SENATE BILL NO. 163–SENATORS SCHEIBLE, D. HARRIS AND SPEARMAN

FEBRUARY 15, 2023

JOINT SPONSOR: ASSEMBLYWOMAN GONZÁLEZ

Referred to Committee on Commerce and Labor

SUMMARY—Requires certain health insurance to cover treatment of certain conditions relating to gender dysphoria and gender incongruence. (BDR 57-129)

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

CONTAINS UNFUNDED MANDATE (§§ 13, 14)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

AN ACT relating to insurance; requiring certain health insurance to include coverage for the treatment of conditions relating to gender dysphoria and gender incongruence; prohibiting such insurers from engaging in certain discrimination on the basis of gender identity or expression; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires public and private policies of health insurance regulated under Nevada law to include certain coverage. (NRS 287.010, 287.04335, 422.2712-422.27241, 689A.04033-689A.0465, 689B.0303-689B.0379, 689C.1655-689C.169, 689C.194, 689C.1945, 689C.195, 695A.184-695A.1875, 695B.1901-695B.1948, 695C.1691-695C.176, 695G.162-695G.177) Existing law also requires employers to provide certain benefits for health care to employees, including the coverage required of health insurers, if the employer provides health benefits for its employees. (NRS 608.1555) **Sections 1.3, 3, 4, 6, 7, 8, 11, 13, 14 and 15** of this bill: (1) require certain public and private policies of health insurance and health care plans, including Medicaid, to cover the treatment of conditions relating to gender dysphoria and gender incongruence; (2) authorize those policies and plans to prescribe requirements that must be satisfied before the insurer will cover surgical treatment for conditions relating to gender dysphoria or gender incongruence for persons who are less than 18 years of age; and (3) require an

insurer to consult with a provider of health care with experience in prescribing or delivering gender-affirming treatment when considering certain appeals of a denial of coverage. **Sections 1.6, 3.6, 4.6, 6.6, 7.6, 8.6, 11.6 and 15.6** of this bill prohibit an insurer from engaging in certain discrimination on the basis of gender identity or expression. **Sections 2, 5, 9 and 12** of this bill make conforming changes to indicate the proper placement of **sections 1.3, 1.6, 4, 4.6, 8, 8.6, 15 and 15.6** in the Nevada Revised Statutes.

Section 10 of this bill authorizes the Commissioner of Insurance to suspend or revoke the certificate of a health maintenance organization that fails to comply with the requirements of **sections 8 and 8.6**. The Commissioner would also be authorized to take such action against other health insurers who fail to comply with the requirements of **sections 1.3, 1.6, 3, 3.6, 4, 4.6, 6, 6.6, 7, 7.6, 11 and 11.6** of this bill. (NRS 680A.200)

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

Section 1. Chapter 689A of NRS is hereby amended by adding thereto the provisions set forth as sections 1.3 and 1.6 of this act.

Sec. 1.3. ***1. Except as otherwise provided in this section, an insurer that issues a policy of health insurance shall include in the policy coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:***

(a) Endocrinologists;

(b) Pediatric endocrinologists;

(c) Social workers;

(d) Psychiatrists;

(e) Psychologists;

(f) Gynecologists;

(g) Speech-language pathologists;

(h) Primary care physicians;

(i) Advanced practice registered nurses;

(j) Physician assistants; and

(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a policy of health insurance to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. An insurer that issues a policy of health insurance shall not categorically refuse to cover medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the policy provides coverage for any such services, procedures

or revisions for purposes other than gender transition or affirmation.

4. An insurer that issues a policy of health insurance may prescribe requirements that must be satisfied before the insurer covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an insured who is less than 18 years of age. Such requirements may include, without limitation, requirements that:

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

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

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

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

(e) Parental consent is provided for the insured unless the insured is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, an insurer must consider the most recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

6. An insurer shall make a reasonable effort to ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer. If, after a reasonable effort, the insurer is unable to make such benefits available through such a provider of health care, the insurer may treat the treatment that the insurer is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the insurer.

