planning commission, the clerk or other designated representative of the governing body shall cause an independent third party with expertise in the business of construction to make a determination of the share of costs. Such a determination is binding on the board of trustees and subdivider. The cost of the independent third party must be paid equally by the board of trustees and the subdivider.

3. If any land purchased by the school district pursuant to the provisions of subsection 2 has not been placed in use as a school site at the end of ~~[10~~

~~***20]***~~ ***15*** years from the date of purchase, the land must be offered to the subdivider or the successor in interest of the subdivider at a sale price equal to the fair market value of the land at the time of the offer, as determined by an independent appraisal paid for by the board ~~[.]~~ ***of trustees.***

4. If the subdivider or the successor in interest of the subdivider does not accept an offer made pursuant to the provisions of subsection 3 or 9, then the board of trustees may:

(a) Sell or lease such property in the manner provided in NRS 277.050 or 393.220 to 393.320, inclusive;

(b) Exchange such property in the manner provided in NRS 277.050 or 393.326 to 393.3293, inclusive; or

(c) Retain such property, if such retention is determined to be in the best interests of the school district.

5. Except as otherwise provided in subsection 6, when any land dedicated to the use of the public school system or any land purchased and used as a school site becomes unsuitable, undesirable or impractical for any school uses or purposes, the board of trustees of the county school district in which the land is located shall dispose of the land as provided in subsection 4.

6. Land dedicated under the provisions of former NRS 116.020, as it read before April 6, 1961, which the board of trustees determines is unsuitable, undesirable or impractical for school purposes may be reconveyed without cost to the dedicator or the successor or successors in interest of the dedicator.

7. Except as otherwise provided in subsection 8, in a county whose population is 100,000 or more but less than 700,000, the school district may purchase the site for a price negotiated between the subdivider and the board of trustees, which price must not exceed the lesser of:

(a) The fair market value of the land at the time the tentative map was approved, as determined by an independent appraisal paid for by the board ~~[,]~~ ***of trustees,*** plus any costs paid by the subdivider with respect to that land between the date the tentative map was approved and the date of purchase; or

(b) The fair market value of the land on the date of purchase, as determined by an independent appraisal paid for by the board ~~[.]~~ ***of trustees.***

8. If, ~~[5~~ ~~***10]***~~ ***8*** years after the date on which the final map that contains the school site was approved, a school district has not purchased the site pursuant to the provisions of subsection 7, the subdivider need not continue to set aside the site pursuant to the provisions of subsection 2.

9. If, ~~[10~~ ~~***20]***~~ ***15*** years after the date on which the final map that contains the school site was approved, construction of a school at the school site has not yet begun, the land purchased by the school district pursuant to subsection 7 must be offered to the subdivider or the successor in interest of the subdivider at a sale price equal to the fair market value of the land at the time of the offer, as determined by an independent appraisal paid for by the board ~~[.]~~ ***of trustees.***

10. Nothing in this section shall be construed to prevent the planning commission of the city or county in which the proposed subdivision is located or its designated representative or, if there is no planning commission, the clerk or other designated representative of the city or county, as applicable, from issuing permits or other authorization for the proposed subdivision during the period in which determination of a school site within the proposed subdivision is being made.

Sec. 3. 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. 4. This act becomes effective on July 1, 2017.

Assemblyman Flores moved the adoption of the amendment.

Amendment adopted.

Bill ordered reprinted, engrossed and to third reading.

Assembly Bill No. 299.

Bill read second time.

The following amendment was proposed by the Committee on Health and Human Services:

Amendment No. 428.

SUMMARY—Requires ~~[certain persons]~~ **the Legislative Committee on Senior Citizens, Veterans and Adults with Special Needs** to ~~[receive]~~ **conduct a study concerning** training ~~[concerning the provision of]~~ **standards for unlicensed persons providing** care ~~[.]~~ **at certain facilities or homes or through certain agencies.** (BDR ~~[40-985)]~~ **S-985)**

AN ACT relating to health care; requiring ~~[a person who provides care to persons in certain facilities for compensation]~~ **the Legislative Committee on Senior Citizens, Veterans and Adults with Special Needs** to ~~[receive]~~ **conduct a study during the 2017-2018 interim concerning standards of** training ~~[concerning the provision of]~~ **for unlicensed persons who provide** care ~~[;]~~ **at certain facilities or homes or through certain agencies;** and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law ~~[requires an employee to receive training to recognize and prevent the abuse of older persons if the employee will provide care to a person in a: (1)]~~ **creates the Legislative Committee on Senior Citizens, Veterans and Adults with Special Needs. (NRS 218E.750) This bill requires the Committee to conduct a study during the 2017-2018 interim concerning standards of training for a person who is not a provider of health care and who provides care to a person through employment or contract at a** facility for intermediate care **,** ~~[; (2)]~~ facility for skilled nursing ~~[; (3)]~~ **, agency to provide nursing in the home,** agency to provide personal care services in the home **,** ~~[; (4)]~~ facility for the care of adults during the day **,** ~~[; (5)]~~ residential facility for groups ~~[;]~~ or ~~[(6)]~~ home for individual residential care. ~~[(NRS 449.093) Section 1 of this bill requires a person who is not a provider of health care and who will provide care to a person through~~

~~employment or a contractual agreement with such a facility to receive]~~ **In addition, this bill requires the Committee to study the creation of a competency evaluation for a person who receives such** training concerning the provision of care **.** ~~[and successfully complete a competency evaluation. The remaining sections of this bill make conforming changes.]~~

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

Delete existing sections 1 through 7 of this bill and replace with the following new sections 1 and 2:

Section 1. **1. The Legislative Committee on Senior Citizens, Veterans and Adults with Special Needs created by NRS 218E.750 shall conduct a study during the 2017-2018 interim concerning standards of training for persons who are not providers of health care and who provide care to a person through employment or a contractual arrangement with a facility for intermediate care, facility for skilled nursing, facility for the care of adults during the day, residential facility for groups, home for individual residential care, an agency to provide nursing in the home or an agency to provide personal care services in the home.**

2. In conducting the study, the Committee shall consider:

(a) The specific types of training that a person who is not a provider of health care must receive before providing care to a person in a facility or home or through an agency described in subsection 1; and

(b) The creation of a competency evaluation that a person who is not a provider of health care must successfully complete concerning the types of care the person will provide at a facility or home or through an agency described in subsection 1.

2. The Committee shall include in its report required by subsection 3 of NRS 218E.760 on or before January 15, 2019, the results of the study conducted pursuant to this section and any recommendations for legislation.

3. As used in this section:

(a) "Agency to provide nursing in the home" has the meaning ascribed to it in NRS 449.0015.

(b) "Agency to provide personal care services in the home" has the meaning ascribed to it in NRS 449.0021.

(c) "Facility for intermediate care" has the meaning ascribed to it in NRS 449.0038.

(d) "Facility for skilled nursing" has the meaning ascribed to it in NRS 449.0039.

(e) "Facility for the care of adults during the day" has the meaning ascribed to it in NRS 449.004.

(f) "Home for individual residential care" has the meaning ascribed to it in NRS 449.0105.
(g) "Residential facility for groups" has the meaning ascribed to it in NRS 449.017.
Sec. 2. **This act becomes effective on July 1, 2017.**

Assemblyman Sprinkle moved the adoption of the amendment.
Amendment adopted.
Bill ordered reprinted, engrossed and to third reading.

Assembly Bill No. 321.
Bill read second time.
The following amendment was proposed by the Committee on Government Affairs:
Amendment No. 365.
SUMMARY—~~[Requires]~~ **Authorizes a county or city to require** a hosting platform to ~~[make]~~ **provide** certain reports **and information** to a county or city. (BDR 20-1138)
AN ACT relating to local government; ~~[requiring]~~ **authorizing** the board of county commissioners of a county and the city council or governing body of an incorporated city to adopt an ordinance requiring certain hosting platforms to submit quarterly reports to the county or city; prescribing the contents of such a report; authorizing the issuance of a subpoena to a hosting platform for the production of certain documents, records or materials; and providing other matters properly relating thereto.
Legislative Counsel's Digest:
This bill ~~[requires]~~ **authorizes** the board of county commissioners of a county or the city council or governing body of an incorporated city to adopt an ordinance requiring the submission of quarterly reports by an online hosting platform that facilitates the rental of a residential unit or a room or space within a residential unit for the purposes of transient lodging. Under this bill, the quarterly report must include certain information concerning the rentals facilitated by the hosting platform in the county or city, as applicable, and the revenue from such rentals. This bill further requires the ordinance to authorize an agency of the county or city, as applicable, to issue a subpoena requiring a hosting platform to produce documents, records or materials necessary for determining whether a rental of a residential unit or a room or space within a residential unit has violated the laws of this State or an ordinance adopted by the county or city in which the residential unit is located.

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

Section 1. Chapter 244 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The board of county commissioners [shall] may adopt an ordinance requiring a hosting platform that facilitates the rental of a residential unit in the county or a room or space within such a residential unit for the purposes of transient lodging to submit a quarterly report to an agency of the county.

2. The report required by subsection 1 must state:

(a) The number of bookings [per year] , listings, owners and lessees for the county;

(b) [Current year-to-date booking value for the county;

(c) Current year-to-date revenue from rentals in the county;

(d)] The average number of bookings per listing for the county;

[(e)] (c) The annual revenue collected per owner or lessee for the county; and

[(f)] (d) The average length of a rental in the county.

3. An ordinance adopted pursuant to subsection 1 must authorize an agency of the county to issue subpoenas for the production of documents, records or materials necessary for determining whether a residential unit in the county or a room or space within such a residential unit has been rented in violation of any law of this State or an ordinance adopted by the board of county commissioners of the county. The ordinance must provide that such a subpoena may be issued only if:

(a) There is evidence sufficient to support a reasonable belief that a residential unit in the county or a room or space within such a residential unit has been rented or is being rented in violation of any law of this State or an ordinance adopted by the board of county commissioners of the county;

(b) The subpoena identifies the rental alleged to be in violation of any law of this State or an ordinance adopted by the board of county commissioners of the county and the provision of law or ordinance allegedly violated.

➥ A subpoena issued pursuant to this subsection must be mailed to the hosting platform by regular and certified mail.

4. An ordinance adopted pursuant to subsection 1 must require a hosting platform to whom a subpoena has been issued to:

(a) Provide notice of the subpoena to the user of the hosting platform who provided the rental identified in the subpoena.

(b) Produce any subpoenaed books, papers or documents not later than 21 days after providing the notice required by paragraph (a) unless otherwise ordered by a court.

5. If a hosting platform that has been issued a subpoena pursuant to an ordinance adopted pursuant to subsection 1 refuses to produce any document, record or material that the subpoena requires, the agency of the county issuing the subpoena may apply to the district court for the judicial district in which the county is located for the enforcement of the subpoena

in the manner provided by law for the enforcement of a subpoena in a civil action.

6. As used in this section:

(a) "Hosting platform" means a person who, for a fee or other charge, provides on an Internet website an online platform that facilitates the rental of a residential unit or a room or space within a residential unit by an owner or lessee of the residential unit for the purposes of transient lodging, including, without limitation, through advertising, matchmaking or other means.

(b) "Residential unit" means a single-family residence or an individual residential unit within a larger building, including, without limitation, an apartment, condominium, townhouse or duplex.

