Amendment No. 580

Assembly Amendment to Senate Bill No. 330 First Reprint (BDR 57-161)

Proposed by: Assembly Committee on Commerce and Labor

Amends: Summary: No Title: No Preamble: No Joint Sponsorship: No Digest: Yes

ASSEMBLY ACTION		Initial and Date	SENATE ACTION		Initial and Date
Adopted ☐	Lost ☐		Adopted ☐	Lost ☐	
Concurred In ☐	Not ☐		Concurred In ☐	Not ☐	
Receded ☐	Not ☐		Receded ☐	Not ☐	

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

SENATE BILL NO. 330–SENATOR LANGE

MARCH 20, 2023

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions related to health care. (BDR 57-161)

FISCAL NOTE: Effect on Local Government: No.
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 health care; revising requirements for certain health insurance plans to provide certain benefits for preventative health care relating to breast cancer; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires most health insurance plans, including individual, group and blanket health insurance policies, small employer plans, benefit contracts provided by fraternal benefit societies, contracts for hospital or medical service, health care plans of health maintenance organizations and plans issued by managed care organizations to include coverage for mammograms. (NRS 689A.0405, 689B.0374, 689C.1674, 695A.1855, 695B.1912, 695C.1735, 695G.1713) **Sections 1-5, 6 and 7** of this bill revise existing provisions requiring coverage for mammograms to require such policies, plans and contracts of health care to additionally provide coverage for imaging tests to screen for breast cancer and diagnostic imaging tests for breast cancer for certain covered persons without requiring any deductible, copayment, coinsurance or any other form of cost-sharing [~~.~~] **, except under certain circumstances relating to the eligibility of health savings accounts associated with policies, plans and contracts of health care that have high deductibles.** **Sections 5.5, 6.5, 7.5 and 8** of this bill make various changes to exclude the Public Employees' Benefits Program and plans of self-insurance for employees of local governments from the requirements of this bill and, thus, the Program and such plans may, but are not required to, provide the coverage set forth in this bill. **Sections 7.2 and 7.3** of this bill make changes necessary so that requirements concerning mammograms that currently apply to the Program and plans of self-insurance for employees of local governments continue to apply to the Program and such plans. **Sections 7.7 and 7.9** of this bill make conforming changes to indicate the proper placement of **sections 7.2 and 7.3**, respectively, in the Nevada Revised Statutes.

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

Section 1. NRS 689A.0405 is hereby amended to read as follows:

689A.0405 1. A policy of health insurance must provide coverage for benefits payable for expenses incurred for [~~a~~] ***:***

(a) A mammogram ~~[every 2 years, or]~~ ***to screen for breast cancer*** annually ~~[if ordered by a provider of health care,]~~ for ~~[women]~~ ***insureds who are*** 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of health insurance shall not:

(a) ~~[Require]~~ ***Except as otherwise provided in subsection 6, require*** an insured to pay a ~~[higher]~~ deductible, ~~[any]~~ copayment ***,*** ~~[or]~~ coinsurance ***or any other form of cost-sharing*** or require a longer waiting period or other condition to obtain any benefit provided in the policy of health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

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

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

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

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

4. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, ~~[2018,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. ***If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified policy of health insurance with respect to the deductible of such a policy of health insurance after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.***

7. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

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

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

(d) "Qualified policy of health insurance" means a policy of health insurance that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 2. NRS 689B.0374 is hereby amended to read as follows:

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

(a) A mammogram ~~[every 2 years, or]~~ ***to screen for breast cancer*** annually ~~[if ordered by a provider of health care,]~~ for ~~[women]~~ ***insureds who are*** 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of group health insurance shall not:

(a) ~~[Require]~~ ***Except as otherwise provided in subsection 6, require*** an insured to pay a ~~[higher]~~ deductible, ~~[any]~~ copayment ***,*** ~~[or]~~ coinsurance ***or any other form of cost-sharing*** or require a longer waiting period or other condition to obtain any benefit provided in the policy of group health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