7. If an insured appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by the insured is not medically necessary, the insurer must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the insured when considering the appeal.

8. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage

required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) "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.

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

Sec. 1.6. ***An insurer that issues a policy of health insurance shall not discriminate against any person with respect to participation or coverage under the policy on the basis of actual or perceived gender identity or expression. Prohibited discrimination includes, without limitation:***

1. Denying, cancelling, limiting or refusing to issue or renew a policy of health insurance on the basis of the actual or perceived gender identity or expression of a person or a family member of the person;

2. Imposing a payment or premium that is based on the actual or perceived gender identity or expression of an insured or a family member of the insured;

3. Designating the actual or perceived gender identity or expression of a person or a family member of the person as grounds to deny, cancel or limit participation or coverage; and

4. Denying, cancelling or limiting participation or coverage on the basis of actual or perceived gender identity or expression, including, without limitation, by limiting or denying coverage for health care services that are:

(a) Related to gender transition, provided that there is coverage under the policy for the services when the services are not related to gender transition; or

(b) Ordinarily or exclusively available to persons of any sex.

Sec. 2. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling

require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~.~~ ***, and sections 1.3 and 1.6 of this act.***

Sec. 2.8. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 3 and 3.6 of this act.

Sec. 3. ***1. Except as otherwise provided in this section, an insurer that issues a policy of group health insurance shall include in the policy coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:***

(a) Endocrinologists;

(b) Pediatric endocrinologists;

(c) Social workers;

(d) Psychiatrists;

(e) Psychologists;

(f) Gynecologists;

(g) Speech-language pathologists;

(h) Primary care physicians;

(i) Advanced practice registered nurses;

(j) Physician assistants; and

(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a policy of group health insurance to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. An insurer that issues a policy of group health insurance shall not categorically refuse to cover medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the policy provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. An insurer that issues a policy of group health insurance may prescribe requirements that must be satisfied before the insurer covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an insured who is less than 18 years of age. Such requirements may include, without limitation, requirements that:

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

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

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

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

(e) Parental consent is provided for the insured unless the insured is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, an insurer must consider the most recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

6. An insurer shall make a reasonable effort to ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer. If, after a reasonable effort, the insurer is unable to make such benefits available through such a provider of health care, the insurer may treat the treatment that the insurer is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the insurer.

7. If an insured appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by the insured is not medically necessary, the insurer must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the insured when considering the appeal.

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

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) "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.

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

Sec. 3.6. ***An insurer that issues a policy of group health insurance shall not discriminate against any person with respect to participation or coverage under the policy on the basis of actual or perceived gender identity or expression. Prohibited discrimination includes, without limitation:***

1. Denying, cancelling, limiting or refusing to issue or renew a policy of group health insurance on the basis of the actual or perceived gender identity or expression of a person or a family member of the person;

2. Imposing a payment or premium that is based on the actual or perceived gender identity or expression of an insured or a family member of the insured;

3. Designating the actual or perceived gender identity or expression of a person or a family member of the person as grounds to deny, cancel or limit participation or coverage; and

4. Denying, cancelling or limiting participation or coverage on the basis of actual or perceived gender identity or expression, including, without limitation, by limiting or denying coverage for health care services that are:

(a) Related to gender transition, provided that there is coverage under the policy for the services when the services are not related to gender transition; or

(b) Ordinarily or exclusively available to persons of any sex.

Sec. 3.8. Chapter 689C of NRS is hereby amended by adding thereto the provisions set forth as sections 4 and 4.6 of this act.