Sec. 2. Chapter 268 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The city council or other governing body of an incorporated city ~~***[shall]***~~ ***may adopt an ordinance requiring a hosting platform that facilitates the rental of a residential unit in the incorporated city or a room or space within such a residential unit for the purposes of transient lodging to submit a quarterly report to an agency of the incorporated city.***

2. The report required by subsection 1 must state:

(a) The number of bookings, ~~***[per year]***~~ ***listings, owners and lessees for the incorporated city;***

(b) ~~***[Current year-to-date booking value for the incorporated city;***~~

~~***(c) Current year-to-date revenue from rentals in the incorporated city;***~~

~~***(d)]***~~ ***The average number of bookings per listing for the incorporated city;***

~~***[(e)]***~~ ***(c) The annual revenues collected per owner or lessee for the incorporated city; and***

~~***[(f)]***~~ ***(d) The average length of a rental in the incorporated city.***

3. An ordinance adopted pursuant to subsection 1 must authorize an agency of the incorporated city to issue subpoenas for the production of documents, records or materials necessary for determining whether a residential unit in the incorporated city or a room or space within such a residential unit has been rented in violation of any law of this State or an ordinance adopted by the city council or governing body of the incorporated city. The ordinance must provide that such a subpoena may be issued only if:

(a) There is evidence sufficient to support a reasonable belief that a residential unit in the incorporated city or a room or space within a residential unit has been rented or is being rented in violation of any law of this State or an ordinance adopted by the city council or governing body of the incorporated city;

(b) The subpoena identifies the rental alleged to be in violation of any law of this State or an ordinance adopted by the city council or governing

body of the incorporated city and the provision of law or ordinance allegedly violated.

➥ ***A subpoena issued pursuant to this subsection must be mailed to the hosting platform by regular and certified mail.***

4. An ordinance adopted pursuant to subsection 1 must require a hosting platform to whom a subpoena has been issued to:

(a) Provide notice of the subpoena to the user of the hosting platform who provided the rental identified in the subpoena.

(b) Produce any subpoenaed books, papers or documents not later than 21 days after providing the notice required by paragraph (a) unless otherwise ordered by a court.

5. If a hosting platform that has been issued a subpoena pursuant to an ordinance adopted pursuant to subsection 1 refuses to produce any document, record or material that the subpoena requires, the agency of the incorporated city issuing the subpoena may apply to the district court for the judicial district in which the investigation is being carried out for the enforcement of the subpoena in the manner provided by law for the enforcement of a subpoena in a civil action.

6. As used in this section:

(a) "Hosting platform" means a person who, for a fee or other charge, provides on an Internet website an online platform that facilitates the rental of a residential unit or a room or space within a residential unit by an owner or lessee of the residential unit for the purposes of transient lodging, including, without limitation, through advertising, matchmaking or other means.

(b) "Residential unit" means a single-family residence or an individual residential unit within a larger building, including, without limitation, an apartment, condominium, townhouse or duplex.

Sec. 3. This act becomes effective on July 1, 2017.

Assemblyman Flores moved the adoption of the amendment.

Amendment adopted.

Bill ordered reprinted, engrossed and to third reading.

Assembly Bill No. 341.

Bill read second time.

The following amendment was proposed by the Committee on Judiciary:

Amendment No. 406.

AN ACT relating to juvenile justice; authorizing an attorney who represents a child in juvenile proceedings to consult with and seek appointment of certain persons; ~~[requiring a peace officer or probation officer who interviews or interrogates a child during juvenile proceedings to make a recording of the interview or interrogation; requiring a child to be represented by an attorney during certain interviews or interrogations; requiring a juvenile court to presume a child is indigent for the purpose of appointing an attorney to represent the child;]~~ urging the Nevada Supreme

Court to adopt certain court rules relating to juvenile justice; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law provides a procedure for adjudicating a child who is alleged to be delinquent or in need of supervision under certain circumstances. (NRS 62D.010) **Section 1** of this bill authorizes an attorney who represents a child in such juvenile proceedings to consult with and seek appointment of certain persons.

~~[Section 2 of this bill requires a peace officer or probation officer who interviews or interrogates a child in juvenile proceedings to make a digital, video or magnetic recording of the interview or interrogation. Section 2 also requires a child be represented by an attorney during such an interview or interrogation.~~

~~Existing law requires a juvenile court to advise the child and the parent or guardian of the child that the child is entitled to be represented by an attorney at all stages of the proceedings. Existing law also: (1) authorizes a parent or guardian, if he or she is indigent, of a child to request the appointment of an attorney to represent the child; and (2) requires the juvenile court to appoint an attorney for a child if the parent or guardian of the child does not retain an attorney for the child and is not likely to retain such an attorney. (NRS 62D.030) Section 3 of this bill requires the juvenile court to presume a child is indigent for the purpose of appointing an attorney in juvenile proceedings.]~~

Section 4 of this bill urges the Nevada Supreme Court to adopt court rules for attorneys who represent juveniles in juvenile proceedings.

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

Section 1. Chapter 62D of NRS is hereby amended by adding thereto a new section to read as follows:

Each attorney who represents a child in proceedings pursuant to the provisions of this title may consult with and seek appointment of, without limitation and when appropriate:

1. Any social worker licensed pursuant to chapter 641B of NRS;

2. Any qualified mental health professional, as defined in NRS 458A.057;

3. Any educator; and

4. Any other expert the attorney deems appropriate.

Sec. 2. ~~[NRS 62D.010 is hereby amended to read as follows:~~

~~62D.010 1. Each proceeding conducted pursuant to the provisions of this title:~~

~~(a) Is not criminal in nature.~~

~~(b) Must be heard separately from the trial of cases against adults.~~

~~(c) Must be heard without a jury.~~

~~(d) May be conducted in an informal manner.~~

(e) May be held at a facility for the detention of children or elsewhere at the discretion of the juvenile court.

(f) Does not require stenographic notes or any other transcript of the proceeding unless ordered by the juvenile court.

2. Except as otherwise provided in this subsection, each proceeding conducted pursuant to the provisions of this title must be open to the public. If the juvenile court determines that all or part of the proceeding must be closed to the public because the closure is in the best interests of the child or the public:

(a) The public must be excluded; and

(b) The juvenile court may order that only those persons who have a direct interest in the case may be admitted. The juvenile court may determine that a victim or any member of the victim's family is a person who has a direct interest in the case and may be admitted.

3. A peace officer or probation officer who interviews or interrogates a child pursuant to the provisions of this title shall make a digital, video or magnetic recording of the interview or interrogation.

4. If a child is interviewed or interrogated by a peace officer or probation officer, the child must be represented by an attorney.] **(Deleted by amendment.)**

Sec. 3. [NRS 62D.030 is hereby amended to read as follows:

62D.030 1. If a child is alleged to be delinquent or in need of supervision, the juvenile court shall [advise] ***:***

(a) Advise the child and the parent or guardian of the child that the child is entitled to be represented by an attorney at all stages of the proceedings [.

2. If a parent or guardian of a child is indigent, the parent or guardian may request the appointment] ***;***

(b) Presume the child is indigent for the purpose of ***appointing*** an attorney to represent the child pursuant to the provisions in NRS 171.188 [.

3.] ***;***

(c) Not require the child to submit an affidavit concerning the child's financial disability; and

(d) Except as otherwise provided in this section, [the juvenile court shall] appoint an attorney for a child if the parent or guardian of the child does not retain an attorney for the child and is not likely to retain an attorney for the child.

[4.] ***3.*** A child may waive the right to be represented by an attorney if:

(a) A petition is not filed and the child is placed under informal supervision pursuant to NRS 62C.200; or

(b) A petition is filed and the record of the juvenile court shows that the waiver of the right to be represented by an attorney is made knowingly, intelligently, voluntarily and in accordance with any applicable standards established by the juvenile court.

[5.] ***4.*** Except as otherwise provided in subsection [6] ***5*** and NRS 424.085, if the juvenile court appoints an attorney to represent a child and:

~~(a) The parent or guardian of the child is not indigent, the parent or guardian shall pay the reasonable fees and expenses of the attorney.~~

~~(b) The parent or guardian of the child is indigent, the juvenile court may order the parent or guardian to reimburse the county or State in accordance with the ability of the parent or guardian to pay.~~

~~**[**6.**]** ***5.*** For the purposes of paragraph (b) of subsection **[**5,**]** ***4,*** the juvenile court shall find that the parent or guardian of the child is indigent if:~~

~~(a) The parent or guardian:~~

~~(1) Receives public assistance, as that term is defined in NRS 422A.065;~~

~~(2) Resides in public housing, as that term is defined in NRS 315.021;~~

~~(3) Has a household income that is less than 200 percent of the federally designated level signifying poverty;~~

~~(4) Is incarcerated pursuant to a sentence imposed upon conviction of a crime; or~~

~~(5) Is housed in a public or private mental health facility; or~~

~~(b) After considering the particular circumstances of the parent or guardian, including, without limitation, the seriousness of the charges against the child, the monthly expenses of the parent or guardian and the rates for attorneys in the area in which the juvenile court is located, the juvenile court determines that the parent or guardian is financially unable, without substantial hardship to the parent or guardian or his or her dependents, to obtain qualified and competent legal counsel.~~

~~**[**7.**]** ***6.*** Each attorney, other than a public defender, who is appointed under the provisions of this section is entitled to the same compensation and expenses from the county as is provided in NRS 7.125 and 7.135 for attorneys appointed to represent persons charged with criminal offenses.**]**~~ **(Deleted by amendment.)**

Sec. 4. The Legislature hereby finds and declares that:

1. In the case of *In re Gault*, 387 U.S. 1 (1967), the United States Supreme Court guaranteed a juvenile's constitutional right to due process under the Fourteenth Amendment, including, without limitation, the right to counsel and the privilege against self-incrimination.

2. Under the existing Nevada Supreme Court Rules:

(a) Rules 205-215 govern the State of Nevada Board of Continuing Legal Education whose powers and duties include, without limitation, providing for programs of continuing legal education.

(b) Rule 250 provides minimum requirements required for defense counsel in cases in which the death penalty is or may be sought or has been imposed, including proceedings for postconviction relief from a judgment of conviction and sentence of death.

3. The Nevada Supreme Court Rules, however, do not specify minimum requirements for attorneys who represent juveniles in proceedings related to juvenile justice.

4. Therefore the Legislature urges the Nevada Supreme Court to adopt appropriate rules for attorneys who represent juveniles to ensure effective assistance of counsel in proceedings related to juvenile justice. These requirements may include, without limitation:

(a) Minimum requirements for courses, programs and continuing legal education in order to provide effective representation of juveniles;

(b) Standards for professional conduct specific to juvenile justice; and

(c) Minimum requirements for attorneys who represent juveniles and are employed by the State Public Defender.

Sec. 5. This act becomes effective upon passage and approval.

Assemblyman Yeager moved the adoption of the amendment.
Amendment adopted.
Bill ordered reprinted, engrossed and to third reading.

Assembly Bill No. 370.
Bill read second time.
The following amendment was proposed by the Committee on Taxation:
Amendment No. 294.

AN ACT relating to taxation; authorizing the Office of Historic Preservation of the State Department of Conservation and Natural Resources to approve and issue a certificate of transferable tax credits to a person who rehabilitates a historic building in this State under certain circumstances; providing for the calculation of the transferable tax credits; requiring the Office to provide notice of certain hearings ~~[,]~~ **concerning an application for transferable tax credits;** requiring a person who rehabilitates a historic building to return any portion of transferable tax credits to which he or she is not entitled; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Section 7 of this bill authorizes a person who undertakes the rehabilitation of a qualified historic building to apply to the Office of Historic Preservation of the State Department of Conservation and Natural Resources for a certificate of transferable tax credits. Under **section 5** of this bill, a building is a "qualified historic building" if the building is **: (1)** at least 50 years of age ~~[and is]~~ **; (2)** nonresidential real property as defined in certain federal laws authorizing tax credits for the rehabilitation of historic buildings ~~[.]~~ **; and (3) eligible for the National Register of Historic Places.** **Section 7** requires the Office to approve an application for transferable tax credits if, in addition to certain other requirements, the applicant incurred certain eligible costs and expenses **of at least $20,000** in connection with the rehabilitation of the building and the Office certifies that the rehabilitation of the building satisfies the standards for the rehabilitation of historic buildings set forth in certain federal regulations. Under **section 7**, the transferable tax credits may be applied to the modified business tax, gaming license fee or the insurance premium tax.

Sections 8 and 9 of this bill provide for the calculation of the amount of transferable tax credits and duration for which such transferable tax credits are valid. Under **section 8**, the amount of transferable tax credits issued to an applicant must be equal to 20 percent of the eligible costs and expenses incurred by the applicant for the rehabilitation [.] **but must not exceed $3 million per qualified rehabilitation.** **Section 9** provides that the transferable tax credits expire [4] **5** years after the date on which the credits are issued.

