

(Reprinted with amendments adopted on May 17, 2021)

FIRST REPRINT

S.B. 420

SENATE BILL NO. 420—SENATORS CANNIZZARO, DONATE, LANGE,  
SPEARMAN; BROOKS, DENIS, DONDERO LOOP, D. HARRIS,  
OHRENSCHALL, RATTI AND SCHEIBLE

APRIL 28, 2021

JOINT SPONSORS: ASSEMBLYMEN  
BENITEZ-THOMPSON AND FRIERSON

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to health insurance.  
(BDR 57-251)

FISCAL NOTE: Effect on Local Government: Increases or Newly  
Provides for Term of Imprisonment in County or City  
Jail or Detention Facility.  
Effect on the State: Yes.

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

AN ACT relating to insurance; providing for the establishment of a public health benefit plan; prescribing certain goals and requirements relating to the plan; requiring certain health carriers to participate in a competitive bidding process to administer the plan; requiring certain providers of health care to participate in the plan; exempting rules and policies governing the plan from certain requirements; requiring the Executive Director of the Silver State Health Insurance Exchange to apply for a federal waiver to allow certain policies to be offered on the Exchange; requiring certain persons to report the abuse and neglect of older persons, vulnerable persons and children; requiring the State Plan for Medicaid to include certain coverage relating to pregnant women; requiring the establishment of a statewide Medicaid managed care program; and providing other matters properly relating thereto.



\* S B 4 2 0 R 1 \*

**Legislative Counsel's Digest:**

Existing law requires the Department of Health and Human Services to administer the Medicaid program, which is a joint program of the state and federal governments to provide health coverage to indigent persons. (NRS 422.270, 439B.120) Existing law also creates the Silver State Health Insurance Exchange to assist natural persons and small businesses in purchasing health coverage. (Chapter 695I of NRS) **Section 10** of this bill requires the Director of the Department, in consultation with the Executive Director of the Exchange and the Commissioner of Insurance, to design, establish and operate a public health benefit plan known as the Public Option. **Section 2** of this bill sets forth the purposes of the Public Option, and **sections 3.5-9** of this bill define terms relevant to the Public Option. **Section 10** requires the Public Option to be available to all natural persons who reside in this State through the Exchange and for direct purchase and authorizes the Director to make the Public Option available to small employers in this State or their employees. **Section 10** requires the Public Option to meet the requirements established by federal and state law for individual health insurance or health insurance for small employers where applicable. **Section 10** also establishes requirements governing the levels of coverage provided by the Public Option and the premiums for the Public Option. **Sections 38 and 41** of this bill remove the requirements relating to premiums on January 1, 2030. **Section 11** of this bill requires the Director, the Commissioner and the Executive Director of the Exchange to apply for certain waivers to obtain federal financial support for the Public Option. **Section 12** of this bill requires the Director to use a statewide competitive bidding process to solicit and enter into contracts with health carriers and other qualified persons to administer the Public Option. **Section 12** requires a health carrier that provides health care services to recipients of Medicaid through managed care to participate in the competitive bidding process. **Section 12** additionally authorizes the Director to directly administer the Public Option if necessary. **Sections 13, 21 and 29** of this bill require providers of health care, including health care facilities, who participate in Medicaid or the Public Employees' Benefits Program or provide care to injured employees under the State's workers' compensation program to enroll in the Public Option as a participating provider of health care. **Section 14** of this bill prescribes requirements governing the establishment of networks and the reimbursement of providers under the Public Option. **Section 15** of this bill establishes the Public Option Trust Fund to hold certain funds for the purpose of implementing the Public Option. **Section 20** of this bill exempts rules and policies governing the Public Option from provisions governing notice-and-comment rulemaking. **Sections 16, 19, 22, 32 and 34-37** of this bill make various changes so that the Public Option is treated similarly to comparable forms of public health insurance.

**Section 16.5** of this bill requires the Executive Director of the Exchange to apply to the federal government for a waiver to authorize certain labor, agricultural and horticultural organizations to offer on the Exchange a policy of insurance to meet the unique needs of tradespersons that can serve as an alternative to the continuation of certain group health benefits. **Section 16.5** requires such a policy to be annually certified by the Executive Director in order to be offered on the Exchange. **Sections 16.3 and 16.8** of this bill make conforming changes to reflect the fact that a policy of insurance offered pursuant to **section 16.5** may not meet all requirements: (1) for individual health insurance prescribed by state law; or (2) to be considered a qualified health plan under federal law. **Section 39.5** of this bill requires the Executive Director to apply for the waiver and submit certain recommendations concerning such policies to the Legislature on or before January 1, 2025.

**Sections 24-28** of this bill expand coverage under Medicaid in various manners. Specifically, **section 24** of this bill requires the Director of the



Department to expand coverage under the State Plan for Medicaid for pregnant women by: (1) providing coverage for pregnant women whose household income is between 165 percent and 200 percent of the federally designated level signifying poverty; (2) providing that pregnant women who are determined by certain entities to qualify for Medicaid are presumptively eligible for Medicaid for a prescribed period of time, without submitting an application for enrollment in Medicaid which includes additional proof of eligibility; and (3) prohibiting the imposition of a requirement that a pregnant woman who is otherwise eligible for Medicaid must reside in the United States for a prescribed period of time before enrolling in Medicaid. **Section 25** of this bill requires Medicaid to cover the services of a community health worker who provides services under the supervision of a physician, physician assistant or advanced practice registered nurse. **Section 26** of this bill requires Medicaid to cover certain costs for doula services provided to Medicaid recipients by a doula who has enrolled with the Division of Health Care Financing and Policy of the Department. **Sections 17 and 33** of this bill require a registered doula to report the suspected abuse, neglect, exploitation, isolation or abandonment of older or vulnerable persons or the suspected abuse or neglect of a child. **Section 27** of this bill requires Medicaid to reimburse services provided to recipients of Medicaid who do not receive services through managed care by an advanced practice registered nurse to the same extent as if those services were provided by a physician. **Section 28** of this bill requires Medicaid to cover breastfeeding supplies, certain prenatal screenings and tests and lactation consultation and support. **Section 18** of this bill makes a conforming change to indicate the proper placement of **sections 24-28** in the Nevada Revised Statutes.

Existing law establishes certain requirements that apply if a Medicaid managed care program is established in this State. (NRS 422.273) **Section 30** of this bill requires the Department to: (1) establish such a program to provide health care services to recipients of Medicaid in all geographic areas of this State; and (2) conduct a statewide procurement process to select health maintenance organizations to provide such services. **Section 30** requires the Medicaid managed care program to include a state-directed payment arrangement to require Medicaid managed care organizations to reimburse critical access hospitals and any affiliated federally-qualified health centers or rural health clinics for covered services at a rate that is equal to or greater than the rate those facilities receive for services provided to recipients of Medicaid on a fee-for-service basis. **Section 31** of this bill makes a conforming change to reflect that the Department is required by **section 30** to establish a Medicaid managed care program.

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

**Section 1.** Title 57 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 2 to 15, inclusive, of this act.

**Sec. 2. *It is hereby declared to be the purpose and policy of the Legislature in enacting this chapter to:***

***1. Leverage the combined purchasing power of the State to lower premiums and costs relating to health insurance for residents of this State;***



2. *Improve access to high-quality, affordable health care for residents of this State, including residents of this State who are employed by small businesses;*

3. *Reduce disparities in access to health care and health outcomes and increase access to health care for historically marginalized communities; and*

4. *Increase competition in the market for individual health insurance in this State to improve the availability of coverage for residents of rural areas of this State.*

**Sec. 3.** *As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 3.5 to 9, inclusive, of this act have the meanings ascribed to them in those sections.*

**Sec. 3.5.** *“Certified community behavioral health clinic” means a community behavioral health clinic certified in accordance with section 223 of the Protecting Access to Medicare Act of 2014, Public Law No. 113-93.*

**Sec. 4.** *“Commissioner” means the Commissioner of Insurance.*

**Sec. 5.** *“Director” means the Director of the Department of Health and Human Services.*

**Sec. 6.** *“Exchange” means the Silver State Health Insurance Exchange.*

**Sec. 6.5.** *“Federally qualified health center” has the meaning ascribed to it in 42 C.F.R. § 405.2401.*

**Sec. 7.** *“Provider of health care” has the meaning ascribed to it in NRS 695G.070.*

**Sec. 8.** *“Public Option” means the Public Option established pursuant to section 10 of this act.*

**Sec. 8.5.** *“Rural health clinic” has the meaning ascribed to it in 42 C.F.R. § 405.2401.*

**Sec. 9.** *“Trust Fund” means the Public Option Trust Fund created by section 15 of this act.*

**Sec. 10. 1.** *The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall design, establish and operate a health benefit plan known as the Public Option.*

**2.** *The Director:*

*(a) Shall make the Public Option available to all natural persons who reside in this State as a policy of individual health insurance through the Exchange and for direct purchase. The provisions of chapter 689A of NRS and other applicable provisions of title 57 of NRS apply to the Public Option when offered as a policy of individual health insurance.*



(b) May make the Public Option available to small employers in this State or their employees to the extent authorized by federal law. The provisions of chapter 689C of NRS and other applicable provisions of title 57 of NRS apply to the Public Option when it is offered as a policy of health insurance for small employers.