Sec. 4. ***1. Except as otherwise provided in this section, a carrier that issues a health benefit plan shall include in the health benefit plan coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:***

(a) Endocrinologists;

(b) Pediatric endocrinologists;

(c) Social workers;

(d) Psychiatrists;

(e) Psychologists;

(f) Gynecologists;

(g) Speech-language pathologists;

(h) Primary care physicians;

(i) Advanced practice registered nurses;

(j) Physician assistants; and

(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a health benefit plan to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. A carrier that issues a health benefit plan shall not categorically refuse to cover medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the plan provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. A carrier that issues a health benefit plan may prescribe requirements that must be satisfied before the carrier covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an insured who is less than 18 years of age. Such requirements may include, without limitation, requirements that:

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

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

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

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

(e) Parental consent is provided for the insured unless the insured is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, a carrier must consider the most recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

6. A carrier shall make a reasonable effort to ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier. If, after a reasonable effort, the carrier is unable to make such benefits available through such a provider of health care, the carrier may treat the treatment that the carrier is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the carrier.

7. If an insured appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by

the insured is not medically necessary, the carrier must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the insured when considering the appeal

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

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

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

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

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

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

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

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

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

(c) "Medically necessary" means health care services or products that a prudent provider of health care would provide to a

patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and:

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

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

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

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

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

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

(d) "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.

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

Sec. 4.6. *A carrier that issues a health benefit plan shall not discriminate against any person with respect to participation or coverage under the plan on the basis of actual or perceived gender identity or expression. Prohibited discrimination includes, without limitation:*

1. Denying, cancelling, limiting or refusing to issue or renew a health benefit plan on the basis of the actual or perceived gender identity or expression of a person or a family member of the person;

2. Imposing a payment or premium that is based on the actual or perceived gender identity or expression of an insured or a family member of the insured;

3. Designating the actual or perceived gender identity or expression of a person or a family member of the person as grounds to deny, cancel or limit participation or coverage; and

4. Denying, cancelling or limiting participation or coverage on the basis of actual or perceived gender identity or expression, including, without limitation, by limiting or denying coverage for health care services that are:

(a) Related to gender transition, provided that there is coverage under the plan for the services when the services are not related to gender transition; or

(b) Ordinarily or exclusively available to persons of any sex.

Sec. 5. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, ***and sections 4 and 4.6 of this act,*** to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 5.8. Chapter 695A of NRS is hereby amended by adding thereto the provisions set forth as sections 6 and 6.6 of this act.

Sec. 6. ***1. Except as otherwise provided in this section, a society that issues a benefit contract shall include in the benefit contract coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:***

(a) Endocrinologists;

(b) Pediatric endocrinologists;

(c) Social workers;

(d) Psychiatrists;

(e) Psychologists;

(f) Gynecologists;

(g) Speech-language pathologists;

(h) Primary care physicians;

(i) Advanced practice registered nurses;

(j) Physician assistants; and

(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a benefit contract to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. A society that issues a benefit contract shall not categorically refuse to cover medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the contract provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. A society that issues a benefit contract may prescribe requirements that must be satisfied before the society covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an insured who is less than 18 years of

age. Such requirements may include, without limitation, requirements that:

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

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

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

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

(e) Parental consent is provided for the insured unless the insured is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, a society must consider the most recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

6. A society shall make a reasonable effort to ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society. If, after a reasonable effort, the society is unable to make such benefits available through such a provider of health care, the society may treat the treatment that the society is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the society.

7. If an insured appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by the insured is not medically necessary, the society must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the insured when considering the appeal.

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

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) "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.

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

Sec. 6.6. ***A society that issues a benefit contract shall not discriminate against any person with respect to participation or coverage under the contract on the basis of actual or perceived gender identity or expression. Prohibited discrimination includes, without limitation:***

1. Denying, cancelling, limiting or refusing to issue or renew a benefit contract on the basis of the actual or perceived gender identity or expression of a person or a family member of the person;

2. Imposing a payment or premium that is based on the actual or perceived gender identity or expression of an insured or a family member of the insured;

3. Designating the actual or perceived gender identity or expression of a person or a family member of the person as grounds to deny, cancel or limit participation or coverage; and

4. Denying, cancelling or limiting participation or coverage on the basis of actual or perceived gender identity or expression, including, without limitation, by limiting or denying coverage for health care services that are:

(a) Related to gender transition, provided that there is coverage under the contract for the services when the services are not related to gender transition; or

(b) Ordinarily or exclusively available to persons of any sex.