Section 10 of this bill requires the Office to meet certain notice requirements before holding a hearing to approve or disapprove an application for transferable tax credits. **Section 11** of this bill requires an applicant to repay any portion of transferable tax credits to which the applicant is not entitled if the applicant becomes ineligible for the tax credits after receiving the tax credits.

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

Section 1. Chapter 360 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 12, inclusive, of this act.

Sec. 2. ***As used in sections 2 to 12, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 6, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***1. "Eligible costs and expenses" means any amount properly chargeable to the capital account of a qualified historic building in connection with a qualified rehabilitation.***

2. The term does not include:

(a) The costs of acquiring any building or interest therein; or

(b) Any expenditures attributable to the enlargement of an existing building.

Sec. 4. ***"Office" means the Office of Historic Preservation of the State Department of Conservation and Natural Resources.***

Sec. 5. ***"Qualified historic building" means a building in this State that is [at] :***

1. At least 50 years of age [and is nonresidential] ;

2. Nonresidential real property as defined in 26 U.S.C. § 168(e)(2)(B) [.] ; and

3. Eligible for listing in the National Register of Historic Places.

Sec. 6. ***"Qualified rehabilitation" means the rehabilitation of a qualified historic building that the Office has certified as meeting the standards for rehabilitation as defined in 36 C.F.R. § 67.7.***

Sec. 7. ***1. A person who undertakes a qualified rehabilitation may apply to the Office for a certificate of eligibility for transferable tax credits for any eligible costs and expenses. The transferable tax [credit] credits may be applied to:***

(a) Any tax imposed by chapters 363A and 363B of NRS;

(b) The gaming license fees imposed by the provisions of NRS 463.370;

(c) Any tax imposed pursuant to chapter 680B of NRS; or

(d) Any combination of the fees and taxes described in paragraphs (a), (b) and (c).

2. The Office shall approve an application for a certificate of eligibility for transferable tax credits if the Office finds that the person undertaking the qualified rehabilitation qualifies for the transferable tax credits pursuant to subsection 3 and shall calculate the estimated amount of the transferable tax credits pursuant to section 8 of this act.

3. To be eligible for transferable tax credits pursuant to this section, a person must:

(a) Submit an application that meets the requirements of subsection 4;

(b) Provide proof satisfactory to the Office that the building is a qualified historic building;

(c) Provide proof satisfactory to the Office that the rehabilitation of the qualified historic building is a qualified rehabilitation;

(d) Provide proof satisfactory to the Office that the applicant has incurred eligible costs and expenses of $20,000 or more in undertaking the qualified rehabilitation;

(e) Not later than 90 days after the date on which the qualified historic building was first placed in service after the qualified rehabilitation, provide the Office with an itemized report of eligible costs and expenses incurred by the applicant and documentation to establish the amount of the eligible costs and expenses incurred by the applicant; and

~~[(e)]~~ (f) Meet any other requirements prescribed by regulation pursuant to this section.

4. An application submitted pursuant to subsection 3 must contain:

(a) The name of the applicant;

(b) A description of the qualified historic building for which the applicant will undertake a qualified rehabilitation;

(c) A summary of the budgeted expenditures for the qualified rehabilitation;

(d) A summary of the eligible costs and expenses; and

(e) Any other information required by regulations adopted by the Office pursuant to subsection 8.

5. If the Office approves an application for a certificate of eligibility for transferable tax credits pursuant to this section, the Office shall immediately forward a copy of the certificate of eligibility which identifies the estimated amount of the tax credits available pursuant to section 8 of this act, to:

(a) The applicant;

(b) The Department; and

(c) The Nevada Gaming Control Board.

6. Within 60 business days after receipt of the report and documentation provided pursuant to paragraph ~~[(e)]~~ (e) of subsection 3 and any other accountings or other information required by the Office, the

Office shall make a final determination of whether a certificate of transferable tax credits will be issued. If the Office determines that all other requirements for the transferable tax credits have been met, the Office shall notify the applicant that the transferable tax credits will be issued. Within 30 days after the receipt of the notice, the applicant shall make an irrevocable declaration of the amount of transferable tax credits that will be applied to each fee or tax set forth in subsection 1, thereby accounting for all of the credits which will be issued. Upon receipt of the declaration, the Office shall issue to the applicant a certificate of transferable tax credits in the amount approved by the Office for the fees or taxes included in the declaration of the applicant. The applicant shall notify the Office upon transferring any of the transferable tax credits. The Office shall notify the Department and the Nevada Gaming Control Board of all transferable tax credits issued, segregated by each fee or tax set forth in subsection 1, ~~[and]~~ the amount of any transferable tax credits transferred and the person or entity to whom the tax credits were transferred.

7. An applicant for transferable tax credits pursuant to this section shall, upon request of the Administrator of the Office, furnish the Administrator with copies of all records necessary to verify that the applicant meets the requirements of subsection 3.

8. The Office:

(a) Shall adopt regulations prescribing:

(1) Any additional requirements to receive transferable tax credits;

(2) Any additional information that must be included with an application;

(3) The application review process; and

(4) The requirements for notice pursuant to section 10 of this act; and

(b) May adopt any other regulations that are necessary to carry out the provisions of sections 2 to 12, inclusive, of this act.

9. The Nevada Tax Commission and the Nevada Gaming Commission:

(a) Shall adopt regulations prescribing the manner in which the transferable tax credits will be administered.

(b) May adopt any other regulations that are necessary to carry out the provisions of sections 2 to 12, inclusive, of this act.

Sec. 8. *1. Except as otherwise provided in subsection 2 and section 9 of this act, the ~~[base]~~ amount of transferable tax credits issued to a person who applies for a transferable tax credit pursuant to section 7 of this act must equal 20 percent of the eligible costs and expenses incurred by the person for a qualified rehabilitation ~~[.]~~ but must not exceed $3,000,000 per qualified rehabilitation.*

2. The Office may:

(a) Reduce the cumulative amount of transferable tax credits that are calculated pursuant to this section by an amount equal to any damages

incurred by the State or any political subdivision of the State as a result of the qualified rehabilitation; or

(b) Withhold the transferable tax credits, in whole or in part, until any pending legal action in this State against the applicant or involving the qualified rehabilitation is resolved.

Sec. 9. *The transferable tax credits issued to any applicant for a qualified rehabilitation pursuant to section 7 of this act expire ~~[4]~~ 5 years after the date on which the transferable tax credits are issued.*

Sec. 10. *1. If the Office receives an application for transferable tax credits pursuant to section 7 of this act, the Office shall, not later than 10 days before a hearing on the application, provide notice of the hearing to:*

(a) The applicant;

(b) The Department; and

(c) The Nevada Gaming Control Board.

2. The notice required by this section must set forth the date, time and location of the hearing on the application. The date of the hearing must be not later than 60 days after the Office receives the completed application.

3. The Office shall issue a decision on the application not later than 30 days after the conclusion of the hearing on the application.

4. Except as otherwise provided in this subsection, if the application is approved, the qualified rehabilitation must begin not more than 90 days after the date on which the decision on the application is issued. The Office may extend by not more than 90 days the period otherwise prescribed by this subsection.

5. An applicant that undertakes a qualified rehabilitation shall submit the report and documentation required by section 7 of this act and all other required information to the Office and the Department within the time required by paragraph ~~[(c)]~~ (e) of subsection 3 of section 7 of this act. If the Office or the Department determines that information submitted pursuant to this subsection is incomplete, the applicant shall, not later than 30 days after receiving notice that the information is incomplete, provide to the Office or the Department, as applicable, all additional information required by the Office or the Department.

6. The Office shall give priority to the approval and processing of an application relating to a qualified rehabilitation that promotes tourism in the State of Nevada.

Sec. 11. *1. A person who applied for a transferable tax credit pursuant to section 7 of this act who is found to have submitted any false statement, representation or certification in any document submitted for the purpose of obtaining transferable tax credits or who otherwise becomes ineligible for transferable tax credits after receiving the transferable tax credits pursuant to section 7 of this act shall repay to the Department or the Nevada Gaming Control Board, as applicable, any portion of the transferable tax credits to which the applicant is not entitled.*

2. Transferable tax credits purchased in good faith are not subject to forfeiture or repayment by the transferee unless the transferee submitted fraudulent information in connection with the purchase.

Sec. 12. ***The Office shall, on or before October 1 of each year, prepare and submit to the Governor and to the Director of the Legislative Counsel Bureau for transmittal to the Legislature an annual report which includes, for the immediately preceding fiscal year:***

1. The number of applications submitted for transferable tax credits pursuant to section 7 of this act;

2. The number of qualified rehabilitations for which transferable tax credits were approved;

3. The amount of transferable tax credits approved;

4. The amount of transferable tax credits used;

5. The amount of transferable tax credits transferred ~~[;]~~ and the person or entity to whom the tax credits were transferred;

6. The amount of transferable tax credits taken against each allowable fee or tax, including the actual amount used and outstanding, in total and for each qualified rehabilitation;

7. The total amount of the eligible costs and expenses incurred by each qualified rehabilitation;

8. The number of persons in Nevada employed by each qualified rehabilitation and the amount of wages paid to those persons; and

9. The period during which each qualified rehabilitation employed persons in Nevada.

Sec. 13. The provisions of subsection 1 of NRS 218D.380 do not apply to any provision of this act that adds or revises a requirement to submit a report to the Legislature.

Sec. 14. This act becomes effective upon passage and approval for the purpose of adopting regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act and on July 1, 2017, for all other purposes.

Assemblywoman Neal moved the adoption of the amendment.

Amendment adopted.

Bill ordered reprinted, engrossed and to third reading.

Assembly Bill No. 408.

Bill read second time.

The following amendment was proposed by the Committee on Health and Human Services:

Amendment No. 568.

AN ACT relating to health care; requiring the State Plan for Medicaid to cover certain preventive health care services and maternity and newborn care; requiring insurers to offer health insurance coverage regardless of the health status of a person; requiring insurers to allow the covered adult child of an insured to remain covered by the health insurance of the insured until

26 years of age; requiring insurers to provide coverage for certain preventive health care services for women, adults and children at no cost; requiring insurers to provide coverage for maternity and newborn care; prohibiting providers of health care ~~[,]~~ **and** insurers ~~[and the Silver State Health Insurance Exchange]~~ from discriminating against a person on certain grounds; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law provides that an insurer may not deny, limit or exclude a benefit provided by a health care plan in certain limited circumstances, including, without limitation, when a person has contracted for a blanket policy of accident or health insurance or in certain cases relating to adoption. (NRS 689B.500, 689C.190, 695A.159, 695B.193, 695C.173, 695F.480) The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) prohibits an insurer from establishing rules for eligibility for a health care plan based on sex or certain health status factors, including, without limitation, preexisting conditions, claims history or genetic information, and also prohibits an insurer from charging a higher premium, deductible or copay based on sex or these health status factors. (42 U.S.C. § 300gg-4) **Sections 15, 31, 41, 48, 57, 68, 80, 83 and 94** of this bill align Nevada law with federal law and require all insurers to offer health insurance coverage regardless of the health status of a person and prohibits an insurer from denying, limiting or excluding a benefit or requiring an insured to pay a higher premium, deductible, coinsurance or copay based on the health status of the insured or the covered spouse or dependent of the insured.

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

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

The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) requires all health insurance plans to include coverage, without any higher deductible or any copay or coinsurance, for certain preventive health care services for women, adults and children, including, without limitation, screenings and tests for certain diseases, counseling, contraceptive drugs, devices and services as well as vaccinations. (42 U.S.C. § 300gg-13; 45 C.F.R. § 147.130) **Sections 17-20, 22, 26-30, 35-39, 50-52, 54, 55, 59-61, 63, 64, 70-72, 76, 77, 85-87, 89 and 90** of this bill align Nevada law with federal law in this manner, and extend these requirements to health insurance purchased by local governments and the Public Employees' Benefits

Program. **Sections 2, 3, 4, 6 and 7** of this bill also require the State Plan for Medicaid to include these preventive health care services for women, adults and children. **Section 93** of this bill requires the Director of the Department of Health and Human Services to adopt regulations specifying the preventive health care services which are required to be covered by insurers and that these requirements must include, without limitation, the preventive health care services currently required by federal law.