(c) Shall comply with all state and federal laws and regulations applicable to insurers when carrying out the provisions of sections 2 to 15, inclusive, of this act, to the extent that such laws and regulations are not waived.

3. The Public Option must:

(a) Be a qualified health plan, as defined in 42 U.S.C. § 18021; and

(b) Provide at least levels of coverage consistent with the actuarial value of one silver plan and one gold plan.

4. Except as otherwise provided in this section, the premiums for the Public Option:

(a) Must be at least 5 percent lower than the reference premium for that zip code; and

(b) Must not increase in any year by a percentage greater than the increase in the Medicare Economic Index for that year.

5. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, may revise the requirements of subsection 4, provided that the average premiums for the Public Option must decrease by at least 15 percent over the first 4 years in which the Public Option is in operation.

6. As used in this section:

(a) “Gold plan” means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a gold level plan.

(b) “Health benefit plan” means a policy, contract, certificate or agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(c) “Medicare Economic Index” means the Medicare Economic Index, as designated by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services pursuant to 42 C.F.R. § 405.504.

(d) “Reference premium” means, for any zip code, the lower of:

(1) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the 2024 plan year, adjusted by the percentage change in the Medicare Economic Index between January 1, 2024, and January 1 of the year to which a premium applies; or



(2) *The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the year immediately preceding the year to which a premium applies.*

(e) *“Silver plan” means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a silver level plan.*

(f) *“Small employer” has the meaning ascribed to it in 42 U.S.C. § 18024(b)(2).*

**Sec. 11.** *1. The Director, the Commissioner and the Executive Director of the Exchange:*

(a) *Shall collaborate to apply to the Secretary of Health and Human Services for a waiver pursuant to 42 U.S.C. § 18052 to obtain pass-through federal funding to carry out the provisions of sections 2 to 15, inclusive, of this act; and*

(b) *May collaboratively apply to the Secretary of Health and Human Services for any other federal waivers or approval necessary to carry out the provisions of sections 2 to 15, inclusive, of this act, including, without limitation, and to the extent necessary, a waiver pursuant to 42 U.S.C. § 1315 of Title XIX of the Social Security Act. Such waivers or approval may include, without limitation, any waiver or approval necessary to:*

(1) *Combine risk pools for the Public Option with risk pools established for Medicaid, if the Director can demonstrate that doing so would lower costs, result in savings to the federal and state governments and not increase the costs of private insurance or Medicaid; or*

(2) *Obtain federal financial participation to subsidize the cost of health insurance for residents of this State with low incomes.*

2. *In preparing an application for any waiver described in subsection 1, the Director, the Commissioner and the Executive Director of the Exchange may contract with an independent actuary to assess the impact of the Public Option on the markets for health care and health insurance in this State and health coverage for natural persons, families and small businesses. The actuary must have specialized expertise or experience with state health insurance exchanges, the type of waiver for which the application is being made, measures to contain the costs of providing health coverage, reforming procedures for the purchasing and delivery of government services and Medicaid managed care programs. A contract pursuant to this subsection is exempt from the provisions of chapter 333 of NRS.*

3. *The Director, the Commissioner and the Executive Director of the Exchange shall:*



(a) Cooperate with the Federal Government in obtaining any waiver for which he or she applies pursuant to this section.

(b) Deposit any money received from the Federal Government pursuant to such a waiver in the Trust Fund.

4. The Director may:

(a) Accept gifts, grants and donations to carry out the provisions of sections 2 to 15, inclusive, of this act. The Director shall deposit any such gifts, grants or donations in the Trust Fund.

(b) Employ or enter into contracts with actuaries and other professionals and may enter into contracts with other state agencies, health carriers or other qualified persons and entities as are necessary to carry out the provisions of sections 2 to 15, inclusive, of this act. Such contracts are exempt from the requirements of chapter 333 of NRS.

**Sec. 12.** 1. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall use a statewide competitive bidding process, including, without limitation, a request for proposals, to solicit and enter into contracts with health carriers or other qualified persons or entities to administer the Public Option. The competitive bidding process must coincide with the statewide procurement process for the Medicaid managed care program established pursuant to NRS 422.273.

2. Each health carrier that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program shall, as a condition of continued participation in the Medicaid managed care program established pursuant to NRS 422.273, submit a good faith proposal in response to a request for proposals issued pursuant to subsection 1.

3. Each proposal submitted pursuant to subsection 2 must demonstrate that the applicant is able to meet the requirements of section 10 of this act.

4. When selecting a health carrier or other qualified person or entity to administer the Public Option, the Director shall prioritize applicants whose proposals:

(a) Demonstrate alignment of networks of providers between the Public Option and the Medicaid managed care program established pursuant to NRS 422.273;

(b) Provide for the inclusion of critical access hospitals, rural health clinics, certified community behavioral health clinics and federally-qualified health centers in the networks of providers for the Public Option and Medicaid managed care program established pursuant to NRS 422.273;



(c) Include proposals for strengthening the workforce in this State and particularly in rural areas of this State for providers of primary care, mental health care and treatment for substance use disorders;

(d) Use payment models for providers included in the networks of providers for the Public Option that increase value for persons enrolled in the Public Option and the State; and

(e) Include proposals to contract with providers of health care in a manner that decreases disparities among different populations in this State with regard to access to health care and health outcomes and supports culturally competent care.

5. Notwithstanding the provisions of subsections 1 to 4, inclusive, the Director may directly administer the Public Option if necessary to carry out the provisions of sections 2 to 15, inclusive, of this act.

6. The Director shall deposit into the Trust Fund any money received from:

(a) A health carrier or other person or entity with which the Director contracts to administer the Public Option pursuant to subsection 1 which relates to duties performed under the contract; or

(b) If the Director directly administers the Public Option pursuant to subsection 5, any money received from any person or entity in the course of administering the Public Option.

7. As used in this section:

(a) "Critical access hospital" means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).

(b) "Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including, without limitation, a sickness and accident health insurance company, a health maintenance organization, a nonprofit hospital and health service corporation or any other entity providing a plan of health insurance, health benefits or health care services.

**Sec. 13.** 1. Except as otherwise provided in subsection 2, each provider of health care who participates in the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043 or the Medicaid program, or who provides care to an injured employee pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, shall:

(a) Enroll as a participating provider in at least one network of providers established for the Public Option; and





(b) Accept new patients who are enrolled in the Public Option to the same extent as the provider or facility accepts new patients who are not enrolled in the Public Option.

2. The Director and the Executive Officer of the Public Employees' Benefits Program may waive the requirements of subsection 1 when necessary to ensure that recipients of Medicaid and officers, employees and retirees of this State who receive benefits under the Public Employees' Benefits Program have sufficient access to covered services.

**Sec. 14. 1.** In establishing networks for the Public Option and reimbursing providers of health care that participate in the Public Option, the Director shall, to the extent practicable:

(a) Ensure that care for persons who were previously covered by Medicaid or the Children's Health Insurance Program and enroll in the Public Option is minimally disrupted;

(b) Encourage the use of payment models that increase value for persons enrolled in the Public Option and the State;

(c) Improve health outcomes for persons enrolled in the Public Option;

(d) Reward providers of health care and medical facilities for delivering high-quality services; and

(e) Lower the cost of care in both urban and rural areas of this State.

2. Except as otherwise provided in subsections 3 to 6, inclusive, reimbursement rates under the Public Option must be, in the aggregate, comparable to or better than reimbursement rates available under Medicare. For the purposes of this section, the aggregate reimbursement rate under Medicare:

(a) Includes any add-on payments or other subsidies that a provider receives under Medicare; and

(b) Does not include payments under Medicare for a patient encounter or a cost-based payment rate under Medicare.

3. If a provider of health care currently receives reimbursement under Medicare at rates that are cost-based, the reimbursement rates for that provider of health care under the Public Option must be comparable to or better than the cost-based reimbursement rates provided for that provider of health care by Medicare.

4. The reimbursement rates for a federally-qualified health center or a rural health clinic under the Public Option must be comparable to or better than the reimbursement rates established for patient encounters under the applicable Prospective Payment System established for Medicare by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.



5. The reimbursement rates for a certified community behavioral health clinic under the Public Option must be comparable to or better than the reimbursement rates established for community behavioral health clinics under the State Plan for Medicaid.

6. The requirements of subsections 2 to 5, inclusive, do not apply to a payment model described in paragraph (b) of subsection 1.

7. As used in this section, “Medicare” means the program of health insurance for aged persons and persons with disabilities established pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq.

**Sec. 15.** 1. There is hereby created in the State Treasury the Public Option Trust Fund as a nonreverting trust fund. The Trust Fund must be administered by the State Treasurer.

2. The Trust Fund consists of:

(a) Any money deposited in the Trust Fund pursuant to sections 11 and 12 of this act;

(b) Any money appropriated by the Legislature for the purpose of carrying out the provisions of sections 2 to 15, inclusive, of this act; and

(c) All income and interest earned on the money in the Trust Fund.

3. Any interest earned on money in the Trust Fund, after deducting any applicable charges, must be credited to the Trust Fund. Money that remains in the Trust Fund at the end of a fiscal year does not revert to the State General Fund, and the balance in the Trust Fund must be carried forward to the next fiscal year.

4. Except as otherwise provided in subsection 5, the money in the Trust Fund must be used to carry out the provisions of sections 2 to 15, inclusive, of this act. Such money must not be used to pay administrative costs that are not directly related to the operations of the Public Option.