Sec. 6.8. Chapter 695B of NRS is hereby amended by adding thereto the provisions set forth as sections 7 and 7.6 of this act.

Sec. 7. ***1. Except as otherwise provided in this section, a hospital or medical services corporation that issues a policy of health insurance shall include in the policy coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:***

(a) Endocrinologists;

(b) Pediatric endocrinologists;
(c) Social workers;
(d) Psychiatrists;
(e) Psychologists;
(f) Gynecologists;
(g) Speech-language pathologists;
(h) Primary care physicians;
(i) Advanced practice registered nurses;
(j) Physician assistants; and
(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a policy of health insurance to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. A hospital or medical services corporation that issues a policy of health insurance shall not categorically refuse to cover medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the policy provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. A hospital or medical services corporation that issues a policy of health insurance may prescribe requirements that must be satisfied before the hospital or medical services corporation covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an insured who is less than 18 years of age. Such requirements may include, without limitation, requirements that:

(a) The treatment must be recommended by a psychologist, psychiatrist or other mental health professional;
(b) The treatment must be recommended by a physician;
(c) The insured must provide a written expression of the desire of the insured to undergo the treatment;
(d) A written plan for treatment that covers at least 1 year must be developed and approved by at least two providers of health care; and
(e) Parental consent is provided for the insured unless the insured is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, a hospital or medical services corporation must consider the most recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

6. A hospital or medical services corporation shall make a reasonable effort to ensure that the benefits required by subsection

1 are made available to an insured through a provider of health care who participates in the network plan of the hospital or medical services corporation. If, after a reasonable effort, the hospital or medical services corporation is unable to make such benefits available through such a provider of health care, the hospital or medical services corporation may treat the treatment that the hospital or medical services corporation is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the hospital or medical services corporation.

7. If an insured appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by the insured is not medically necessary, the hospital or medical services corporation must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the insured when considering the appeal.

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

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

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

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

(2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to

prevent the development of anticipated secondary sex characteristics in young adolescents.

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

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

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

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

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

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

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

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

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

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

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

(d) "Network plan" means a policy of health insurance offered by a hospital or medical services corporation 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 hospital or medical services corporation. The term does not include an arrangement for the financing of premiums.

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

Sec. 7.6. ***A hospital or medical services corporation that issues a policy of health insurance shall not discriminate against any person with respect to participation or coverage under the policy on the basis of actual or perceived gender identity or expression. Prohibited discrimination includes, without limitation:***

1. Denying, cancelling, limiting or refusing to issue or renew a policy of health insurance on the basis of the actual or perceived gender identity or expression of a person or a family member of the person;

2. Imposing a payment or premium that is based on the actual or perceived gender identity or expression of an insured or a family member of the insured;

3. Designating the actual or perceived gender identity or expression of a person or a family member of the person as grounds to deny, cancel or limit participation or coverage; and

4. Denying, cancelling or limiting participation or coverage on the basis of actual or perceived gender identity or expression, including, without limitation, by limiting or denying coverage for health care services that are:

(a) Related to gender transition, provided that there is coverage under the policy for the services when the services are not related to gender transition; or

(b) Ordinarily or exclusively available to persons of any sex.

Sec. 7.8. Chapter 695C of NRS is hereby amended by adding thereto the provisions set forth as sections 8 and 8.6 of this act.