The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) prohibits a provider of health care or state health insurance exchange who receives federal money from discriminating against a person on the basis of race, color, national origin, sex, age, or disability in providing health care services to the person. The Act also prohibits an insurer who receives federal money from discriminating against a person on those same grounds, as well as gender identity or expression. (42 U.S.C. § 18116; 45 C.F.R. § 92.207) The federal regulation that prohibits insurers from discriminating on the basis of gender identity or expression is no longer enforceable, however, because it was recently held to exceed the statutory authority granted by the Act. (*Franciscan Alliance Inc., v. Burwell*, 2016 WL 7638311 (N.D. Tex. Dec. 31, 2016)) Federal regulations also require providers of health care, state health insurance exchanges and insurers to provide certain assistive services and notice of these nondiscrimination provisions to all persons who receive health care services. (45 C.F.R. §§ 92.8, 92.201, 92.202) **Sections 11 [,] and 12 [and 91]** of this bill **generally** align Nevada law with federal law, **and** [prohibiting] **prohibit** a provider of health care [,] **or** an insurer [or the Silver State Health Insurance Exchange] from discriminating against a person on these grounds, including, without limitation, discrimination based on gender identity or expression or sexual orientation.

WHEREAS, Passage of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by Congress in 2010, granted all Nevadans certain rights relating to health insurance coverage and provided greater access to health care benefits in this State; and

WHEREAS, Congress currently is considering the repeal of the Patient Protection and Affordable Care Act; and

WHEREAS, The Nevada Legislature wishes to ensure that all Nevadans continue to have access to certain rights and health care benefits currently guaranteed by the Patient Protection and Affordable Care Act; and

WHEREAS, The Nevada Legislature intends to maintain, not expand, those rights and health care benefits as they existed on January 1, 2017; now, therefore,

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

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

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

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

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

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

(d) Contraceptive drugs, devices and services;

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

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

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

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

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

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

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

(c) Smoking cessation programs;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) Counseling concerning breast cancer chemoprevention.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 9. 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 687B.408, 689B.030 to 689B.050, inclusive, ***and sections 25 to 28, inclusive, of this act*** and 689B.287 ***and 689B.500 and 689B.520*** apply to coverage provided pursuant to this paragraph.

(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. 10. 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 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and sections 83 to 89, inclusive, of this act,*** in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

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

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

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

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

4. A provider of health care must take reasonable steps to ensure that a person with limited English proficiency or physical or mental disabilities who receives health care services from the provider has access to any

assistance services which may be needed for the person to communicate effectively with the provider.

5. As used in this section:

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

(b) "Health care service" means the care and observation of patients, the diagnosis of human diseases, the treatment and rehabilitation of patients, or related services.

(c) "Sexual orientation" has the meaning ascribed to it in NRS 118.093.

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

1. Except as otherwise provided in subsection 2, an insurer who offers a policy of health insurance shall not refuse to provide coverage to or discriminate against a person based on race, color, national origin, sex, age, physical or mental disability, sexual orientation or gender identity or expression. Such discriminatory actions include, without limitation:

(a) Cancelling a policy;

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

(c) Limiting coverage of a claim; or

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

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

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

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

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

6. As used in this section:

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

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

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

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0413, 689A.044, 689A.0445, 689B.031, 689B.0313, 689B.0317,

689B.0374, 695B.1912, 695B.1914, 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1745, 695C.1751, 695G.170, 695G.171 and 695G.177, ***and sections 38, 39, 54, 55 and 89 of this act,*** any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:

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

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

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

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

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, 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.

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

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

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

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

(d) Contraceptive drugs, devices and services;

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

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

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

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

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

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

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

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

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

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

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

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

3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, 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.

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

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

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

(c) Smoking cessation programs;

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

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

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

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

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

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

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

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

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

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

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

3. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, 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.

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

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

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

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

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

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

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

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

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

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

(c) An annual mammogram for women 40 years of age or older ~~[.]~~ ***;***

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

(e) Counseling concerning breast cancer chemoprevention.

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

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

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

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

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

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

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

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

4. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[October 1, 1989,]~~ ***January 1,***

2018, 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 subsection 1 is void.

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

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

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

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

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

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

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

[2.] ***3.*** Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

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

[3.] ***4.*** An individual health benefit plan [that offers coverage for maternity care and pediatric care of newborn infants] may not:

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

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

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

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

(e) Except as otherwise provided in subsection [4,] ***5,*** restrict benefits for any portion of a hospital stay required pursuant to the provisions of this

section in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

~~[4.]~~ ***5.*** Nothing in this section:

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

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

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

6. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, 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.

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

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

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

689A.044 1. A policy of health insurance must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

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

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

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

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

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

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

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

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

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

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

4. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***January 1, 2018,*** 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 subsection 1 is void.

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

5. As used in this section:

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

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

Sec. 23. 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 sections 15 to 19, inclusive, of this act.***

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

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

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

Sec. 26. ***1. An insurer that offers or issues a policy of group health insurance shall include in the policy coverage for such preventive health***

care services relating to women as the Director of the Department of Health and Human Services requires.

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

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

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

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

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

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

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

3. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, 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.

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

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

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

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

(d) Contraceptive drugs, devices and services;

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

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

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

of the United States Department of Health and Human Services or its successor organization.

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

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

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

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

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

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

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

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

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

3. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, 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.

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

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

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

(c) Smoking cessation programs;

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

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

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

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

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

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

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

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

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

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

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

3. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, 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.

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

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

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

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

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

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

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

689B.0313 1. A policy of group health insurance must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

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

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

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

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

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

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

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

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

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

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

4. A policy ***of group health insurance*** subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***January 1, 2018,*** 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 subsection 1 is void.

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

5. As used in this section:

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

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

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

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

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

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

(c) An annual mammogram for women 40 years of age or older ~~[.]~~ ***;***

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

(e) Counseling concerning breast cancer chemoprevention.

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

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

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

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

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

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

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

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

4. A policy ***of group health insurance*** subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[October 1, 1989,]~~ ***January 1, 2018,*** 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 subsection 1 is void.

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

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

689B.500 ~~[A carrier that issues a group health plan or coverage under blanket accident and health insurance or group health insurance shall not deny, exclude or limit a benefit for a preexisting condition.]~~

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

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

~~[2.]~~ ***3.*** Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

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

~~[3.]~~ ***4.*** A group health plan or coverage under group health insurance ~~[that offers coverage for maternity care and pediatric care of newborn infants]~~ may not:

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

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

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

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

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

~~[4.]~~ ***5.*** Nothing in this section:

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

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

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

6. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

3. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any

provision of the plan or the renewal which is in conflict with this section is void.

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

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

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

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

(d) Contraceptive drugs, devices and services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Smoking cessation programs;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. As used in this section:

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

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

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

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

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

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

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

(e) Counseling concerning breast cancer chemoprevention.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

2. A carrier that offers health insurance coverage to small employers pursuant to this chapter shall not establish rules of eligibility, including, but not limited to, rules which define applicable waiting periods, for the initial or continued enrollment under a health benefit plan offered by the carrier that are based on the following factors relating to the eligible employee or a dependent of the eligible employee:

(a) Health status.

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

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

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

(h) Disability.

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

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

5. Nothing in this section:

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

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

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

6. As used in this section:

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

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

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

689C.194 1. ***A carrier that offers or issues a health benefit plan shall include in the plan coverage for such health care services relating to maternal and newborn care as the Director of the Department of Health and Human Services requires.***

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

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

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

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

~~[2.]~~ ***3.*** Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

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

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

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

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

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

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

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

~~[4.]~~ ***5.*** Nothing in this section:

(a) Prohibits a health benefit plan or carrier from imposing a deductible, coinsurance or other mechanism for sharing costs relating to benefits for

hospital stays in connection with childbirth for a mother or newborn child covered by the plan, except that such coinsurance or other mechanism for sharing costs for any portion of a hospital stay required by this section may not be greater than the coinsurance or other mechanism for any preceding portion of that stay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 45. 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 sections 34 to 39, inclusive, 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. 46. NRS 689C.440 is hereby amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Contraceptive drugs, devices and services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Smoking cessation programs;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

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

4. A benefit contract may not:

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

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

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

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

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

5. Nothing in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. As used in this section:

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

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

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

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

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

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

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

(e) Counseling concerning breast cancer chemoprevention.

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

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

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

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

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

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

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

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

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

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

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

Sec. 57. *1. An insurer shall offer or issue a contract for hospital or medical service to any person regardless of the health status of the person, the spouse of the person or any dependent of the person. Such health status includes, without limitation:*

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Contraceptive drugs, devices and services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Smoking cessation programs;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

➥ If a different length of stay is provided in the guidelines established by the American College of Obstetricians and Gynecologists, or its successor organization, and the American Academy of Pediatrics, or its successor

organization, the contract for hospital or medical service may follow such guidelines in lieu of following the length of stay set forth above. The provisions of this subsection do not apply to any contract for hospital or medical service in any case in which the decision to discharge the mother or newborn infant before the expiration of the minimum length of stay set forth in this subsection is made by the attending physician of the mother or newborn infant.

3. Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

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

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

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

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

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

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

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

5. Nothing in this section:

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

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

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

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

7. The Director of the Department of Health and Human Services shall adopt regulations to establish the health care services which must be covered by a contract for hospital or medical service pursuant to subsection 1.

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

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

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

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

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

(c) An annual mammogram for women 40 years of age or older ~~[.]~~ ***;***

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

(e) Counseling concerning breast cancer chemoprevention.

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

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

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

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

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

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

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

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

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

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

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

695B.1925 1. A ~~[policy of health insurance]~~ ***contract for hospital or medical service*** issued by a hospital or medical service corporation must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

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

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

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

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

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

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

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

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

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

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

4. A ~~[policy]~~ ***contract for hospital or medical service*** subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***January 1, 2018,*** 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 subsection 1 is void.

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

5. As used in this section:

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

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

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

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

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

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

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

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

2. The contract may require that notification of:

(a) The birth of a newly born child;

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

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

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

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

4. ~~[A corporation shall not restrict the coverage of a dependent child adopted or placed for adoption solely because of a preexisting condition the~~

child has at the time the child would otherwise become eligible for coverage pursuant to that contract. Any provision relating to an exclusion for a preexisting condition must comply with NRS 689C.190.

5.] For covered services provided to the child, the corporation shall reimburse noncontracted providers of health care to an amount equal to the average amount of payment for which the organization has agreements, contracts or arrangements for those covered services.

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

695B.2555 A [converted contract must not exclude a preexisting condition not excluded by the group contract, but a] converted contract may provide that any hospital, surgical or medical benefits payable under it may be reduced by the amount of any benefits payable under the group contract after his or her termination. A converted contract may provide that during the first contract year the benefits payable under it, together with the benefits payable under the group contract, must not exceed those that would have been payable if the subscriber's coverage under the group contract had remained in effect.

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

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Contraceptive drugs, devices and services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Smoking cessation programs;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

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

4. A health care plan may not:

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

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

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

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

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

5. Nothing in this section:

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

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

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

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

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

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

Sec. 74. 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.1735 to~~] ***695C.1751,*** 695C.1755, [~~inclusive,~~] 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.1694, 695C.1695, 695C.1708, 695C.1731, 695C.17345 [~~and~~] ***, 695C.1735, 695C.1745 and*** 695C.1757 ***and sections 68 to 73, inclusive, 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.

Sec. 75. NRS 695C.173 is hereby amended to read as follows:

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

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

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

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

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

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

(a) The birth of a newly born child;

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

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

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

3. The coverage for newly born and adopted children and children placed for adoption consists of preventive health care services as well as coverage of injury or sickness, including the necessary care and treatment of medically

diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center under major medical policies, and with respect to basic policies to the extent such costs are charged by the treatment center.

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

~~5.]~~ For covered services provided to the child, the health maintenance organization shall reimburse noncontracted providers of health care to an amount equal to the average amount of payment for which the organization has agreements, contracts or arrangements for those covered services.