5. If the State Treasurer determines that there is sufficient money in the Trust Fund to carry out the provisions of sections 2 to 15, inclusive, of this act, for the current fiscal year, the Director may use a portion determined by the State Treasurer of any additional money in the Trust Fund to increase the affordability of the Public Option.

**Sec. 16.** NRS 683A.176 is hereby amended to read as follows:  
683A.176 “Third party” means:

1. An insurer, as that term is defined in NRS 679B.540;

2. A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides a pharmacy benefits plan;



3. A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~for~~

4. *The Public Option established pursuant to section 10 of this act; or*

5. Any other insurer or organization that provides health coverage or benefits or coverage of prescription drugs as part of workers' compensation insurance in accordance with state or federal law.

➤ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

**Sec. 16.3.** NRS 689A.020 is hereby amended to read as follows:

689A.020 Nothing in this chapter applies to or affects:

1. Any policy of liability or workers' compensation insurance with or without supplementary expense coverage therein.

2. Any group or blanket policy.

3. Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to health insurance as to:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(b) Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

4. Reinsurance, except as otherwise provided in NRS 689A.470 to 689A.740, inclusive, and 689C.610 to 689C.940, inclusive, relating to the program of reinsurance.

5. *Any policy of insurance offered on the Silver State Health Insurance Exchange in accordance with section 16.5 of this act.*

**Sec. 16.5.** Chapter 695I of NRS is hereby amended by adding thereto a new section to read as follows:

1. *The Executive Director, in collaboration with the Director of the Department of Health and Human Services, shall apply to the Secretary of Health and Human Services for a waiver pursuant to 42 U.S.C. § 18052 to authorize an organization described in section 501(c)(5) of the Internal Revenue Code that processes health claims in this State to offer on the Exchange a policy of insurance to meet the unique needs of tradespersons, including, without limitation, persons who work temporary or seasonal jobs, that is capable of serving as an alternative to the*



1 continuation of group health benefits under the Consolidated  
2 Omnibus Budget Reconciliation Act of 1985.

3 2. The application for a waiver submitted pursuant to  
4 subsection 1 must include, without limitation, an application for a  
5 waiver of any provisions of federal law or regulations that would  
6 otherwise require a policy described in subsection 1 to meet the  
7 requirements of chapter 689A of NRS in order to be offered on the  
8 Exchange or for persons who purchase the plan on the Exchange  
9 to receive applicable federal subsidies.

10 3. To be offered on the Exchange, a policy of insurance  
11 described in subsection 1 must:

12 (a) Meet all requirements established by the Federal Act for a  
13 qualified health plan, to the extent that those requirements do not  
14 prevent an organization described in section 501(c)(5) of the  
15 Internal Revenue Code from offering such a policy; and

16 (b) Be certified by the Executive Director. Such certification  
17 must be renewed annually.

18 4. The Executive Director shall prescribe:

19 (a) Requirements for certification of a policy of insurance  
20 pursuant to paragraph (b) of subsection 3; and

21 (b) Criteria to determine when a person becomes eligible for a  
22 policy of insurance described in subsection 1. Those criteria must  
23 address:

24 (1) Persons who recently began employment but have not  
25 yet met the requirements concerning hours of work necessary to  
26 receive insurance through their employer; and

27 (2) Persons who have recently lost their jobs.

28 5. When performing the duties described in subsections 1 and  
29 4, the Executive Director shall consult with organizations  
30 described in section 501(c)(5) of the Internal Revenue Code and  
31 other interested persons and entities concerning the requirements  
32 for certification of a policy of insurance described in subsection 1  
33 and the criteria described in paragraph (b) of subsection 4.

34 **Sec. 16.8.** NRS 695I.210 is hereby amended to read as  
35 follows:

36 695I.210 1. The Exchange shall:

37 (a) Create and administer a health insurance exchange;

38 (b) Facilitate the purchase and sale of qualified health plans  
39 consistent with established patterns of care within the State;

40 (c) Provide for the establishment of a program to assist qualified  
41 small employers in Nevada in facilitating the enrollment of their  
42 employees in qualified health plans offered in the small group  
43 market;

44 (d) ~~[Make]~~ Except as otherwise authorized by a waiver  
45 obtained pursuant to section 16.5 of this act, make only qualified



1 health plans available to qualified individuals and qualified small  
2 employers ; ~~on or after January 1, 2014;~~ and

3 (e) Unless the Federal Act is repealed or is held to be  
4 unconstitutional or otherwise invalid or unlawful, perform all duties  
5 that are required of the Exchange to implement the requirements of  
6 the Federal Act.

7 2. The Exchange may:

8 (a) Enter into contracts with any person, including, without  
9 limitation, a local government, a political subdivision of a local  
10 government and a governmental agency, to assist in carrying out the  
11 duties and powers of the Exchange or the Board; and

12 (b) Apply for and accept any gift, donation, bequest, grant or  
13 other source of money to carry out the duties and powers of the  
14 Exchange or the Board.

15 3. The Exchange is subject to the provisions of chapter 333 of  
16 NRS.

17 **Sec. 17.** NRS 200.5093 is hereby amended to read as follows:

18 200.5093 1. Any person who is described in subsection 4 and  
19 who, in a professional or occupational capacity, knows or has  
20 reasonable cause to believe that an older person or vulnerable  
21 person has been abused, neglected, exploited, isolated or abandoned  
22 shall:

23 (a) Except as otherwise provided in subsection 2, report the  
24 abuse, neglect, exploitation, isolation or abandonment of the older  
25 person or vulnerable person to:

26 (1) The local office of the Aging and Disability Services  
27 Division of the Department of Health and Human Services;

28 (2) A police department or sheriff's office; or

29 (3) A toll-free telephone service designated by the Aging and  
30 Disability Services Division of the Department of Health and  
31 Human Services; and

32 (b) Make such a report as soon as reasonably practicable but not  
33 later than 24 hours after the person knows or has reasonable cause to  
34 believe that the older person or vulnerable person has been abused,  
35 neglected, exploited, isolated or abandoned.

36 2. If a person who is required to make a report pursuant to  
37 subsection 1 knows or has reasonable cause to believe that the  
38 abuse, neglect, exploitation, isolation or abandonment of the older  
39 person or vulnerable person involves an act or omission of the  
40 Aging and Disability Services Division, another division of the  
41 Department of Health and Human Services or a law enforcement  
42 agency, the person shall make the report to an agency other than the  
43 one alleged to have committed the act or omission.

44 3. Each agency, after reducing a report to writing, shall forward  
45 a copy of the report to the Aging and Disability Services Division of



the Department of Health and Human Services and the Unit for the Investigation and Prosecution of Crimes.

4. A report must be made pursuant to subsection 1 by the following persons:

(a) Every physician, dentist, dental hygienist, chiropractor, optometrist, podiatric physician, medical examiner, resident, intern, professional or practical nurse, physician assistant licensed pursuant to chapter 630 or 633 of NRS, perfusionist, psychiatrist, psychologist, marriage and family therapist, clinical professional counselor, clinical alcohol and drug counselor, alcohol and drug counselor, music therapist, athletic trainer, driver of an ambulance, paramedic, licensed dietitian, holder of a license or a limited license issued under the provisions of chapter 653 of NRS or other person providing medical services licensed or certified to practice in this State, who examines, attends or treats an older person or vulnerable person who appears to have been abused, neglected, exploited, isolated or abandoned.

(b) Any personnel of a hospital or similar institution engaged in the admission, examination, care or treatment of persons or an administrator, manager or other person in charge of a hospital or similar institution upon notification of the suspected abuse, neglect, exploitation, isolation or abandonment of an older person or vulnerable person by a member of the staff of the hospital.

(c) A coroner.

(d) Every person who maintains or is employed by an agency to provide personal care services in the home.

(e) Every person who maintains or is employed by an agency to provide nursing in the home.

(f) Every person who operates, who is employed by or who contracts to provide services for an intermediary service organization as defined in NRS 449.4304.

(g) Any employee of the Department of Health and Human Services, except the State Long-Term Care Ombudsman appointed pursuant to NRS 427A.125 and any of his or her advocates or volunteers where prohibited from making such a report pursuant to 45 C.F.R. § 1321.11.

(h) Any employee of a law enforcement agency or a county's office for protective services or an adult or juvenile probation officer.

(i) Any person who maintains or is employed by a facility or establishment that provides care for older persons or vulnerable persons.

(j) Any person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding the abuse, neglect, exploitation, isolation or abandonment of an



1 older person or vulnerable person and refers them to persons and  
2 agencies where their requests and needs can be met.

3 (k) Every social worker.

4 (l) Any person who owns or is employed by a funeral home or  
5 mortuary.

6 (m) Every person who operates or is employed by a peer support  
7 recovery organization, as defined in NRS 449.01563.

8 (n) Every person who operates or is employed by a community  
9 health worker pool, as defined in NRS 449.0028, or with whom a  
10 community health worker pool contracts to provide the services of a  
11 community health worker, as defined in NRS 449.0027.

12 *(o) Every person who is enrolled with the Division of Health*  
13 *Care Financing and Policy of the Department of Health and*  
14 *Human Services to provide doula services to recipients of*  
15 *Medicaid pursuant to section 26 of this act.*

16 5. A report may be made by any other person.