Sec. 8. ***1. Except as otherwise provided in this section, a health maintenance organization that issues a health care plan shall include in the health care plan coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:***

(a) Endocrinologists;

(b) Pediatric endocrinologists;

(c) Social workers;

(d) Psychiatrists;

(e) Psychologists;

(f) Gynecologists;

(g) Speech-language pathologists;

(h) Primary care physicians;

(i) Advanced practice registered nurses;

(j) Physician assistants; and

(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a health care plan to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. A health maintenance organization that issues a health care plan shall not categorically refuse to cover medically

necessary gender-affirming treatments or procedures or revisions to prior treatments if the plan provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. A health maintenance organization that issues a health care plan may prescribe requirements that must be satisfied before the health maintenance organization covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an enrollee who is less than 18 years of age. Such requirements may include, without limitation, requirements that:

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

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

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

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

(e) Parental consent is provided for the enrollee unless the enrollee is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, a health maintenance organization must consider the most recent Standards of Care prescribed by the World Professional Association for Transgender Health, or its successor organization.

6. A health maintenance organization shall make a reasonable effort to 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. If, after a reasonable effort, the health maintenance organization is unable to make such benefits available through such a provider of health care, the health maintenance organization may treat the treatment that the health maintenance organization is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the health maintenance organization.

7. If an enrollee appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by the enrollee is not medically necessary, the health maintenance organization must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment

concerning the medical necessity of the treatment requested by the enrollee when considering the appeal.

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

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) "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.

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

Sec. 8.6. *A health maintenance organization that issues a health care plan shall not discriminate against any person with respect to participation or coverage under the plan on the basis of actual or perceived gender identity or expression. Prohibited discrimination includes, without limitation:*

1. Denying, cancelling, limiting or refusing to issue or renew a health care plan on the basis of the actual or perceived gender identity or expression of a person or a family member of the person;

2. Imposing a payment or premium that is based on the actual or perceived gender identity or expression of an enrollee or a family member of the enrollee;

3. Designating the actual or perceived gender identity or expression of a person or a family member of the person as grounds to deny, cancel or limit participation or coverage; and

4. Denying, cancelling or limiting participation or coverage on the basis of actual or perceived gender identity or expression, including, without limitation, by limiting or denying coverage for health care services that are:

(a) Related to gender transition, provided that there is coverage under the plan for the services when the services are not related to gender transition; or

(b) Ordinarily or exclusively available to persons of any sex.

Sec. 9. 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 ***and sections 8 and 8.6 of this act*** apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 10. NRS 695C.330 is hereby amended to read as follows:

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

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant

to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, or 695C.207 ~~[;]~~ ***or sections 8 and 8.6 of this act;***

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

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

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

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

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

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

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

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

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

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

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees or creditors or to the general public;

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

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

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

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional

groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 10.8. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 11 and 11.6 of this act.

Sec. 11. ***1. Except as otherwise provided in this section, a managed care organization that issues a health care plan shall include in the health care plan coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:***

(a) Endocrinologists;

(b) Pediatric endocrinologists;

(c) Social workers;

(d) Psychiatrists;

(e) Psychologists;

(f) Gynecologists;

(g) Speech-language pathologists;

(h) Primary care physicians;

(i) Advanced practice registered nurses;

(j) Physician assistants; and

(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require a health care plan to include coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. A managed care organization that issues a health care plan shall not categorically refuse to cover medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the plan provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. A managed care organization that issues a health care plan may prescribe requirements that must be satisfied before the managed care organization covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an insured who is less than 18 years of age. Such requirements may include, without limitation, requirements that:

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

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

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

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

(e) Parental consent is provided for the insured unless the insured is expressly authorized by law to consent on his or her own behalf.

5. When determining whether treatment is medically necessary for the purposes of this section, a managed care organization must consider the most recent Standards of Care prescribed by the World Professional Association for Transgender Health, or its successor organization.

6. A managed care organization shall make a reasonable effort to ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization. If, after a reasonable effort, the managed care organization is unable to make such benefits available through such a provider of health care, the managed care organization may treat the treatment that the managed care organization is unable to make available through such a provider of health care in the same manner as other services provided by a provider of health care who does not participate in the network plan of the managed care organization.