Sec. 76. NRS 695C.1735 is hereby amended to read as follows:

695C.1735 1. A health maintenance ***organization which offers or issues a health care*** plan must provide coverage for benefits payable for expenses incurred for:

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

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

(c) An annual mammogram for women 40 years of age or older ~~[.]~~ ***;***

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

(e) Counseling concerning breast cancer chemoprevention.

2. A health ~~[maintenance]~~ ***care*** plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.

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

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

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

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

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

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

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

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

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

Sec. 77. NRS 695C.1745 is hereby amended to read as follows:

695C.1745 1. A health care plan of a health maintenance organization must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

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

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

2. A health care plan of a health maintenance organization must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.

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

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

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

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

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

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

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

4. Any evidence of coverage subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with subsection 1 is void.

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

5. As used in this section:

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

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

Sec. 78. 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 sections 68 to 73, inclusive, of this act*** 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;

(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. 79. Chapter 695F of NRS is hereby amended by adding thereto the provisions set forth as sections 80 and 81 of this act.

Sec. 80. ***1. A prepaid limited health service organization shall offer or issue evidence of coverage to any person regardless of the health status of the person, the spouse of the person or any dependent of the person. Such health status includes, without limitation:***

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

Sec. 81. ***1. A prepaid limited health service organization that offers or issues evidence of coverage which provides coverage for dependent children shall continue to make such coverage available for an adult child of an enrollee until such child reaches 26 years of age.***

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

Sec. 82. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 83 to 89, inclusive, of this act.

Sec. 83. ***1. A managed care organization shall offer or issue a health care plan to any person regardless of the health status of the person, the spouse of the person or any dependent of the person. Such health status includes, without limitation:***

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

Sec. 84. ***1. A managed care organization that offers or issues a health care plan which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age.***

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

Sec. 85. ***1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for such preventive health care services relating to women as the Director of the Department of Health and Human Services requires.***

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

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

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

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

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

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

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

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

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

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

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

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

(d) Contraceptive drugs, devices and services;

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

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

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

of the United States Department of Health and Human Services or its successor organization.

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

Sec. 86. ***1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for such preventive health care services relating to persons 18 years of age or older as the Director of the Department of Health and Human Services requires.***

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

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

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

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

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

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

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

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

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

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

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

(c) Smoking cessation programs;

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

(e) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention

of the United States Department of Health and Human Services or its successor organization.

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

Sec. 87. ***1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for such preventive health care services relating to persons less than 18 years of age as the Director of the Department of Health and Human Services requires.***

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

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

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

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

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

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

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

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

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

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

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

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

(d) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention

of the United States Department of Health and Human Services or its successor organization.

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

Sec. 88. ***1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for such health care services relating to maternal and newborn care as the Director of the Department of Health and Human Services requires.***

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

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

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

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

3. Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

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

4. A health care plan may not:

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

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

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

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

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

5. Nothing in this section:

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

(b) Prohibits an arrangement for payment between a managed care organization and a provider of health care that uses capitation or other financial incentives, if the arrangement is designed to provide services efficiently and consistently in the best interest of the mother and her newborn infant.

(c) Prevents a managed care organization from negotiating with a provider of health care concerning the level and type of reimbursement to be provided in accordance with this section.

6. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

7. The Director of the Department of Health and Human Services shall adopt regulations to establish the health care services which must be covered by a health care plan pursuant to subsection 1.

8. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 89. *1. A managed care organization which offers or issues a health care plan must provide coverage for benefits payable for expenses incurred for:*

(a) An annual cytologic screening test for women 18 years of age or older;

(b) A baseline mammogram for women between the ages of 35 and 40 years;

(c) An annual mammogram for women 40 years of age or older;

(d) Counseling concerning genetic testing for breast cancer; and

(e) Counseling concerning breast cancer chemoprevention.

2. A health care plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.

3. A managed care organization that offers or issues a health care plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health care plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. An evidence of coverage subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with subsection 1 is void.

5. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 90. NRS 695G.171 is hereby amended to read as follows:

695G.171 1. A health care plan issued by a managed care organization must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

(a) Deoxyribonucleic acid testing for high-risk strains of the human papillomavirus; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. A health care plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.

3. ***A managed care organization that offers or issues a health care plan shall not:***

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health care plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. An evidence of coverage for a health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after [July 1, 2007,] ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal thereof which is in conflict with subsection 1 is void.

[4. For the purposes of this section, "human]

5. As used in this section:

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 91. [Chapter 695I of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 2, the Exchange shall not discriminate against a person on the basis of race, color, national origin, sex, age, physical or mental disability, sexual orientation or gender identity or expression, including, without limitation, offering qualified health plans that discriminate in such a manner.

2. The Exchange may make distinctions based on sex or gender identity or expression, if the Exchange has an exceedingly persuasive justification for the distinction, which may include, without limitation, that the distinction is substantially related to the achievement of an important health or scientific objective.

3. The Exchange must provide reasonable notice to a person relating to the provisions of this section.

4. The Exchange must take reasonable steps to ensure that a person with limited English proficiency or physical or mental disabilities has access to any assistance services which may be needed for the person to transact business with the Exchange.

5. As used in this section:

(a) "Gender identity or expression" has the meaning ascribed to it in NRS 193.0148.

(b) "Sexual orientation" has the meaning ascribed to it in NRS 118.093.] **(Deleted by amendment.)**

Sec. 92. 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. 93. 1. The Director of the Department of Health and Human Services shall adopt regulations as soon as possible after the effective date of this act which establish the health care services which must be covered by a policy of health insurance, policy of group health insurance, health benefit plan, benefit contract, contract for hospital or medical service or health care plan pursuant to sections 2 to 5, inclusive, 17, 18, 19, 21, 26, 27, 28, 32, 35, 36, 37, 43, 50 to 53, inclusive, 59 to 62, inclusive, 70 to 73, inclusive, and 85 to 88, inclusive, of this act.

2. The regulations adopted pursuant to subsection 1 must include, without limitation, the health care services which are required to be covered pursuant to 45 C.F.R. § 147.130 and the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended.

Sec. 94. NRS 689A.523, 689A.585, 689B.450, 689C.082, 695A.159 and 695F.480 are hereby repealed.

Sec. 95. This act becomes effective:

1. Upon passage and approval for the purposes of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

2. On January 1, 2018, for all other purposes.

LEADLINES OF REPEALED SECTIONS

689A.523 "Exclusion for a preexisting condition" defined.

689A.585 "Preexisting condition" defined.

689B.450 "Preexisting condition" defined.

689C.082 "Preexisting condition" defined.

695A.159 Society prohibited from restricting coverage of child based on preexisting condition when person who is eligible for group coverage adopts or assumes legal obligation for child.

695F.480 Organization prohibited from restricting coverage of child based on preexisting condition if person who is eligible for group coverage adopts or assumes legal obligation for child.

Assemblyman Sprinkle moved the adoption of the amendment.

Amendment adopted.

Bill ordered reprinted, engrossed and to third reading.

Assembly Bill No. 428.

Bill read second time.

The following amendment was proposed by the Committee on Health and Human Services:

Amendment No. 426.

[CONTAINS UNFUNDED MANDATE (§ 5)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)]

AN ACT relating to controlled substances; [authorizing certain health care professionals to issue an order for an opioid antagonist to a public or private school;] authorizing a pharmacist to furnish an opioid antagonist without a prescription under certain circumstances; [providing for public and private schools to obtain and maintain opioid antagonists under certain conditions; providing immunity to certain persons for acts or omissions relating to the acquisition, possession or administration of opioid antagonists in certain circumstances;] and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law authorizes certain physicians, physician assistants and advanced practice registered nurses to prescribe and dispense an opioid antagonist to a person at risk of experiencing an opioid-related drug overdose, or to a family member, friend or other person who is in a position to assist a person experiencing an opioid-related drug overdose. (Chapter 453C of NRS, NRS 453C.100) Existing law further provides for the development of standardized procedures and protocols under which a registered pharmacist may furnish an opioid antagonist. (NRS 453C.120) **[Section 2 of this]** **This** bill authorizes a pharmacist to furnish an opioid antagonist without a prescription from a health care professional authorized to prescribe an opioid antagonist to a person at risk of experiencing an opioid-related drug overdose, or to a family member, friend or other person who is in a position to assist such a person. **[Section 2]** **This bill** also prohibits the development of standardized procedures and protocols that prevent a pharmacist from dispensing an opioid antagonist without a prescription.

[Existing law authorizes certain health care professionals to issue an order for auto-injectable epinephrine to a public or private school to be maintained at the school for the treatment of anaphylaxis that may be experienced by any person at the school. (NRS 630.374, 632.239, 633.707) Section 1 of this bill authorizes certain health care professionals to issue such an order for opioid antagonists to a public and private school for the treatment of an opioid-related drug overdose that may be experienced by any person at the school. Section 1 also provides that a health care professional is not subject to disciplinary action for issuing such an order to a school.

Existing law requires each public school, including each charter school, to obtain an order from certain health care professionals for auto-injectable epinephrine to maintain the drug at the school. (NRS 386.870) Existing law similarly authorizes a private school to obtain and maintain auto-injectable epinephrine at the school. (NRS 394.1995) Section 5 of this bill enacts a similar requirement on each public school, including each charter school, to obtain and maintain an order for opioid antagonists. Section 8 of this bill similarly authorizes a private school to obtain and maintain opioid antagonists at the school. If a public or private school obtains an order for

~~opioid antagonists, sections 3, 5 and 8 of this bill allow a school nurse or other designated employee of the public or private school, as applicable, who has received training in the storage and administration of opioid antagonists to possess and administer opioid antagonists to a pupil on the premises of the school during the school day who is reasonably believed to be experiencing an opioid-related drug overdose. Sections 6-8 of this bill require training in the storage and administration of opioid antagonists to be provided to designated employees of a public or private school.~~

~~Section 9 of this bill requires a registered pharmacist to transfer an order for an opioid antagonist to another registered pharmacist at the request of a public or private school for which the order was issued. Section 9 also exempts a pharmacist who dispenses an opioid antagonist pursuant to such an order from liability for certain damages relating to the acquisition, possession, provision or administration of an opioid antagonist not amounting to gross negligence or reckless, willful or wanton conduct.~~**]**

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. **[**~~Chapter 453C of NRS is hereby amended by adding thereto a new section to read as follows:~~

~~***1. Notwithstanding any other provision of law, a health care professional authorized to prescribe an opioid antagonist may issue to a public or private school an order to allow the school to obtain and maintain opioid antagonists at the school, regardless of whether any person at the school has been diagnosed with a condition which may cause the person to require such medication for the treatment of an opioid-related drug overdose.***~~

~~***2. An order issued pursuant to subsection 1 must contain:***~~

~~***(a) The name and signature of the health care professional and the address of the health care professional if not immediately available to the pharmacist;***~~

~~***(b) The classification of the license of the health care professional;***~~

~~***(c) The name of the public or private school to which the order is issued;***~~

~~***(d) The name, strength and quantity of the opioid antagonist authorized to be obtained and maintained by the order; and***~~

~~***(e) The date of issue.***~~

~~***3. A health care professional is not subject to disciplinary action solely for issuing a valid order pursuant to subsection 1 to a public or private school and without knowledge of a specific natural person who requires the medication.***~~

~~***4. A health care professional is not liable for any error or omission concerning the acquisition, possession, provision or administration of an opioid antagonist maintained by a public or private school pursuant to an order issued by the health care professional pursuant to subsection 1 not***~~

~~***resulting from gross negligence or reckless, willful or wanton conduct of the health care professional.***~~

~~***5. As used in this section:***~~

~~***(a) "Private school" has the meaning ascribed to it in NRS 394.103.***~~

~~***(b) "Public school" has the meaning ascribed to it in NRS 385.007.]***~~ **(Deleted by amendment.)**

Sec. 2. NRS 453C.120 is hereby amended to read as follows:

453C.120 1. Notwithstanding any other provision of law, a registered pharmacist may ***, with or without a prescription from a health care professional authorized to prescribe an opioid antagonist,*** furnish an opioid antagonist in accordance with standardized procedures or protocols developed and approved by the State Board of Pharmacy pursuant to this section.