17 6. If a person who is required to make a report pursuant to  
18 subsection 1 knows or has reasonable cause to believe that an older  
19 person or vulnerable person has died as a result of abuse, neglect,  
20 isolation or abandonment, the person shall, as soon as reasonably  
21 practicable, report this belief to the appropriate medical examiner or  
22 coroner, who shall investigate the cause of death of the older person  
23 or vulnerable person and submit to the appropriate local law  
24 enforcement agencies, the appropriate prosecuting attorney, the  
25 Aging and Disability Services Division of the Department of Health  
26 and Human Services and the Unit for the Investigation and  
27 Prosecution of Crimes his or her written findings. The written  
28 findings must include the information required pursuant to the  
29 provisions of NRS 200.5094, when possible.

30 7. A division, office or department which receives a report  
31 pursuant to this section shall cause the investigation of the report to  
32 commence within 3 working days. A copy of the final report of the  
33 investigation conducted by a division, office or department, other  
34 than the Aging and Disability Services Division of the Department  
35 of Health and Human Services, must be forwarded within 30 days  
36 after the completion of the report to the:

37 (a) Aging and Disability Services Division;

38 (b) Repository for Information Concerning Crimes Against  
39 Older Persons or Vulnerable Persons created by NRS 179A.450;  
40 and

41 (c) Unit for the Investigation and Prosecution of Crimes.

42 8. If the investigation of a report results in the belief that an  
43 older person or vulnerable person is abused, neglected, exploited,  
44 isolated or abandoned, the Aging and Disability Services Division  
45 of the Department of Health and Human Services or the county's





1 office for protective services may provide protective services to the  
2 older person or vulnerable person if the older person or vulnerable  
3 person is able and willing to accept them.

4 9. A person who knowingly and willfully violates any of the  
5 provisions of this section is guilty of a misdemeanor.

6 10. As used in this section, "Unit for the Investigation and  
7 Prosecution of Crimes" means the Unit for the Investigation and  
8 Prosecution of Crimes Against Older Persons or Vulnerable Persons  
9 in the Office of the Attorney General created pursuant to  
10 NRS 228.265.

11 **Sec. 18.** NRS 232.320 is hereby amended to read as follows:

12 232.320 1. The Director:

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

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

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

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

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

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

26 (b) Shall administer, through the divisions of the Department,  
27 the provisions of chapters 63, 424, 425, 427A, 432A to 442,  
28 inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS  
29 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, *and*  
30 *sections 24 to 28, inclusive, of this act*, 422.580, 432.010 to  
31 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to  
32 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all  
33 other provisions of law relating to the functions of the divisions of  
34 the Department, but is not responsible for the clinical activities of  
35 the Division of Public and Behavioral Health or the professional line  
36 activities of the other divisions.

37 (c) Shall administer any state program for persons with  
38 developmental disabilities established pursuant to the  
39 Developmental Disabilities Assistance and Bill of Rights Act of  
40 2000, 42 U.S.C. §§ 15001 et seq.

41 (d) Shall, after considering advice from agencies of local  
42 governments and nonprofit organizations which provide social  
43 services, adopt a master plan for the provision of human services in  
44 this State. The Director shall revise the plan biennially and deliver a





copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

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

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

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

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

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

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

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

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

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

**Sec. 19.** NRS 232.459 is hereby amended to read as follows:

232.459 1. The Advocate shall:

(a) Respond to written and telephonic inquiries received from consumers and injured employees regarding concerns and problems related to health care and workers' compensation;

(b) Assist consumers and injured employees in understanding their rights and responsibilities under health care plans, including, without limitation, the Public Employees' Benefits Program ~~and~~ *and the Public Option*, and policies of industrial insurance;

(c) Identify and investigate complaints of consumers and injured employees regarding their health care plans, including, without limitation, the Public Employees' Benefits Program ~~and~~ *and the Public Option*, and policies of industrial insurance and assist those consumers and injured employees to resolve their complaints, including, without limitation:



(1) Referring consumers and injured employees to the appropriate agency, department or other entity that is responsible for addressing the specific complaint of the consumer or injured employee; and

(2) Providing counseling and assistance to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program ~~§~~ *and the Public Option*, and policies of industrial insurance;

(d) Provide information to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program ~~§~~ *and the Public Option*, and policies of industrial insurance in this State;

(e) Establish and maintain a system to collect and maintain information pertaining to the written and telephonic inquiries received by the Office for Consumer Health Assistance;

(f) Take such actions as are necessary to ensure public awareness of the existence and purpose of the services provided by the Advocate pursuant to this section;

(g) In appropriate cases and pursuant to the direction of the Advocate, refer a complaint or the results of an investigation to the Attorney General for further action;

(h) Provide information to and applications for prescription drug programs for consumers without insurance coverage for prescription drugs or pharmaceutical services;

(i) Establish and maintain an Internet website which includes:

(1) Information concerning purchasing prescription drugs from Canadian pharmacies that have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328;

(2) Links to websites of Canadian pharmacies which have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328; and

(3) A link to the website established and maintained pursuant to NRS 439A.270 which provides information to the general public concerning the charges imposed and the quality of the services provided by the hospitals and surgical centers for ambulatory patients in this State;

(j) Assist consumers with accessing a navigator, case manager or facilitator to help the consumer obtain health care services;

(k) Assist consumers with scheduling an appointment with a provider of health care who is in the network of providers under contract to provide services to participants in the health care plan under which the consumer is covered;

(l) Assist consumers with filing complaints against health care facilities and health care professionals;



(m) Assist consumers with filing complaints with the Commissioner of Insurance against issuers of health care plans; and

(n) On or before January 31 of each year, compile a report of aggregated information submitted to the Office for Consumer Health Assistance pursuant to NRS 687B.675, aggregated for each type of provider of health care for which such information is provided and submit the report to the Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the Legislative Committee on Health Care; and

(2) In odd-numbered years, the next regular session of the Legislature.

2. The Advocate may adopt regulations to carry out the provisions of this section and NRS 232.461 and 232.462.

3. As used in this section:

(a) “Health care facility” has the meaning ascribed to it in NRS 162A.740.

(b) “Navigator, case manager or facilitator” has the meaning ascribed to it in NRS 687B.675.

*(c) “Public Option” means the Public Option established pursuant to section 10 of this act.*

**Sec. 20.** NRS 233B.039 is hereby amended to read as follows:

233B.039 1. The following agencies are entirely exempted from the requirements of this chapter:

(a) The Governor.

(b) Except as otherwise provided in NRS 209.221, the Department of Corrections.

(c) The Nevada System of Higher Education.

(d) The Office of the Military.

(e) The Nevada Gaming Control Board.

(f) Except as otherwise provided in NRS 368A.140 and 463.765, the Nevada Gaming Commission.

(g) Except as otherwise provided in NRS 425.620, the Division of Welfare and Supportive Services of the Department of Health and Human Services.

(h) Except as otherwise provided in NRS 422.390, the Division of Health Care Financing and Policy of the Department of Health and Human Services.

(i) Except as otherwise provided in NRS 533.365, the Office of the State Engineer.

(j) The Division of Industrial Relations of the Department of Business and Industry acting to enforce the provisions of NRS 618.375.

(k) The Administrator of the Division of Industrial Relations of the Department of Business and Industry in establishing and



1 adjusting the schedule of fees and charges for accident benefits  
2 pursuant to subsection 2 of NRS 616C.260.

3 (l) The Board to Review Claims in adopting resolutions to carry  
4 out its duties pursuant to NRS 445C.310.

5 (m) The Silver State Health Insurance Exchange.

6 (n) The Cannabis Compliance Board.

7 2. Except as otherwise provided in subsection 5 and NRS  
8 391.323, the Department of Education, the Board of the Public  
9 Employees' Benefits Program and the Commission on Professional  
10 Standards in Education are subject to the provisions of this chapter  
11 for the purpose of adopting regulations but not with respect to any  
12 contested case.

13 3. The special provisions of:

14 (a) Chapter 612 of NRS for the adoption of an emergency  
15 regulation or the distribution of regulations by and the judicial  
16 review of decisions of the Employment Security Division of the  
17 Department of Employment, Training and Rehabilitation;

18 (b) Chapters 616A to 617, inclusive, of NRS for the  
19 determination of contested claims;

20 (c) Chapter 91 of NRS for the judicial review of decisions of the  
21 Administrator of the Securities Division of the Office of the  
22 Secretary of State; and

23 (d) NRS 90.800 for the use of summary orders in contested  
24 cases,

25 ➤ prevail over the general provisions of this chapter.

26 4. The provisions of NRS 233B.122, 233B.124, 233B.125 and  
27 233B.126 do not apply to the Department of Health and Human  
28 Services in the adjudication of contested cases involving the  
29 issuance of letters of approval for health facilities and agencies.