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

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

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

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

4. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, ~~[2018,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. ***If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified policy of group health insurance with respect to the deductible of such a policy of group health insurance after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.***

7. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

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

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

(d) "Qualified policy of group health insurance" means a policy of group health insurance that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 3. NRS 689C.1674 is hereby amended to read as follows:

689C.1674 1. A health benefit plan must provide coverage for benefits payable for expenses incurred for ~~[a]~~ ***:***

(a) A mammogram ~~[every 2 years, or]~~ ***to screen for breast cancer*** annually ~~[if ordered by a provider of health care,]~~ for ~~[women]~~ ***insureds who are*** 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

3. Except as otherwise provided in subsection 5, a carrier that offers or issues a health benefit plan shall not:

(a) ~~[Require]~~ ***Except as otherwise provided in subsection 6, require*** an insured to pay a ~~[higher]~~ deductible, ~~[any]~~ copayment ***,*** ~~[or]~~ coinsurance ***or any other form of cost-sharing*** or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use any such benefit;

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

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

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

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

4. A plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, ~~[2018,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. ***If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified health benefit plan with respect to the deductible of such a health benefit plan after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.***

7. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

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

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

(d) "Qualified health benefit plan" means a health benefit plan that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 4. NRS 695A.1855 is hereby amended to read as follows:

695A.1855 1. A benefit contract must provide coverage for benefits payable for expenses incurred for ~~[a]~~ ***:***

(a) A mammogram ~~[every 2 years, or]~~ ***to screen for breast cancer*** annually ~~[if ordered by a provider of health care,]~~ for ~~[women]~~ ***insureds who are*** 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

3. Except as otherwise provided in subsection 5, a society that offers or issues a benefit contract shall not:

(a) ~~[Require]~~ ***Except as otherwise provided in subsection 6, require*** an insured to pay a ~~[higher]~~ deductible, ~~[any]~~ copayment ***,*** ~~[or]~~ coinsurance ***or any other form of cost-sharing*** or require a longer waiting period or other condition for coverage to obtain any benefit provided in a benefit contract pursuant to subsection 1;

(b) Refuse to issue a benefit contract or cancel a benefit contract solely because the person applying for or covered by the contract uses or may use any such benefit;

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

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

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

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

4. A benefit contract subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, ~~[2018,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the benefit contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. ***If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified benefit contract with respect to the deductible of such a benefit contract after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph***

(a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.

7. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

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

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

(d) "Qualified benefit contract" means a benefit contract that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 5. NRS 695B.1912 is hereby amended to read as follows:

695B.1912 1. An insurer that offers or issues a contract for hospital or medical service must provide coverage for benefits payable for expenses incurred for ~~[a]~~ ***:***

(a) A mammogram ~~[every 2 years, or]~~ ***to screen for breast cancer*** annually ~~[if ordered by a provider of health care,]~~ for ~~[women]~~ ***insureds who are*** 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a contract for hospital or medical service shall not:

(a) ~~[Require]~~ ***Except as otherwise provided in subsection 6, require*** an insured to pay a ~~[higher]~~ deductible, ~~[any]~~ copayment **,** ~~[or]~~ coinsurance ***or any other form of cost-sharing*** or require a longer waiting period or other condition to obtain any benefit provided in a contract for hospital or medical service pursuant to subsection 1;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use any such benefit;

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

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

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

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

4. A contract for hospital or medical service subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, ~~[2018,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. ***If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified contract for hospital or medical service with respect to the deductible of such a contract for hospital or medical service after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.***

7. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

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

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

(d) "Qualified contract for hospital or medical service" means a contract for hospital or medical service that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 5.5. NRS 695C.050 is hereby amended to read as follows:

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

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

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

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

5. The provisions of NRS 695C.1694 to 695C.1698, inclusive, 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333, 695C.17345, 695C.17347, 695C.1735, 695C.1737, 695C.1743, 695C.1745 and 695C.1757 apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