2. The State Board of Pharmacy ~~[may,]~~ ***:***

(a) May, in consultation with representatives of the Nevada Pharmacist Association, other appropriate professional licensing boards, state agencies and other interested parties, develop standardized procedures or protocols to enable a registered pharmacist and other appropriate entities to furnish an opioid antagonist pursuant to this section.

(b) May not prohibit a pharmacist from furnishing an opioid antagonist to a person without a prescription.

3. Standardized procedures or protocols adopted pursuant to this section must ensure that a person receive education before being furnished with an opioid antagonist pursuant to this section. The education must include, without limitation:

(a) Information concerning the prevention and recognition of and responses to opioid-related drug overdoses;

(b) Methods for the safe administration of opioid antagonists to a person experiencing an opioid-related drug overdose;

(c) Potential side effects and adverse events connected with the administration of opioid antagonists;

(d) The importance of seeking emergency medical assistance for a person experiencing an opioid-related drug overdose even after the administration of an opioid antagonist; and

(e) Information concerning the provisions of NRS 453C.150.

4. A pharmacist shall, before furnishing an opioid antagonist pursuant to this section, complete a training program on the use of opioid antagonists. The program must include at least 1 hour of approved continuing education on the use of opioid antagonists.

5. This section does not:

(a) Affect any provision of law concerning the confidentiality of medical information.

(b) Confer any authority on a registered pharmacist to prescribe an opioid antagonist or any other prescription medication or controlled substance.

Sec. 3. ~~[NRS 454.303 is hereby amended to read as follows:~~

~~454.303 A school nurse or other employee of a public or private school who is authorized pursuant to NRS 386.870 or 394.1995 to administer auto-injectable epinephrine ***or an opioid antagonist*** may possess and administer auto-injectable epinephrine ***or an opioid antagonist, as applicable,*** maintained by the school if the school nurse or other employee has received training in the proper storage and administration of auto-injectable epinephrine ***or an opioid antagonist, as applicable,*** as required by NRS 386.870 or 394.1995.]~~ **(Deleted by amendment.)**

Sec. 4. ~~[NRS 386.865 is hereby amended to read as follows:~~

~~386.865 1. Each public school shall ensure that auto-injectable epinephrine ***and any opioid antagonist*** maintained at the school is stored in a designated, secure location that is unlocked and easily accessible.~~

~~2. Each school district shall establish a policy for the schools within the district, other than charter schools, regarding the proper handling and transportation of auto-injectable epinephrine **[.]** ***and opioid antagonists.***~~

~~3. Not later than 30 days after the last day of each school year, each school district and charter school shall submit a report to the Division of Public and Behavioral Health of the Department of Health and Human Services identifying the number of doses of auto-injectable epinephrine ***and opioid antagonists*** that were administered at each public school within the school district or charter school, as applicable, during the school year.]~~ **(Deleted by amendment.)**

Sec. 5. ~~[NRS 386.870 is hereby amended to read as follows:~~

~~386.870 1. Each public school, including, without limitation, each charter school, shall obtain an order from a physician, osteopathic physician, physician assistant or advanced practice registered nurse, for auto-injectable epinephrine pursuant to NRS 630.374, 632.239 or 633.707 and acquire at least two doses of the medication to be maintained at the school. If a dose of auto-injectable epinephrine maintained by the public school is used or expires, the public school shall ensure that at least two doses of the medication are available at the school and obtain additional doses to replace the used or expired doses if necessary.~~

~~2. ***Each public school, including, without limitation, each charter school, shall obtain an order from a health care professional authorized to prescribe an opioid antagonist for an opioid antagonist pursuant to section 1 of this act and acquire at least two doses of the medication to be maintained at the school. If a dose of an opioid antagonist maintained by the public school is used or expires, the public school shall ensure that at least two doses of the medication are available at the school and obtain additional doses to replace the used or expired doses if necessary.***~~

~~***3.*** Auto-injectable epinephrine ***or an opioid antagonist*** maintained by a public school pursuant to this section may be administered:~~

~~(a) At a public school other than a charter school, by a school nurse or any other employee of the public school who has been designated by the school nurse and has received training in the proper storage and administration of auto-injectable epinephrine [;] ***or an opioid antagonist, as applicable;*** or~~

~~(b) At a charter school, by the employee designated to be authorized to administer auto-injectable epinephrine ***or an opioid antagonist, as applicable,*** pursuant to NRS 388A.547 if the person has received the training in the proper storage and administration of auto-injectable epinephrine [.~~

~~3.] ***or the opioid antagonist, as applicable.***~~

~~***4.*** A school nurse or other designated employee of a public school may administer auto-injectable epinephrine ***or an opioid antagonist*** maintained at the school to any pupil on the premises of the public school during regular school hours whom the school nurse or other designated employee reasonably believes is experiencing anaphylaxis [.~~

~~4.] ***or an opioid-related drug overdose, as applicable.***~~

~~***5.*** A public school may accept gifts, grants and donations from any source for the support of the public school in carrying out the provisions of this section, including, without limitation, the acceptance of auto-injectable epinephrine ***or opioid antagonists*** from a manufacturer or wholesaler of auto-injectable epinephrine [.] ***or opioid antagonists.***~~

~~***6. As used in this section:***~~

~~***(a) "Health care professional" has the meaning ascribed to it in NRS 453C.030.***~~

~~***(b) "Opioid antagonist" has the meaning ascribed to it in NRS 453C.040.***~~

~~***(c) "Opioid-related drug overdose" has the meaning ascribed to it in NRS 453C.050.]***~~ **(Deleted by amendment.)**

Sec. 6. ~~[NRS 388A.547 is hereby amended to read as follows:~~

~~388A.547 1. Each charter school shall designate one or more employees of the school who is authorized to administer auto-injectable epinephrine [.] ***and an opioid antagonist.***~~

~~2. Each charter school shall ensure that each person so designated receives training in the proper storage and administration of auto-injectable epinephrine [.] ***and opioid antagonists.***~~

~~***3. As used in this section, "opioid antagonist" has the meaning ascribed to it in NRS 453C.040.]***~~ **(Deleted by amendment.)**

Sec. 7. ~~[NRS 391.291 is hereby amended to read as follows:~~

~~391.291 1. The provision of nursing services in a school district by school nurses and other qualified personnel must be under the direction and supervision of a chief nurse who is a registered nurse as provided in NRS 632.240 and who:~~

~~(a) Holds an endorsement to serve as a school nurse issued pursuant to regulations adopted by the Commission; or~~

~~(b) Is employed by a state, county, city or district health department and provides nursing services to the school district in the course of that employment.~~

~~2. A school district shall not employ a person to serve as a school nurse unless the person holds an endorsement to serve as a school nurse issued pursuant to regulations adopted by the Commission.~~

~~3. The chief nurse shall ensure that each school nurse:~~

~~(a) Coordinates with the principal of each school to designate employees of the school who are authorized to administer auto-injectable epinephrine [;] ***and opioid antagonists;*** and~~

~~(b) Provides the employees so designated with training concerning the proper storage and administration of auto-injectable epinephrine [.] ***and opioid antagonists.***~~

~~***4. As used in this section, "opioid antagonist" has the definition ascribed to it in NRS 453C.040.]***~~ **(Deleted by amendment.)**

Sec. 8. ~~[NRS 394.1995 is hereby amended to read as follows:~~

~~394.1995 1. A private school may obtain an order from a physician, osteopathic physician, physician assistant or advanced practice registered nurse for auto-injectable epinephrine pursuant to NRS 630.374, 632.239 or 633.707 to be maintained at the school. If a dose of auto-injectable epinephrine maintained by the private school is used or expires, the private school may obtain additional doses of auto-injectable epinephrine to replace the used or expired auto-injectable epinephrine.~~

~~2. ***A private school may obtain an order from a health care professional authorized to prescribe an opioid antagonist for an opioid antagonist pursuant to section 1 of this act to be maintained at the school. If a dose of an opioid antagonist maintained by the private school is used or expires, the private school may obtain an additional dose of an opioid antagonist to replace the used or expired opioid antagonist.***~~

~~***3.*** Auto-injectable epinephrine ***or an opioid antagonist*** maintained by a private school pursuant to this section may be administered by a school nurse or any other employee of the private school who has received training in the proper storage and administration of auto-injectable epinephrine [.~~

~~3.] ***or an opioid antagonist, as applicable.***~~

~~***4.*** A school nurse or other trained employee may administer auto-injectable epinephrine ***or an opioid antagonist*** maintained at the school to any pupil on the premises of the private school during regular school hours whom the school nurse or other trained employee reasonably believes is experiencing anaphylaxis [.~~

~~4.] ***or an opioid-related drug overdose, as applicable.***~~

~~***5.*** A private school shall ensure that auto-injectable epinephrine ***or any opioid antagonist*** maintained at the school is stored in a designated, secure location that is unlocked and easily accessible.~~

~~***6. As used in this section:***~~

(a) "Health care professional" has the meaning ascribed to it in NRS 453C.030.

(b) "Opioid antagonist" has the meaning ascribed to it in NRS 453C.040.

(c) "Opioid-related drug overdose" has the meaning ascribed to it in NRS 453C.050.] **(Deleted by amendment.)**

Sec. 9. [NRS 639.2357 is hereby amended to read as follows:

639.2357 1. Upon the request of a patient, or a public or private school or an authorized entity for which an order was issued pursuant to NRS 630.374, 632.239 [or] , 633.707 [,] *or section 1 of this act,* a registered pharmacist shall transfer a prescription or order to another registered pharmacist.

2. A registered pharmacist who transfers a prescription or order pursuant to subsection 1 shall comply with any applicable regulations adopted by the Board relating to the transfer.

3. The provisions of this section do not authorize or require a pharmacist to transfer a prescription or order in violation of:

(a) Any law or regulation of this State;

(b) Federal law or regulation; or

(c) A contract for payment by a third party if the patient is a party to that contract.

4. A pharmacist is not liable for any error or omission concerning the acquisition, possession, provision or administration of auto-injectable epinephrine *or an opioid antagonist* that the pharmacist has dispensed to a public or private school or authorized entity pursuant to an order issued pursuant to NRS 630.374, 632.239 [or] , 633.707 *or section 1 of this act* not resulting from gross negligence or reckless, willful or wanton conduct of the pharmacist.

5. As used in this section [, "authorized] *:*

(a) "Authorized entity" has the meaning ascribed to it in NRS 450B.710.

(b) "Opioid antagonist" has the meaning ascribed to it in NRS 453C.040.] **(Deleted by amendment.)**

Sec. 10. [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.] **(Deleted by amendment.)**

Sec. 11. This act becomes effective:

1. 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

2. On July 1, 2017, for all other purposes.

Assemblyman Sprinkle moved the adoption of the amendment.

Amendment adopted.

Bill ordered reprinted, engrossed and to third reading.

MOTIONS, RESOLUTIONS AND NOTICES

Assemblywoman Carlton moved that upon return from the printer, Assembly Bills Nos. 370 and 428 be rereferred to the Committee on Ways and Means.

Motion carried.

Assemblywoman Benitez-Thompson moved that Assembly Bills Nos. 26, 101, 242, 253, and 298 be taken from their positions on the General File and placed after Assembly Bill No. 485 on the General File.

Motion carried.

Assemblywoman Benitez-Thompson moved that Assembly Joint Resolution No. 10 be taken from its position on the General File and placed at the top of the General File.

Motion carried.

GENERAL FILE AND THIRD READING

Assembly Joint Resolution No. 10.

Resolution read third time.

Remarks by Assemblymen Brooks, Edwards, Marchant, Hansen, Elliot Anderson, and Fumo.

ASSEMBLYMAN BROOKS:

Assembly Joint Resolution No. 10 expresses opposition to the development of a repository for spent nuclear fuel and high-level radioactive waste at Yucca Mountain in the state of Nevada. The resolution protests any attempt by the United States Congress to move forward with the repository for spent nuclear fuel and high-level radioactive waste at the site; calls on the President of the United States to veto legislation that would locate such waste in this state; and calls on the Secretary of Energy to find the proposed repository unsuitable, abandon consideration of Yucca Mountain as a site, and initiate a process to find alternative strategies for dealing with such waste.