30 5. The provisions of this chapter do not apply to:

31 (a) Any order for immediate action, including, but not limited  
32 to, quarantine and the treatment or cleansing of infected or infested  
33 animals, objects or premises, made under the authority of the State  
34 Board of Agriculture, the State Board of Health, or any other agency  
35 of this State in the discharge of a responsibility for the preservation  
36 of human or animal health or for insect or pest control;

37 (b) An extraordinary regulation of the State Board of Pharmacy  
38 adopted pursuant to NRS 453.2184;

39 (c) A regulation adopted by the State Board of Education  
40 pursuant to NRS 388.255 or 394.1694;

41 (d) The judicial review of decisions of the Public Utilities  
42 Commission of Nevada;

43 (e) The adoption, amendment or repeal of policies by the  
44 Rehabilitation Division of the Department of Employment, Training  
45 and Rehabilitation pursuant to NRS 426.561 or 615.178;



(f) The adoption or amendment of a rule or regulation to be included in the State Plan for Services for Victims of Crime by the Department of Health and Human Services pursuant to NRS 217.130;

(g) The adoption, amendment or repeal of rules governing the conduct of contests and exhibitions of unarmed combat by the Nevada Athletic Commission pursuant to NRS 467.075; ~~for~~

(h) The adoption, amendment or repeal of regulations by the Director of the Department of Health and Human Services pursuant to NRS 447.335 to 447.350, inclusive ~~to~~; or

*(i) The adoption, amendment or repeal of any rule or policy governing the Public Option established pursuant to the chapter created by sections 2 to 15, inclusive, of this act.*

6. The State Board of Parole Commissioners is subject to the provisions of this chapter for the purpose of adopting regulations but not with respect to any contested case.

**Sec. 21.** NRS 287.0434 is hereby amended to read as follows:  
287.0434 The Board may:

1. Use its assets only to pay the expenses of health care for its members and covered dependents, to pay its employees' salaries and to pay administrative and other expenses.

2. Enter into contracts relating to the administration of the Program, including, without limitation, contracts with licensed administrators and qualified actuaries. Each such contract with a licensed administrator:

(a) Must be submitted to the Commissioner of Insurance not less than 30 days before the date on which the contract is to become effective for approval as to the licensing and fiscal status of the licensed administrator and status of any legal or administrative actions in this State against the licensed administrator that may impair his or her ability to provide the services in the contract.

(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.

3. Enter into contracts with physicians, surgeons, hospitals, health maintenance organizations and rehabilitative facilities for medical, surgical and rehabilitative care and the evaluation, treatment and nursing care of members and covered dependents. The Board shall not enter into a contract pursuant to this subsection unless:

(a) Provision is made by the Board to offer all the services specified in the request for proposals, either by a health maintenance organization or through separate action of the Board.

(b) The rates set forth in the contract are based on:



(1) For active and retired state officers and employees and their dependents, the commingled claims experience of such active and retired officers and employees and their dependents for whom the Program provides primary health insurance coverage in a single risk pool; and

(2) For active and retired officers and employees of public agencies enumerated in NRS 287.010 that contract with the Program to obtain group insurance by participation in the Program and their dependents, the commingled claims experience of such active and retired officers and employees and their dependents for whom the Program provides primary health insurance coverage in a single risk pool.

*(c) For a contract with a physician, surgeon, hospital or rehabilitative facility, the physician, surgeon, hospital or rehabilitative facility has also complied with the requirements of section 13 of this act.*

4. Enter into contracts for the services of other experts and specialists as required by the Program.

5. Charge and collect from an insurer, health maintenance organization, organization for dental care or nonprofit medical service corporation, a fee for the actual expenses incurred by the Board or a participating public agency in administering a plan of insurance offered by that insurer, organization or corporation.

6. Charge and collect the amount due from local governments pursuant to paragraph (b) of subsection 4 of NRS 287.023. If the payment of a local government pursuant to that provision is delinquent by more than 90 days, the Board shall notify the Executive Director of the Department of Taxation pursuant to NRS 354.671.

**Sec. 22.** NRS 333.705 is hereby amended to read as follows:

333.705 1. Except as otherwise provided in this section, a using agency shall not enter into a contract with a person to provide services for the using agency if:

(a) The person is a current employee of an agency of this State;

(b) The person is a former employee of an agency of this State and less than 2 years have expired since the termination of the person's employment with the State; or

(c) The person is employed by the Department of Transportation for a transportation project that is entirely funded by federal money and the term of the contract is for more than 4 years,

➔ unless the using agency submits a written disclosure to the State Board of Examiners indicating the services to be provided pursuant to the contract and the person who will be providing those services and, after reviewing the disclosure, the State Board of Examiners approves entering into a contract with the person. The requirements



1 of this subsection apply to any person employed by a business or  
2 other entity that enters into a contract to provide services for a using  
3 agency if the person will be performing or producing the services  
4 for which the business or entity is employed.

5 2. The provisions of paragraph (b) of subsection 1 apply to  
6 employment through a temporary employment service. A temporary  
7 employment service providing employees for a using agency shall  
8 provide the using agency with the names of the employees to be  
9 provided to the agency. The State Board of Examiners shall not  
10 approve a contract pursuant to paragraph (b) of subsection 1 unless  
11 the Board determines that one or more of the following  
12 circumstances exist:

13 (a) The person provides services that are not provided by any  
14 other employee of the using agency or for which a critical labor  
15 shortage exists; or

16 (b) A short-term need or unusual economic circumstance exists  
17 for the using agency to contract with the person.

18 3. The approval by the State Board of Examiners to contract  
19 with a person pursuant to subsection 1:

20 (a) May occur at the same time and in the same manner as the  
21 approval by the State Board of Examiners of a proposed contract  
22 pursuant to subsection 7 of NRS 333.700; and

23 (b) Must occur before the date on which the contract becomes  
24 binding on the using agency.

25 4. A using agency may contract with a person pursuant to  
26 paragraph (a) or (b) of subsection 1 without obtaining the approval  
27 of the State Board of Examiners if the term of the contract is for less  
28 than 4 months and the head of the using agency determines that an  
29 emergency exists which necessitates the contract. If a using agency  
30 contracts with a person pursuant to this subsection, the using agency  
31 shall submit a copy of the contract and a description of the  
32 emergency to the State Board of Examiners, which shall review the  
33 contract and the description of the emergency and notify the using  
34 agency whether the State Board of Examiners would have approved  
35 the contract if it had not been entered into pursuant to this  
36 subsection.

37 5. Except as otherwise provided in subsection 9, a using  
38 agency shall, not later than 10 days after the end of each fiscal  
39 quarter, report to the Interim Finance Committee concerning all  
40 contracts to provide services for the using agency that were entered  
41 into by the using agency during the fiscal quarter with a person who  
42 is a current or former employee of a department, division or other  
43 agency of this State.

44 6. Except as otherwise provided in subsection 9, a using  
45 agency shall not contract with a temporary employment service



1 unless the contracting process is controlled by rules of open  
2 competitive bidding.

3 7. Each board or commission of this State and each institution  
4 of the Nevada System of Higher Education that employs a  
5 consultant shall, at least once every 6 months, submit to the Interim  
6 Finance Committee a report setting forth:

7 (a) The number of consultants employed by the board,  
8 commission or institution;

9 (b) The purpose for which the board, commission or institution  
10 employs each consultant;

11 (c) The amount of money or other remuneration received by  
12 each consultant from the board, commission or institution; and

13 (d) The length of time each consultant has been employed by the  
14 board, commission or institution.

15 8. A using agency, board or commission of this State and each  
16 institution of the Nevada System of Higher Education:

17 (a) Shall make every effort to limit the number of contracts it  
18 enters into with persons to provide services which have a term of  
19 more than 2 years and which are in the amount of less than  
20 \$1,000,000; and

21 (b) Shall not enter into a contract with a person to provide  
22 services without ensuring that the person is in active and good  
23 standing with the Secretary of State.

24 9. The provisions of subsections 1 to 6, inclusive, do not apply  
25 to:

26 (a) The Nevada System of Higher Education or a board or  
27 commission of this State.

28 (b) The employment of professional engineers by the  
29 Department of Transportation if those engineers are employed for a  
30 transportation project that is entirely funded by federal money.

31 (c) Contracts in the amount of \$1,000,000 or more entered into:

32 (1) Pursuant to the State Plan for Medicaid established  
33 pursuant to NRS 422.063.

34 (2) For financial services.

35 (3) Pursuant to the Public Employees' Benefits Program.

36 (4) *Pursuant to the Public Option established pursuant to*  
37 *section 10 of this act.*

38 (d) The employment of a person by a business or entity which is  
39 a provider of services under the State Plan for Medicaid and which  
40 provides such services on a fee-for-service basis or through  
41 managed care.

42 (e) The employment of a former employee of an agency of this  
43 State who is not receiving retirement benefits under the Public  
44 Employees' Retirement System during the duration of the contract.





1     **Sec. 23.** Chapter 422 of NRS is hereby amended by adding  
2 thereto the provisions set forth as sections 24 to 28, inclusive, of this  
3 act.