6. The provisions of NRS 695C.1735 do not apply to a health maintenance organization that provides health care services to ~~[members]~~ :

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

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

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

Sec. 6. NRS 695C.1735 is hereby amended to read as follows:

695C.1735 1. A health care plan of a health maintenance organization must provide coverage for benefits payable for expenses incurred for ~~[a]~~ ***:***

(a) A mammogram ~~[every 2 years, or]~~ ***to screen for breast cancer*** annually ~~[if ordered by a provider of health care,]~~ for ~~[women]~~ ***enrollees who are*** 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the enrollee's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the enrollee.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the enrollee's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

3. Except as otherwise provided in subsection 5, a health maintenance organization that offers or issues a health care plan shall not:

(a) ~~[Require]~~ ***Except as otherwise provided in subsection 6, require*** an enrollee to pay a ~~[higher]~~ deductible, ~~[any]~~ copayment ***,*** ~~[or]~~ coinsurance ***or any other form of cost-sharing*** or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any benefit provided in the health care plan pursuant to subsection 1;

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

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

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

4. A health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, ~~[~~2018,~~]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. ***If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an enrollee pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified health care plan with respect to the deductible of such a health care plan after the enrollee has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.***

7. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

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

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

(d) "Qualified health care plan" means a health care plan of a health maintenance organization that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 6.5. NRS 695G.090 is hereby amended to read as follows:

695G.090 1. Except as otherwise provided in subsection 3, the provisions of this chapter apply to each organization and insurer that operates as a managed care organization and may include, without limitation, an insurer that issues a policy of health insurance, an insurer that issues a policy of individual or group health insurance, a carrier serving small employers, a fraternal benefit society, a hospital or medical service corporation and a health maintenance organization.

2. In addition to the provisions of this chapter, each managed care organization shall comply with:

(a) The provisions of chapter 686A of NRS, including all obligations and remedies set forth therein; and

(b) Any other applicable provision of this title.

3. The provisions of NRS 695G.127, 695G.164, 695G.1645, 695G.167 and 695G.200 to 695G.230, inclusive, do not apply to a managed care organization that provides health care services to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. ~~[This subsection does]~~

4. The provisions of NRS 695C.1735 do not apply to a managed care organization that provides health care services to members of the Public Employees' Benefits Program.

5. Subsections 3 and 4 do not exempt a managed care organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 7. NRS 695G.1713 is hereby amended to read as follows:

695G.1713 1. A health care plan issued by a managed care organization must provide coverage for benefits payable for expenses incurred for ~~[a]~~ ***:***

(a) A mammogram ~~[every 2 years, or]~~ ***to screen for breast cancer*** annually ~~[if ordered by a provider of health care,]~~ for ~~[women]~~ ***insureds who are*** 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

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

3. Except as otherwise provided in subsection 5, a managed care organization that offers or issues a health care plan which provides coverage for prescription drugs shall not:

(a) ~~[Require]~~ ***Except as otherwise provided in subsection 6, require*** an insured to pay a ~~[higher]~~ deductible, ~~[any]~~ copayment ***,*** ~~[or]~~ coinsurance ***or any other form of cost-sharing*** or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

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

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

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

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

4. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, ~~[~~2018,~~]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a managed care organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. ***If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified health care plan with respect to the deductible of such a health care plan after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.***

7. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

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

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

(d) "Qualified health care plan" means a health care plan issued by a managed care organization that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 7.1. Chapter 287 of NRS is hereby amended by adding thereto the provisions set forth as sections 7.2 and 7.3 of this act.

Sec. 7.2. ***1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance shall provide coverage for benefits payable for expenses incurred for a mammogram every 2 years, or annually if ordered by a provider of health care, for women 40 years of age or older.***

2. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the governing body.

3. Except as otherwise provided in subsection 5, the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance shall not:

(a) ~~[Require]~~ Except as otherwise provided in subsection 6, require an insured to pay a higher deductible, any copayment or coinsurance or require a

longer waiting period or other condition to obtain any benefit provided in the plan of self-insurance pursuant to subsection 1;

(b) Refuse to issue a plan of self-insurance or cancel a plan of self-insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

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

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

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

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

4. A plan of self-insurance subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified plan of self-insurance with respect to the deductible of such a plan of self-insurance after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.

7. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a plan of self-insurance provided by the governing body of a local governmental agency under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the governing body. The term does not include an arrangement for the financing of premiums.

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

(d) "Qualified plan of self-insurance" means a plan of self-insurance that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 7.3. *1. If the Board provides health insurance through a plan of self-insurance, it shall provide coverage for benefits payable for expenses incurred for*

a mammogram every 2 years, or annually if ordered by a provider of health care, for women 40 years of age or older.

2. If the Board provides health insurance through a plan of self-insurance, it must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the Board.

3. Except as otherwise provided in subsection 5, if the Board provides health insurance through a plan of self-insurance, it shall not:

(a) ~~[Require]~~ Except as otherwise provided in subsection 6, require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the plan of self-insurance pursuant to subsection 1;

(b) Refuse to issue a plan of self-insurance or cancel a plan of self-insurance solely because the person applying for or covered by the plan uses or may use any such benefit;

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

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

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

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

4. A plan of self-insurance described in subsection 1 which is delivered, issued for delivery or renewed on or after January 1, 2024, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, if the Board provides health insurance through a plan of self-insurance, the Board may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. If the application of paragraph (a) of subsection 3 would result in the ineligibility of a health savings account of an insured pursuant to 26 U.S.C. § 223, the prohibitions of paragraph (a) of subsection 3 shall apply only for a qualified plan of self-insurance with respect to the deductible of such a plan of self-insurance after the insured has satisfied the minimum deductible pursuant to 26 U.S.C. § 223, except with respect to items or services that constitute preventive care pursuant to 26 U.S.C. § 223(c)(2)(C), in which case the prohibitions of paragraph (a) of subsection 3 shall apply regardless of whether the minimum deductible under 26 U.S.C. § 223 has been satisfied.

7. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a plan of self-insurance provided by the Board under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a

defined set of providers under contract with the Board. The term does not include an arrangement for the financing of premiums.

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

(d) "Qualified plan of self-insurance" means a plan of self-insurance that has a high deductible and is in compliance with 26 U.S.C. § 223 for the purposes of establishing a health savings account.

Sec. 7.5. NRS 287.010 is hereby amended to read as follows:

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

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

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

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 686A.135, 687B.352, 687B.408, 687B.723, 687B.725, 689B.030 to ***689B.0369, inclusive, 689B.0375 to*** 689B.050, inclusive, 689B.265, 689B.287 and 689B.500 apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and 689B.500 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.

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

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

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political

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

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

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

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

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

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

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

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

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

Sec. 7.7. NRS 287.040 is hereby amended to read as follows:

287.040 The provisions of NRS 287.010 to 287.040, inclusive, ***and section 7.2 of this act*** do not make it compulsory upon any governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada, except as otherwise provided in NRS 287.021 or subsection 4 of NRS 287.023 or in an agreement entered into pursuant to subsection 3 of NRS 287.015, to pay any premiums, contributions or other costs for group insurance, a plan of benefits or medical or hospital services established pursuant to NRS 287.010, 287.015, 287.020 or paragraph (b), (c) or (d) of subsection 1 of NRS 287.025, for coverage under the Public Employees' Benefits Program, or to make any contributions to a trust fund established pursuant to NRS 287.017, or upon any officer or employee of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of this State to accept any such coverage or to assign his or her wages or salary in payment of premiums or contributions therefor.

Sec. 7.9. NRS 287.0402 is hereby amended to read as follows:

287.0402 As used in NRS 287.0402 to 287.049, inclusive, ***and section 7.3 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 287.0404 to 287.04064, inclusive, have the meanings ascribed to them in those sections.

Sec. 8. NRS 287.04335 is hereby amended to read as follows:

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

that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 9. This act becomes effective on January 1, 2024.