As a fourth generation Nevadan, it is disturbing to me that Washington is even considering ignoring years of bipartisan work to end any kind of licensing at Yucca Mountain. This resolution is now more important than ever. Congress needs to understand the severity of the situation. Reviving the licensing process to store nuclear waste at Yucca Mountain is not only dangerous for Nevada's health and safety, but it will be catastrophic for Nevada's tourism economy.

ASSEMBLYMAN EDWARDS:

My professional training as a naval officer included defending against and surviving a nuclear attack on my ship. In fact, it was my job to make sure that happened. The training showed me the real dangers of nuclear power. It also showed me that we could safely control and manage nuclear energy. Suffice it to say that because of my professional education and Navy experience and because of my many friendships with nuclear engineers, I am keenly aware of the fearmongering, political posturing, hype, and gross misinformation that have permeated discussions about Yucca Mountain for years. If honesty is the best policy, then Yucca Mountain discussions have been some of the worst.

Here is the crux of the bill right now, though. The Governor has already spoken in opposition to Yucca. Senator Heller has also spoken against it. Dina Titus has also spoken against it. Nevada has already poked the Washington political bear about this three times, and many times throughout the years. If we keep poking at it, I believe we will get its attention, but probably not in the way you hope. For those who are not President Trump fans—and I am guessing there are

1 or 2 or 27—you need to consider how many pokes he and the Republican Congress will take before they do something. President Trump is a businessman at his core. Leaving tens of billions of dollars sitting in escrow or trust accomplishing nothing will not make sense to him. The law has long required the federal government to find a storage facility. Its failure to do so has resulted in multiple successful lawsuits. These lawsuits are costing us billions of dollars a year. Once President Trump puts these two pieces together, he may very well put those billions of dollars to use, whether we like it or not. Remember, too, that Yucca Mountain is on federal land that we do not control. The feds could force their plans on us and we would have no say. The result might not be a smart or mutually beneficial arrangement.

I believe that to keep Nevada in the decision-making process about Yucca, we should not poke the Administration. Assembly Joint Resolution 10, I believe, diminishes Nevada's role in the conversation and in that decision-making process. We could do a variety of things at Yucca aside from long-term nuclear storage. But if we keep poking the Republican majority and the Administration, we will get a response from an Administration that relishes counterpunching. Do you really want to risk that? There is no good reason for us to do this. This does not serve the interests of our constituents. Nevada has made its point about Yucca Mountain plenty already, and I fear that if we keep pushing, we might get counterpunched. I think it is fair to say that the Trump Administration is like no other. I believe that we need to adapt to the new reality and not poke it. Therefore, I would urge that we all vote no.

ASSEMBLYMAN MARCHANT:

I will also be voting no today, but not because I want Yucca Mountain to be a permanent repository of nuclear waste. I would like to take the opportunity, since President Trump may want to really do something about this, to talk to him about repurposing the plant to something that can benefit Nevada and allow us to make billions of dollars for the state of Nevada. That would be my goal—to convince President Trump to look at it in another way.

ASSEMBLYMAN HANSEN:

I actually rise in support of Assembly Joint Resolution 10. I believe right now that in Nevada, if we were to have a referendum on Yucca Mountain, I do not think there is any question that the citizens of the state of Nevada would oppose having the nuclear dump. I will say that in my own party, I will bet it is closer to 50-50. However, I think there is something very important about this whole issue that is beyond Yucca Mountain.

I think Nevadans have a right to determine how we use the public lands within the borders of the state of Nevada. There is a huge inconsistency in our body on these issues. On the one hand, we are going to say we do not want the federal government forcing Yucca Mountain down our throat, and on the other hand, we say these are federal public lands. There are 330 million Americans that essentially own the public lands in the state of Nevada. There are only 3 million Nevadans. So even if all Nevadans, every single one of them, said no, there are still 327 million Americans that have a right to use the public lands in the state of Nevada. If they decide they want to put all of their garbage into our backyard, that is their right because it is also their backyard. It is the old joke about democracy: What is democracy? It is two wolves and sheep voting on what to eat for lunch. In this case, it is 49 other states determining where to put the trash, and we are the one sheep.

I would say this: If we are going to be consistent, we have to have state control of the public lands within the state of Nevada. Right now in Nevada, we have 3 million acres that are tied up in the nuclear test range; we have 2.5 million acres that are tied up in wilderness study areas; we now have Gold Butte and Basin and Range National Monuments that were created with the stroke of a pen. Over a million acres were pretty much taken away from the rights of Nevadans. The naval test range in the Fallon area is going up to 900,000 acres of public lands that we are no longer going to be able to access.

If we are going to be consistent in this body, in 2013 we passed—and you were here, Mr. Speaker, at the time—we voted for A.B. 227 in which we called for a study for the state of Nevada to determine if it is feasible for us to transfer the public lands in Nevada to some level of state ownership. All 17 counties participated in this; all 17 counties supported it. It is feasible, it is something we should do. If this body is going to be consistent and say no to Yucca Mountain, then we better say yes to the idea of Nevada taking over more control of its own public lands.

Frankly, in a democracy when you are sharing the ownership of this land with 330 million other Americans, we really do not have a right to tell them no. They have every bit as much right to the ownership of this land as we do. On behalf of the state of Nevada, I urge my colleagues to vote yes on this, but then in the future when we have these other resolutions, we better be consistent. We cannot, on the one hand, salute the President for using the Antiquities Act to take away a million acres—

Mr. Speaker requested the privilege of the Chair for the purpose of making the following remarks:

SPEAKER FRIERSON:

We have three minutes, but I would also ask you to speak to the resolution and not to other bills.

ASSEMBLYMAN HANSEN:

Very good. I will jump on that, I promise, when that comes up in the next few days, Mr. Speaker. The bottom line is if we are going to be consistent in this body, we need to be consistent on all our public lands policies.

ASSEMBLYMAN ELLIOT ANDERSON:

For me, this issue is pretty simple. I would say to my colleagues that when it comes down to it, we do not get the benefits of energy from nuclear waste because we do not want it, so we should not be forced to take the negative side. The states that have decided to pursue nuclear energy as a policy should be the ones to deal with that nuclear waste. We have determined in our energy portfolio that we want to go with clean energy because we do not create those byproducts. It is only right that the states that have chosen to go with that type of energy policy should deal with the negative effects. It is just a bit of personal responsibility on their part that they need to take that waste and quit jamming it down our throats.

ASSEMBLYMAN FUMO:

I also rise in support of Assembly Joint Resolution 10. I, for one, am not afraid of a fight. I stand in support of A.J.R. 10. I do not see it as poking the Administration; I see it as standing up for what we think is right. It is frustrating to see politicians in Washington, D.C. completely ignoring the will and the safety of Nevadans.

Storing nuclear waste a hundred miles from Las Vegas in an unstable and unsuitable environment is incredibly dangerous, not to mention that it will threaten the lifeblood of our economy in Las Vegas, tourism. I am proud of all the Nevada elected officials for standing united with our federal delegation to work together across party lines to stop this and protect every Nevadan. We need to send a clear message to Congress that we will not stand for our state to be used as a dumping ground for nuclear waste. We need to pass A.J.R. 10.

Roll call on Assembly Joint Resolution No. 10:

YEAS—32.

NAYS—Edwards, Ellison, Krasner, Marchant, Oscarson, Wheeler—6.

EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.

Assembly Joint Resolution No. 10 having received a constitutional majority, Mr. Speaker declared it passed.

Resolution ordered transmitted to the Senate.

Assembly Bill No. 35.

Bill read third time.

Remarks by Assemblyman Daly.

ASSEMBLYMAN DALY:

Assembly Bill 35 expands the authority of Nevada's Commissioner of Insurance to examine and supervise insurers. The bill adopts portions of the National Association of Insurance Commissioners' [NAIC] Corporate Governance Annual Disclosure Model Act, which increases

the disclosure requirements for all insurers domiciled in Nevada. It also adopts portions of the NAIC's Insurance Holding Company System Regulatory Act, which allows the Commissioner to act as a supervisor for an internationally active insurance group in certain circumstances. Finally, A.B. 35 makes changes to provisions governing captive insurers, including, without limitation, state-chartered risk retention groups.

Roll call on Assembly Bill No. 35:
YEAS—36.
NAYS—Krasner, Marchant—2.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 35 having received a two-thirds majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 54.
Bill read third time.
Remarks by Assemblyman Ohrenschall.

ASSEMBLYMAN OHRENSCHALL:
Assembly Bill 54 revises the circumstances under which an employer is required to report certain accidents or motor vehicle crashes to the Division of Industrial Relations. The bill requires an employer to report an accident or crash if it results in the hospitalization of at least one employee, rather than the current standard of three or more. Additionally, if the accident or crash causes the loss of an eye or an amputation, the employer must report it to the Division within 24 hours.

Roll call on Assembly Bill No. 54:
YEAS—38.
NAYS—None.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 54 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 61.
Bill read third time.
Remarks by Assemblywoman Bustamante Adams.

ASSEMBLYWOMAN BUSTAMANTE ADAMS:
Assembly Bill 61 allows the Commissioner of Financial Institutions to authorize a foreign trust company licensed in another state and subject to federal regulation to act as a fiduciary, solicit business, and engage in the business of a trust company in Nevada without first obtaining a license in Nevada under certain circumstances. The bill also allows the Commissioner to authorize a foreign independent trust company, licensed in another state but not subject to federal regulation, to solicit business in Nevada without first obtaining a license in Nevada under certain circumstances.

Roll call on Assembly Bill No. 61:
YEAS—38.
NAYS—None.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 61 having received a two-thirds majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 64.
Bill read third time.
Remarks by Assemblyman Elliot Anderson.

ASSEMBLYMAN ELLIOT ANDERSON:
Assembly Bill 64 provides that a student with a disability who does not satisfy certain State Board of Education requirements for a standard high school diploma may receive a standard diploma by demonstrating proficiency through a portfolio of work, or may receive an adjusted diploma by satisfying the requirements of his or her individualized education program.

Roll call on Assembly Bill No. 64:
YEAS—38.
NAYS—None.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 64 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.
Assembly Bill No. 70.
Bill read third time.
Remarks by Assemblyman Flores.

ASSEMBLYMAN FLORES:
Assembly Bill 70 limits to 18 percent the amount of the property tax revenue collected in a redevelopment area that must be set aside to improve and preserve public educational facilities that are located within the redevelopment area or that serve pupils who reside within the redevelopment area. The bill also removes the requirement that the educational facilities be existing facilities, expands the purposes for which money may be spent in connection with such facilities, and authorizes such spending for facilities, educational programs, and activities that are located in or within one mile of the redevelopment area.

Roll call on Assembly Bill No. 70:
YEAS—34.
NAYS—Ellison, McArthur, Titus, Wheeler—4.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 70 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 89.
Bill read third time.
Remarks by Assemblyman Oscarson.

ASSEMBLYMAN OSCARSON:
Assembly Bill 89 prohibits the Department of Health and Human Services from suspending programs and duties relating to the collection and dissemination of information relating to surgical centers for ambulatory patients. In addition, the measure requires the Division of Public and Behavioral Health to submit a quarterly report to the Legislature concerning information submitted to the Division by a surgical center for ambulatory patients relating to the discharge location of its patients.
Just a quick mention to all those who came together and supported this. It was a long road but they did it. I appreciate the Nevada Hospital Association and the Nevada Ambulatory Surgery Center Association working together to make this happen.

Roll call on Assembly Bill No. 89:
YEAS—38.
NAYS—None.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 89 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 95.
Bill read third time.
Roll call on Assembly Bill No. 95:
YEAS—38.
NAYS—None.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 95 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 98.
Bill read third time.
Remarks by Assemblywoman Bustamante Adams.

ASSEMBLYWOMAN BUSTAMANTE ADAMS:
Assembly Bill 98, as amended, removes the limit on the number of people employed within the Office of Grant Procurement, Coordination and Management of the Department of Administration from two unclassified positions in addition to the Administrator and instead allows the Administrator to hire the necessary number of classified and unclassified employees within the limits of money appropriated or authorized.