4     **Sec. 24.** 1. *The Director shall, to the extent authorized by*  
5 *federal law, include in the State Plan for Medicaid authorization*  
6 *for:*

7     (a) *A pregnant woman whose household income is at or below*  
8 *200 percent of the federally designated level signifying poverty to*  
9 *enroll in Medicaid.*

10    (b) *A pregnant woman who is determined by a qualified*  
11 *provider to be presumptively eligible for Medicaid to enroll in*  
12 *Medicaid until the last day of the month immediately following the*  
13 *month of enrollment without submitting an application for*  
14 *enrollment in Medicaid which includes additional proof of*  
15 *eligibility.*

16    2. *Unless otherwise required by federal law, the Director*  
17 *shall not include in the State Plan for Medicaid a requirement that*  
18 *a pregnant woman who is otherwise eligible for Medicaid must*  
19 *reside in the United States for a prescribed period of time before*  
20 *enrolling in Medicaid.*

21    3. *As used in this section, “qualified provider” has the*  
22 *meaning ascribed to it in 42 U.S.C. § 1396r-1(b)(2).*

23    **Sec. 25.** 1. *The Director shall include in the State Plan for*  
24 *Medicaid a requirement that the State, to the extent authorized by*  
25 *federal law, pay the nonfederal share of expenditures incurred for*  
26 *the services of a community health worker who provides services*  
27 *under the supervision of a physician, physician assistant or*  
28 *advanced practice registered nurse.*

29    2. *As used in this section, “community health worker” has*  
30 *the meaning ascribed to it in NRS 449.0027.*

31    **Sec. 26.** 1. *The Director shall, to the extent authorized by*  
32 *federal law, include in the State Plan for Medicaid a requirement*  
33 *that the State pay the nonfederal share of expenditures incurred*  
34 *for doula services provided by an enrolled doula.*

35    2. *The Department shall apply to the Secretary of Health and*  
36 *Human Services for a waiver granted pursuant to 42 U.S.C. §*  
37 *1315 or apply for an amendment of the State Plan for Medicaid*  
38 *that authorizes the Department to receive federal funding to*  
39 *include in the State Plan for Medicaid coverage of doula services*  
40 *provided by an enrolled doula. The Department shall fully*  
41 *cooperate in good faith with the Federal Government during the*  
42 *application process to satisfy the requirements of the Federal*  
43 *Government for obtaining a waiver or amendment pursuant to this*  
44 *section.*



3. A person who wishes to receive reimbursement through the Medicaid program for doula services provided to a recipient of Medicaid must submit to the Division:

(a) An application for enrollment in the form prescribed by the Division; and

(b) Proof that he or she possesses the required training and qualifications prescribed by the Division pursuant to subsection 4.

4. The Division, in consultation with community-based organizations that provide services to pregnant women in this State, shall prescribe the required training and qualifications for enrollment pursuant to subsection 3 to receive reimbursement through Medicaid for doula services.

5. As used in this section:

(a) “Doula services” means services to provide education and support relating to childbirth, including, without limitation, emotional and physical support provided during pregnancy, labor, birth and the postpartum period.

(b) “Enrolled doula” means a doula who is enrolled with the Division pursuant to this section to receive reimbursement through Medicaid for doula services.

**Sec. 27.** 1. The Director shall include in the State Plan for Medicaid a requirement that, except as otherwise provided in subsection 2, the State must provide reimbursement for the services of an advanced practice registered nurse, including, without limitation, a certified nurse-midwife, to the same extent as if the services were provided by a physician.

2. The provisions of subsection 1 do not apply to services provided to a recipient of Medicaid who receives health care services through the Medicaid managed care program established pursuant to NRS 422.273.

3. As used in this section, “certified nurse-midwife” means a person who is:

(a) Certified as a nurse-midwife by the American Midwifery Certification Board, or its successor organization; and

(b) Licensed as an advanced practice registered nurse pursuant to NRS 632.237.

**Sec. 28.** 1. To the extent that money is available, the Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:

(a) Supplies for breastfeeding a child until the child’s first birthday. Such supplies include, without limitation, electric or hospital-grade breast pumps that:

(1) Have been prescribed or ordered by a qualified provider of health care; and



(2) *Are medically necessary or are necessary for the mother of the child to return to work.*

(b) *Such prenatal screenings and tests as are recommended by the American College of Obstetricians and Gynecologists, or its successor organization.*

2. *The Director shall include in the State Plan for Medicaid a requirement that, to the extent that federal financial participation is available, the State must pay the nonfederal share of expenditures incurred for lactation consultation and support.*

3. *As used in this section:*

(a) *"Medically necessary" has the meaning ascribed to it in NRS 695G.055.*

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

**Sec. 29.** NRS 422.2372 is hereby amended to read as follows:  
422.2372 The Administrator shall:

1. Supply the Director with material on which to base proposed legislation.

2. Cooperate with the Federal Government and state governments for the more effective attainment of the purposes of this chapter.

3. Coordinate the activities of the Division with other agencies, both public and private, with related or similar activities.

4. Keep a complete and accurate record of all proceedings, record and file all bonds and contracts, and assume responsibility for the custody and preservation of all papers and documents pertaining to the office of the Administrator.

5. Inform the public in regard to the activities and operation of the Division, and provide other information which will acquaint the public with the financing of Medicaid programs.

6. Conduct studies into the causes of the social problems with which the Division is concerned.

7. Invoke any legal, equitable or special procedures for the enforcement of orders issued by the Administrator or the enforcement of the provisions of this chapter.

8. *Exclude from participation in Medicaid any provider of health care that fails to comply with the requirements of section 13 of this act.*

9. Exercise any other powers that are necessary and proper for the standardization of state work, to expedite business and to promote the efficiency of the service provided by the Division.

**Sec. 30.** NRS 422.273 is hereby amended to read as follows:

422.273 1. *The Department shall:*

(a) *Establish a Medicaid managed care program to provide health care services to recipients of Medicaid in all geographic*



*areas of this State. The program is not required to provide services to recipients of Medicaid who are aged, blind or disabled pursuant to Title XVI of the Social Security Act, 42 U.S.C. §§ 1381 et seq.*

*(b) Conduct a statewide procurement process to select health maintenance organizations to provide the services described in paragraph (a).*

2. For ~~{any}~~ *the* Medicaid managed care program established ~~{in the State of Nevada,}~~ *pursuant to subsection 1,* the Department shall contract only with a health maintenance organization that has:

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

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

(c) Negotiated in good faith with the University of Nevada School of Medicine to provide health care services to recipients of Medicaid ~~{; and}~~

*(d) Complied with the provisions of subsection 2 of section 12 of this act.*

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

~~{2-}~~ 3. During the development and implementation of ~~{any}~~ *the* Medicaid managed care program, the Department shall cooperate with the University of Nevada School of Medicine by assisting in the provision of an adequate and diverse group of patients upon which the school may base its educational programs.

~~{3-}~~ 4. The University of Nevada School of Medicine may establish a nonprofit organization to assist in any research necessary for the development of ~~{a}~~ *the* Medicaid managed care program, receive and accept gifts, grants and donations to support such a program and assist in establishing educational services about the program for recipients of Medicaid.

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

~~{5-}~~ 6. *The Medicaid managed care program must include, without limitation, a state-directed payment arrangement established in accordance with 42 C.F.R. § 438.6(c) to require a Medicaid managed care organization to reimburse a critical access hospital and any federally-qualified health center or rural*



*health clinic affiliated with a critical access hospital for covered services at a rate that is equal to or greater than the rate received by the critical access hospital, federally-qualified health center or rural health clinic, as applicable, for services provided to recipients of Medicaid on a fee-for-service basis.*

7. The provisions of this section apply to any managed care organization, including a health maintenance organization, that provides health care services to recipients of Medicaid under the State Plan for Medicaid or the Children’s Health Insurance Program pursuant to a contract with the Division. Such a managed care organization or health maintenance organization is not required to establish a system for conducting external reviews of adverse determinations in accordance with chapter 695B, 695C or 695G of NRS. This subsection does not exempt such a managed care organization or health maintenance organization for services provided pursuant to any other contract.

~~6.1~~ 8. As used in this section, unless the context otherwise requires:

(a) *“Critical access hospital” means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).*

(b) “Federally-qualified health center” has the meaning ascribed to it in 42 U.S.C. § 1396d(1)(2)(B).

~~(b)~~ (c) “Health maintenance organization” has the meaning ascribed to it in NRS 695C.030.

~~(c)~~ (d) “Managed care organization” has the meaning ascribed to it in NRS 695G.050.

(e) *“Rural health clinic” has the meaning ascribed to it in 42 C.F.R. § 405.2401.*

**Sec. 31.** NRS 422.4053 is hereby amended to read as follows:

422.4053 1. Except as otherwise provided in subsection 2, the Department shall directly manage, direct and coordinate all payments and rebates for prescription drugs and all other services and payments relating to the provision of prescription drugs under the State Plan for Medicaid and the Children’s Health Insurance Program.

2. The Department may enter into a contract with:

(a) A pharmacy benefit manager for the provision of any services described in subsection 1.

(b) A health maintenance organization pursuant to NRS 422.273 for the provision of any of the services described in subsection 1 for recipients of Medicaid or recipients of insurance through the Children’s Health Insurance Program who receive coverage through

~~the~~ the Medicaid managed care program ~~established pursuant to~~ *NRS 422.273.*



3. A contract entered into pursuant to subsection 2 must:

(a) Include the provisions required by NRS 422.4056; and

(b) Require the pharmacy benefit manager or health maintenance organization, as applicable, to disclose to the Department any information relating to the services covered by the contract, including, without limitation, information concerning dispensing fees, measures for the control of costs, rebates collected and paid and any fees and charges imposed by the pharmacy benefit manager or health maintenance organization pursuant to the contract.

4. In addition to meeting the requirements of subsection 3, a contract entered into pursuant to:

(a) Paragraph (a) of subsection 2 may require the pharmacy benefit manager to provide the entire amount of any rebates received for the purchase of prescription drugs, including, without limitation, rebates for the purchase of prescription drugs by an entity other than the Department, to the Department.

(b) Paragraph (b) of subsection 2 must require the health maintenance organization to provide to the Department the entire amount of any rebates received for the purchase of prescription drugs, including, without limitation, rebates for the purchase of prescription drugs by an entity other than the Department, less an administrative fee in an amount prescribed by the contract. The Department shall adopt policies prescribing the maximum amount of such an administrative fee.

**Sec. 32.** NRS 427A.605 is hereby amended to read as follows:

427A.605 1. The Director may establish a program to negotiate discounts and rebates for hearing devices and related costs, including, without limitation, ear molds, batteries and FM systems, for children in this State who are deaf or hard of hearing on behalf of entities described in subsection 2 who participate in the program.

2. The following persons and entities may participate in a program established pursuant to subsection 1:

(a) The Public Employees' Benefits Program;

(b) A governing body of a county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency that provides health coverage to employees through a self-insurance reserve fund pursuant to NRS 287.010;

(c) An insurer that holds a certificate of authority to transact insurance in this State pursuant to chapter 680A of NRS;

(d) An employer or employee organization based in this State that provides health coverage to employees through a self-insurance reserve fund;



(e) A governmental agency or nonprofit organization that purchases hearing devices for children in this State who are deaf or hard of hearing;

(f) A resident of this State who does not have coverage for hearing devices; ~~and~~

(g) *The Public Option established pursuant to section 10 of this act; and*

(h) Any other person or entity that provides health coverage or otherwise purchases hearing devices for children in this State who are deaf or hard of hearing.

3. A person or entity described in subsection 2 may participate in any program established pursuant to subsection 1 by submitting an application to the Department in the form prescribed by the Department.

**Sec. 33.** NRS 432B.220 is hereby amended to read as follows:

432B.220 1. Any person who is described in subsection 4 and who, in his or her professional or occupational capacity, knows or has reasonable cause to believe that a child has been abused or neglected shall:

(a) Except as otherwise provided in subsection 2, report the abuse or neglect of the child to an agency which provides child welfare services or to a law enforcement agency; and

(b) Make such a report as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the child has been abused or neglected.

2. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that the abuse or neglect of the child involves an act or omission of:

(a) A person directly responsible or serving as a volunteer for or an employee of a public or private home, institution or facility where the child is receiving child care outside of the home for a portion of the day, the person shall make the report to a law enforcement agency.

(b) An agency which provides child welfare services or a law enforcement agency, the person shall make the report to an agency other than the one alleged to have committed the act or omission, and the investigation of the abuse or neglect of the child must be made by an agency other than the one alleged to have committed the act or omission.

3. Any person who is described in paragraph (a) of subsection 4 who delivers or provides medical services to a newborn infant and who, in his or her professional or occupational capacity, knows or has reasonable cause to believe that the newborn infant has been affected by a fetal alcohol spectrum disorder or prenatal substance use disorder or has withdrawal symptoms resulting from prenatal



substance exposure shall, as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the newborn infant is so affected or has such symptoms, notify an agency which provides child welfare services of the condition of the infant and refer each person who is responsible for the welfare of the infant to an agency which provides child welfare services for appropriate counseling, training or other services. A notification and referral to an agency which provides child welfare services pursuant to this subsection shall not be construed to require prosecution for any illegal action.

4. A report must be made pursuant to subsection 1 by the following persons:

(a) A person providing services licensed or certified in this State pursuant to, without limitation, chapter 450B, 630, 630A, 631, 632, 633, 634, 634A, 635, 636, 637, 637B, 639, 640, 640A, 640B, 640C, 640D, 640E, 641, 641A, 641B, 641C or 653 of NRS.

(b) Any personnel of a medical facility licensed pursuant to chapter 449 of NRS who are engaged in the admission, examination, care or treatment of persons or an administrator, manager or other person in charge of such a medical facility upon notification of suspected abuse or neglect of a child by a member of the staff of the medical facility.

(c) A coroner.

(d) A member of the clergy, practitioner of Christian Science or religious healer, unless the person has acquired the knowledge of the abuse or neglect from the offender during a confession.

(e) A person employed by a public school or private school and any person who serves as a volunteer at such a school.

(f) Any person who maintains or is employed by a facility or establishment that provides care for children, children's camp or other public or private facility, institution or agency furnishing care to a child.

(g) Any person licensed pursuant to chapter 424 of NRS to conduct a foster home.

(h) Any officer or employee of a law enforcement agency or an adult or juvenile probation officer.

(i) Except as otherwise provided in NRS 432B.225, an attorney.

(j) Any person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding abuse or neglect of a child and refers them to persons and agencies where their requests and needs can be met.

(k) Any person who is employed by or serves as a volunteer for a youth shelter. As used in this paragraph, "youth shelter" has the meaning ascribed to it in NRS 244.427.





(l) Any adult person who is employed by an entity that provides organized activities for children, including, without limitation, a person who is employed by a school district or public school.

*(m) Any person who is enrolled with the Division of Health Care Financing and Policy of the Department of Health and Human Services to provide doula services to recipients of Medicaid pursuant to section 26 of this act.*

5. A report may be made by any other person.

6. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that a child has died as a result of abuse or neglect, the person shall, as soon as reasonably practicable, report this belief to an agency which provides child welfare services or a law enforcement agency. If such a report is made to a law enforcement agency, the law enforcement agency shall notify an agency which provides child welfare services and the appropriate medical examiner or coroner of the report. If such a report is made to an agency which provides child welfare services, the agency which provides child welfare services shall notify the appropriate medical examiner or coroner of the report. The medical examiner or coroner who is notified of a report pursuant to this subsection shall investigate the report and submit his or her written findings to the appropriate agency which provides child welfare services, the appropriate district attorney and a law enforcement agency. The written findings must include, if obtainable, the information required pursuant to the provisions of subsection 2 of NRS 432B.230.

7. The agency, board, bureau, commission, department, division or political subdivision of the State responsible for the licensure, certification or endorsement of a person who is described in subsection 4 and who is required in his or her professional or occupational capacity to be licensed, certified or endorsed in this State shall, at the time of initial licensure, certification or endorsement:

(a) Inform the person, in writing or by electronic communication, of his or her duty as a mandatory reporter pursuant to this section;

(b) Obtain a written acknowledgment or electronic record from the person that he or she has been informed of his or her duty pursuant to this section; and

(c) Maintain a copy of the written acknowledgment or electronic record for as long as the person is licensed, certified or endorsed in this State.

8. The employer of a person who is described in subsection 4 and who is not required in his or her professional or occupational



1 capacity to be licensed, certified or endorsed in this State must, upon  
2 initial employment of the person:

3 (a) Inform the person, in writing or by electronic  
4 communication, of his or her duty as a mandatory reporter pursuant  
5 to this section;

6 (b) Obtain a written acknowledgment or electronic record from  
7 the person that he or she has been informed of his or her duty  
8 pursuant to this section; and

9 (c) Maintain a copy of the written acknowledgment or electronic  
10 record for as long as the person is employed by the employer.

11 9. Before a person may serve as a volunteer at a public school  
12 or private school, the school must:

13 (a) Inform the person, in writing or by electronic  
14 communication, of his or her duty as a mandatory reporter pursuant  
15 to this section and NRS 392.303;

16 (b) Obtain a written acknowledgment or electronic record from  
17 the person that he or she has been informed of his or her duty  
18 pursuant to this section and NRS 392.303; and

19 (c) Maintain a copy of the written acknowledgment or electronic  
20 record for as long as the person serves as a volunteer at the school.

21 10. As used in this section:

22 (a) "Private school" has the meaning ascribed to it in  
23 NRS 394.103.

24 (b) "Public school" has the meaning ascribed to it in  
25 NRS 385.007.

26 **Sec. 34.** NRS 439B.260 is hereby amended to read as follows:

27 439B.260 1. A major hospital shall reduce or discount the  
28 total billed charge by at least 30 percent for hospital services  
29 provided to an inpatient who:

30 (a) Has no policy of health insurance or other contractual  
31 agreement with a third party that provides health coverage for the  
32 charge;

33 (b) Is not eligible for coverage by a state or federal program of  
34 public assistance that would provide for the payment of the charge;  
35 and

36 (c) Makes reasonable arrangements within 30 days after the date  
37 that notice was sent pursuant to subsection 2 to pay the hospital bill.

38 2. A major hospital shall include on or with the first statement  
39 of the hospital bill provided to the patient after his or her discharge a  
40 notice of the reduction or discount available pursuant to this section,  
41 including, without limitation, notice of the criteria a patient must  
42 satisfy to qualify for a reduction or discount.

43 3. A major hospital or patient who disputes the reasonableness  
44 of arrangements made pursuant to paragraph (c) of subsection 1 may



1 submit the dispute to the Bureau for Hospital Patients for resolution  
2 as provided in NRS 232.462.

3 4. A major hospital shall reduce or discount the total billed  
4 charge of its outpatient pharmacy by at least 30 percent to a patient  
5 who is eligible for Medicare.

6 5. As used in this section, "third party" means:

7 (a) An insurer, as that term is defined in NRS 679B.540;

8 (b) A health benefit plan, as that term is defined in NRS  
9 687B.470, for employees which provides coverage for services and  
10 care at a hospital;

11 (c) A participating public agency, as that term is defined in NRS  
12 287.04052, and any other local governmental agency of the State of  
13 Nevada which provides a system of health insurance for the benefit  
14 of its officers and employees, and the dependents of officers and  
15 employees, pursuant to chapter 287 of NRS; ~~for~~

16 (d) *The Public Option established pursuant to section 10 of*  
17 *this act; or*

18 (e) Any other insurer or organization providing health coverage  
19 or benefits in accordance with state or federal law.