Roll call on Assembly Bill No. 98:
YEAS—38.
NAYS—None.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 98 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 107.
Bill read third time.
Remarks by Assemblywoman Bilbray-Axelrod.

ASSEMBLYWOMAN BILBRAY-AXELROD:
Assembly Bill 107 provides that the eviction case court file in any action for summary eviction is automatically sealed if summary eviction is denied or dismissed or the landlord fails to file an affidavit of complaint as required.

Roll call on Assembly Bill No. 107:
YEAS—38.
NAYS—None.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.

Assembly Bill No. 107 having received a constitutional majority, Mr. Speaker declared it passed, as amended.

Bill ordered transmitted to the Senate.

Assembly Bill No. 117.

Bill read third time.

Remarks by Assemblyman Flores.

ASSEMBLYMAN FLORES:

Assembly Bill 117 requires school districts to adopt a policy ensuring that each student in grades 9 through 12 at a public high school will meet individually with an educational staff member at least once a year to review the student's academic plan. Such a meeting must use the student's academic records and the results of certain tests and assessments, if those results are available, to review areas of the student's academic strengths and weaknesses.

If it is determined that the student requires remediation, the staff member must coordinate with the student and his or her parent or guardian to revise the student's academic plan.

When we are not in this building, I am always visiting high schools and speaking to kids. I am very passionate about it. I think it is incredibly important. Mentoring is very important to me. One of the conversations we often have is what is your end goal, what is your objective after you graduate and they often say college. When I ask them Do you know the process, do you know what you need in order for you to go to whatever university you want, they always say no. They have no idea because they have never sat down and done that roadmap.

I know some colleagues in here are intending to vote no because you think this is an unfunded mandate, but it is not. Already by law, in NRS [*Nevada Revised Statutes*], there must be an academic plan that must be visited every single year. That is already in the law. They have to do that already. All I am saying is, when you meet and have that academic plan reviewed, you have this conversation about the roadmap to where you are going, whether it is a trade school, or UNLV [University of Nevada, Las Vegas], or Harvard, or UNR [University of Nevada, Reno]. So I urge those of you considering voting no because you think it is an unfunded mandate, it is not. I would really appreciate your support on this bill.

Roll call on Assembly Bill No. 117:

YEAS—33.

NAYS—Ellison, Marchant, McArthur, Titus, Wheeler—5.

EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.

Assembly Bill No. 117 having received a constitutional majority, Mr. Speaker declared it passed, as amended.

Bill ordered transmitted to the Senate.

Assembly Bill No. 125.

Bill read third time.

Remarks by Assemblywoman Diaz.

ASSEMBLYWOMAN DIAZ:

Assembly Bill 125 changes provisions related to court interpreters. The Court Administrator is required to adopt regulations for a program to certify or register court interpreters for persons with limited English proficiency who are witnesses, defendants, and litigants. The measure provides that a court interpreter is required to obtain a certificate or registration. In addition, provisions relating to the appointment of alternate court interpreters are removed. Lastly, a court will appoint an interpreter if a certified or registered court interpreter is not available.

I want to clarify for my colleagues that this is a bright line. We as a state are saying that in order for someone to be competent to interpret in a court proceeding, they should be certified or they should be registered. In my eyes, it is not valid for someone who does not have the competency to do the interpreting to be appointed to do so. We as legislators are saying that this

is what all courts in our state should strive to provide for limited English proficient people. I would also like to remind my colleagues that through the amendment, I did remove the part about having to be applied to civil proceedings and I hope that everyone supports this measure.

Roll call on Assembly Bill No. 125:
YEAS—38.
NAYS—None.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 125 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 128.
Bill read third time.
Roll call on Assembly Bill No. 128:
YEAS—38.
NAYS—None.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 128 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 133.
Bill read third time.
Remarks by Assemblyman Elliot Anderson.

ASSEMBLYMAN ELLIOT ANDERSON:
Assembly Bill 133, among other things, provides that a request for emergency assistance by a tenant does not constitute a nuisance.
It may not be completely clear about why I am doing this based upon reading the measure, so I thought I would speak. This is a bill to protect victims of crime, particularly victims who have suffered domestic violence. In a number of other states and municipalities, landlords have gone after victims of domestic violence for repeatedly calling police, even though they were making those calls in good faith. The bill is supported by local governments, after the amendments. Thank you, and I would appreciate your support.

Roll call on Assembly Bill No. 133:
YEAS—37.
NAYS—Ellison.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 133 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 135.
Bill read third time.
Remarks by Assemblymen Yeager, Tolles, and Mr. Speaker.

ASSEMBLYMAN YEAGER:
Assembly Bill 135 deals with prosecutions involving driving under the influence of a controlled substance as well as boating under the influence of a controlled substance. The measure does two things. It eliminates urine tests so that blood tests would be required for

prosecutions, and the second thing that is does is require that a certain marijuana metabolite be tested for. That is a marijuana metabolite that is scientifically proven to actually impair a driver.

I know there have been some concerns expressed about Assembly Bill 135 as it may relate to workers' compensation. Although this bill deals with prosecutions for driving under the influence, I realize there are some concerns, and I am committed to working with folks that have expressed those concerns to try and have those resolved by the end of session.

Mr. Speaker requested the privilege of the Chair for the purpose of making the following remarks:

I also agreed to provide an opportunity to address the workers' compensation implications as they were not relevant to this particular bill, but something that had a tangential effect that we will certainly address.

ASSEMBLYWOMAN TOLLES:

I also rise in support of Assembly Bill 135 because it does provide law enforcement with a more accurate measure of driving impairments. I do share those concerns about the potential impact on workers' compensation regulations and will join you all in working to address those concerns in legislation relating to those corresponding chapters.

Roll call on Assembly Bill No. 135:

YEAS—34.

NAYS—Ellison, Marchant, McArthur, Titus—4.

EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.

Assembly Bill No. 135 having received a constitutional majority, Mr. Speaker declared it passed, as amended.

Bill ordered transmitted to the Senate.

Assembly Bill No. 150.

Bill read third time.

Remarks by Assemblyman Sprinkle.

ASSEMBLYMAN SPRINKLE:

Assembly Bill 150 makes changes to the regulation of private professional guardians, including revising the qualifications needed for a person to serve as a private professional guardian. Each entity that serves as a private professional guardian must employ a private professional guardian who is certified by the Center for Guardianship Certification. The measure also requires certain persons working for a private professional guardian entity to submit fingerprints to the Division of Financial Institutions every five years.

Roll call on Assembly Bill No. 150:

YEAS—38.

NAYS—None.

EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.

Assembly Bill No. 150 having received a two-thirds majority, Mr. Speaker declared it passed, as amended.

Bill ordered transmitted to the Senate.

Assembly Bill No. 169.

Bill read third time.

Remarks by Assemblyman Carrillo.

ASSEMBLYMAN CARRILLO:

Assembly Bill 169 provides that a county recorder has the discretion to accept and record a document that does not meet formatting requirements and removes the fee charged for such documents. The bill also sets the recording fee for certain documents at $25 and $1 per page for

copying a record. Finally, the bill increases the additional fee collected for recording certain documents from $3 to $5. This bill is effective on October 1, 2017.

Roll call on Assembly Bill No. 169:
YEAS—33.
NAYS—Krasner, Marchant, McArthur, Titus, Wheeler—5.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 169 having received a two-thirds majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 173.
Bill read third time.
Remarks by Assemblywoman Krasner.

ASSEMBLYWOMAN KRASNER:
Assembly Bill 173 changes the requirements for applying for a name change. The applicant for a name change must submit with the verified petition to the district court a statement signed under penalty of perjury that the applicant is not changing his or her name for a fraudulent purpose. In addition, the requirement that an applicant publish a notice of the name change in a newspaper of general circulation in the county once a week for three weeks in a row is changed to one time.

Roll call on Assembly Bill No. 173:
YEAS—37.
NAYS—Pickard.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 173 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 180.
Bill read third time.
Remarks by Assemblywoman Monroe-Moreno.

ASSEMBLYWOMAN MONROE-MORENO:
Assembly Bill 180 enacts the Juvenile Justice Bill of Rights. The measure sets forth certain rights of a child who is detained in a detention facility and requires the facility to inform the child of those rights. However, reasonable restrictions on the rights of a child may be imposed if those restrictions are necessary to preserve order, security, or safety. A child who believes that his or her rights have been violated is authorized to raise and redress a grievance. Lastly, each detention facility must establish policies to ensure that a child who is detained has timely access to clinically appropriate psychotropic medication. This bill is effective on July 1, 2017.

Roll call on Assembly Bill No. 180:
YEAS—38.
NAYS—None.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 180 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 190.
Bill read third time.
Remarks by Assemblywoman Diaz.

ASSEMBLYWOMAN DIAZ:
Assembly Bill 190 expands certain statutory requirements related to the completion of safety and health hazard recognition and prevention training to workers and supervisors at sites related to the entertainment industry. Not later than 15 days after an individual is hired, a worker or supervisory employee is required to obtain a card stating that he or she has completed an approved training course, and the completion card must be presented to the employer. If a worker or supervisory employee fails to do so, the employer must suspend or terminate the employment of the individual. The bill provides that an employer who fails to suspend or terminate an employee, as required, is subject to an administrative fine.

The measure also provides that for the first year after the effective date of the bill, employees may satisfy the safety training requirements by completing an alternative course provided by an employer, and it requires such an employer to maintain certain records. Finally, A.B. 190 requires the Division of Industrial Relations of Nevada's Department of Business and Industry to approve courses for fulfilling the requirements of the bill and directs the Division to establish a registry of providers of approved courses. This bill is effective on January 1, 2018. The provisions of the bill allowing an employee to satisfy the safety training requirements by completing an alternative course provided by an employer expire on December 31, 2018.

Roll call on Assembly Bill No. 190:
YEAS—33.
NAYS—Hansen, Marchant, McArthur, Titus, Wheeler—5.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.

Assembly Bill No. 190 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 196.
Bill read third time.
Remarks by Assemblyman McCurdy.

ASSEMBLYMAN MCCURDY:
Assembly Bill 196 requires the Commission on Professional Standards in Education to establish by regulation the requirements for a teacher, administrator, or other educator to obtain an endorsement in cultural competency on his or her license.

Cultural competency is a key in today's culturally diverse classrooms. It can be learned and practiced to better serve diverse students, their families, and their communities. I urge all my colleagues to support this piece of legislation. Thank you.

Roll call on Assembly Bill No. 196:
YEAS—32.
NAYS—Ellison, Hansen, Marchant, McArthur, Titus, Wheeler—6.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.

Assembly Bill No. 196 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

Assembly Bill No. 218.
Bill read third time.

Roll call on Assembly Bill No. 218:
YEAS—37.
NAYS—Titus.
EXCUSED—Paul Anderson, Araujo, Hambrick, Woodbury—4.
Assembly Bill No. 218 having received a constitutional majority, Mr. Speaker declared it passed, as amended.
Bill ordered transmitted to the Senate.

MOTIONS, RESOLUTIONS AND NOTICES

Assemblywoman Benitez-Thompson moved that Assembly Bills Nos. 26, 101, 228, 231, 232, 235, 241, 242, 244, 246, 253, 255, 286, 297, 298, 304, 310, 316, 317, 324, 340, 346, 347, 350, 356, 372, 376, 393, 410, 412, 424, 427, 444, 445, 455, 459, and 485; Assembly Joint Resolutions Nos. 4, 9, 11, and 13; Assembly Joint Resolution No. 10 of the 78th Session be taken from the General File and placed on the General File for the next legislative day.
Motion carried.

GUESTS EXTENDED PRIVILEGE OF ASSEMBLY FLOOR

On request of Assemblywoman Krasner, the privilege of the floor of the Assembly Chamber for this day was extended to Gerald O'Driscoll and Maralene Martin.

Assemblywoman Benitez-Thompson moved that the Assembly adjourn until Monday, April 24, 2017, at 2 p.m.
Motion carried.

Assembly adjourned at 1:32 p.m.

Approved: JASON FRIERSON
Speaker of the Assembly

Attest: SUSAN FURLONG
Chief Clerk of the Assembly