20 ➡ The term does not include an insurer that provides coverage  
21 under a policy of casualty or property insurance.

22 **Sec. 35.** NRS 439B.665 is hereby amended to read as follows:

23 439B.665 1. On or before February 1 of each year, a  
24 nonprofit organization that advocates on behalf of patients or funds  
25 medical research in this State and has received a payment, donation,  
26 subsidy or anything else of value from a manufacturer, third party or  
27 pharmacy benefit manager or a trade or advocacy group for  
28 manufacturers, third parties or pharmacy benefit managers during  
29 the immediately preceding calendar year shall:

30 (a) Compile a report which includes:

31 (1) For each such contribution, the amount of the  
32 contribution and the manufacturer, third party or pharmacy benefit  
33 manager or group that provided the payment, donation, subsidy or  
34 other contribution; and

35 (2) The percentage of the total gross income of the  
36 organization during the immediately preceding calendar year  
37 attributable to payments, donations, subsidies or other contributions  
38 from each manufacturer, third party, pharmacy benefit manager or  
39 group; and

40 (b) Except as otherwise provided in this paragraph, post the  
41 report on an Internet website that is maintained by the nonprofit  
42 organization and accessible to the public. If the nonprofit  
43 organization does not maintain an Internet website that is accessible  
44 to the public, the nonprofit organization shall submit the report  
45 compiled pursuant to paragraph (a) to the Department.



2. As used in this section, "third party" means:

(a) An insurer, as that term is defined in NRS 679B.540;

(b) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for prescription drugs;

(c) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~or~~

(d) *The Public Option established pursuant to section 10 of this act; or*

(e) Any other insurer or organization that provides health coverage or benefits in accordance with state or federal law.

➔ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

**Sec. 36.** NRS 439B.736 is hereby amended to read as follows:

439B.736 1. "Third party" includes, without limitation:

(a) The issuer of a health benefit plan, as defined in NRS 695G.019, which provides coverage for medically necessary emergency services;

(b) The Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043; ~~and~~

(c) *The Public Option established pursuant to section 10 of this act; and*

(d) Any other entity or organization that elects pursuant to NRS 439B.757 for the provisions of NRS 439B.700 to 439B.760, inclusive, to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons.

2. The term does not include the State Plan for Medicaid, the Children's Health Insurance Program or a health maintenance organization, as defined in NRS 695C.030, or managed care organization, as defined in NRS 695G.050, when providing 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.

**Sec. 37.** NRS 449A.162 is hereby amended to read as follows:

449A.162 1. Except as otherwise provided in subsection 3, if a hospital provides hospital care to a person who has a policy of health insurance issued by a third party that provides health coverage for care provided at that hospital and the hospital has a contractual agreement with the third party, the hospital:



(a) Shall proceed with any efforts to collect on any amount owed to the hospital for the hospital care in accordance with the provisions of NRS 449A.159.

(b) Shall not collect or attempt to collect from the patient or other responsible party more than the sum of the amounts of any deductible, copayment or coinsurance payable by or on behalf of the patient under the policy of health insurance.

(c) Shall not collect or attempt to collect that amount from:

(1) Any proceeds or potential proceeds of a civil action brought by or on behalf of the patient, including, without limitation, any amount awarded for medical expenses; or

(2) An insurer other than an insurer that provides coverage under a policy of health insurance or an insurer that provides coverage for medical payments under a policy of casualty insurance.

2. If the hospital collects or receives any payments from an insurer that provides coverage for medical payments under a policy of casualty insurance, the hospital shall, not later than 30 days after a determination is made concerning coverage, return to the patient any amount collected or received that is in excess of the deductible, copayment or coinsurance payable by or on behalf of the patient under the policy of health insurance.

3. This section does not apply to:

(a) Amounts owed to the hospital which are not covered under the policy of health insurance; or

(b) Medicaid, Medicare, the Children's Health Insurance Program or any other public program which may pay all or part of the bill.

4. This section does not limit any rights of a patient to contest an attempt to collect an amount owed to a hospital, including, without limitation, contesting a lien obtained by a hospital.

5. As used in this section, "third party" means:

(a) An insurer, as defined in NRS 679B.540;

(b) A health benefit plan, as defined in NRS 687B.470, for employees which provides coverage for services and care at a hospital;

(c) A participating public agency, as defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; ~~for~~

(d) *The Public Option established pursuant to section 10 of this act; or*

(e) Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.



**Sec. 38.** Section 10 of this act is hereby amended to read as follows:

Sec. 10. 1. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, shall design, establish and operate a health benefit plan known as the Public Option.

2. The Director:

(a) Shall make the Public Option available to all natural persons who reside in this State as a policy of individual health insurance through the Exchange and for direct purchase. The provisions of chapter 689A of NRS and other applicable provisions of title 57 of NRS apply to the Public Option when offered as a policy of individual health insurance.

(b) May make the Public Option available to small employers in this State or their employees to the extent authorized by federal law. The provisions of chapter 689C of NRS and other applicable provisions of title 57 of NRS apply to the Public Option when it is offered as a policy of health insurance for small employers.

(c) Shall comply with all state and federal laws and regulations applicable to insurers when carrying out the provisions of sections 2 to 15, inclusive, of this act, to the extent that such laws and regulations are not waived.

3. The Public Option must:

(a) Be a qualified health plan, as defined in 42 U.S.C. § 18021; and

(b) Provide at least levels of coverage consistent with the actuarial value of one silver plan and one gold plan.

4. ~~Except as otherwise provided in this section, the premiums for the Public Option:~~

~~—(a) Must be at least 5 percent lower than the reference premium for that zip code; and~~

~~—(b) Must not increase in any year by a percentage greater than the increase in the Medicare Economic Index for that year.~~

~~5. The Director, in consultation with the Commissioner and the Executive Director of the Exchange, may revise the requirements of subsection 4, provided that the average premiums for the Public Option must decrease by at least 15 percent over the first 4 years in which the Public Option is in operation.~~

~~6.~~ As used in this section:



(a) “Gold plan” means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a gold level plan.

(b) “Health benefit plan” means a policy, contract, certificate or agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(c) “Medicare Economic Index” means the Medicare Economic Index, as designated by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services pursuant to 42 C.F.R. § 405.504.

(d) “Reference premium” means, for any zip code, the lower of:

(1) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the 2024 plan year, adjusted by the percentage change in the Medicare Economic Index between January 1, 2024, and January 1 of the year to which a premium applies; or

(2) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the year immediately preceding the year to which a premium applies.

(e) “Silver plan” means a qualified health plan that meets the requirements established by 42 U.S.C. § 18022 for a silver level plan.

(f) “Small employer” has the meaning ascribed to it in 42 U.S.C. § 18024(b)(2).

**Sec. 39.** 1. The Director of the Department of Health and Human Services, the Commissioner of Insurance and the Executive Director of the Silver State Health Insurance Exchange shall apply for the waiver described in paragraph (a) of subsection 1 of section 11 of this act not later than January 1, 2024; and

2. The Director of the Department of Health and Human Services shall make the Public Option available to natural persons who reside in this State in accordance with the provisions of section 10 of this act for the coverage year that begins on January 1, 2026.

**Sec. 39.5.** On or before January 1, 2025, the Executive Director of the Silver State Health Insurance Exchange, in collaboration with the Department of Health and Human Services, shall:

1. Apply for the waiver described in subsection 1 of section 16.5 of this act; and

2. Submit to the Director of the Legislative Counsel Bureau for transmittal to the 83rd Session of the Legislature a report of recommendations concerning any revisions to Nevada law necessary to:



(a) Authorize an organization described in section 501(c)(5) of the Internal Revenue Code to offer a policy of insurance described in subsection 1 of section 16.5 of this act for direct purchase outside the Exchange as a policy of individual health insurance;

(b) Align state law concerning individual health insurance with the requirements in the request for the waiver described in subsection 1 of section 16.5 of this act; and

(c) Ensure that any state subsidies available to reduce the cost of premiums for individual health insurance are available for a policy of insurance described in subsection 1 of section 16.5 of this act.

**Sec. 40.** Notwithstanding the provisions of NRS 218D.430 and 218D.435, a committee, other than the Assembly Standing Committee on Ways and Means and the Senate Standing Committee on Finance, may vote on this act before the expiration of the period prescribed for the return of a fiscal note in NRS 218D.475. This section applies retroactively from and after March 22, 2021.

**Sec. 41.** 1. This section and sections 16.3, 16.5, 16.8, 39, 39.5 and 40 become effective upon passage and approval.

2. Sections 1 to 16, inclusive, 17, 19 to 22, inclusive, and 29 to 37, inclusive, of this act become effective:

(a) Upon passage and approval for the purposes of procurement and any other preparatory administrative tasks necessary to carry out the provisions of those sections; and

(b) On January 1, 2026, for all other purposes.

3. Sections 18, 23 and 25 to 28, inclusive, of this act become effective on July 1, 2021.

4. Section 24 of this act becomes effective on July 1, 2022.

5. Section 38 of this act becomes effective on January 1, 2030.