7. If an insured appeals the denial of a claim or coverage under this section on the grounds that the treatment requested by the insured is not medically necessary, the managed care organization must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the insured when considering the appeal.

8. Evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2023, has the legal effect of including the coverage

required by subsection 1, and any provision of the plan or renewal which is in conflict with the provisions of this section is void.

9. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) "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.

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

Sec. 11.6. ***A managed care organization that issues a health care plan shall not discriminate against any person with respect to participation or coverage under the plan on the basis of actual or perceived gender identity or expression. Prohibited discrimination includes, without limitation:***

1. Denying, cancelling, limiting or refusing to issue or renew a health care plan on the basis of the actual or perceived gender identity or expression of a person or a family member of the person;

2. Imposing a payment or premium that is based on the actual or perceived gender identity or expression of an insured or a family member of the insured;

3. Designating the actual or perceived gender identity or expression of a person or a family member of the person as grounds to deny, cancel or limit participation or coverage; and

4. Denying, cancelling or limiting participation or coverage on the basis of actual or perceived gender identity or expression, including, without limitation, by limiting or denying coverage for health care services that are:

(a) Related to gender transition, provided that there is coverage under the plan for the services when the services are not related to gender transition; or

(b) Ordinarily or exclusively available to persons of any sex.

Sec. 12. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

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

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

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

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

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

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

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, ***and sections 15 and 15.6 of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

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

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in 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. 13. 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.050, inclusive, ***and sections 3 and 3.6 of this act,*** 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. 14. 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.174, inclusive, ***and sections 11 and 11.6 of this act,*** 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. 14.8. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 15 and 15.6 of this act.

Sec. 15. ***1. Except as otherwise provided in this section, the Director shall include in the State Plan for Medicaid a requirement that the State, to the extent authorized by federal law, must pay the nonfederal share of expenditures incurred for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such treatment includes medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:***

(a) Endocrinologists;

(b) Pediatric endocrinologists;

(c) Social workers;

(d) Psychiatrists;

(e) Psychologists;

(f) Gynecologists;

(g) Speech-language pathologists;

(h) Primary care physicians;

(i) Advanced practice registered nurses;

(j) Physician assistants; and

(k) Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

2. This section does not require the Director to include in the State Plan for Medicaid coverage for cosmetic surgery performed by a plastic surgeon or reconstructive surgeon that is not medically necessary.

3. The Department shall not categorically refuse to cover any medically necessary gender-affirming treatments or procedures or revisions to prior treatments if the State Plan for Medicaid provides coverage for any such services, procedures or revisions for purposes other than gender transition or affirmation.

4. When determining whether treatment is medically necessary for the purposes of this section, the Department must consider the most recent Standards of Care published by the World Professional Association for Transgender Health, or its successor organization.

5. If a person appeals the denial of a payment or coverage under this section on the grounds that the treatment requested by the person is not medically necessary, the Division must consult with a provider of health care who has experience in prescribing or delivering gender-affirming treatment concerning the medical necessity of the treatment requested by the person when considering the appeal.

6. As used in this section:

(a) "Cosmetic surgery":

(1) Means a surgical procedure that:

(I) Does not meaningfully promote the proper function of the body;

(II) Does not prevent or treat illness or disease; and

(III) Is primarily directed at improving the appearance of a person.

(2) Includes, without limitation, cosmetic surgery directed at preserving beauty.

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

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

(2) A strong desire to be rid of primary or secondary sex characteristics because of a marked difference between such sex characteristics and gender identity or expression or a desire to

prevent the development of anticipated secondary sex characteristics in young adolescents.

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 15.6. ***The Department shall not discriminate against any person with respect to participation or coverage under Medicaid on the basis of actual or perceived gender identity or expression. Prohibited discrimination includes, without limitation:***

1. Denying, cancelling, limiting or refusing to issue a payment or coverage on the basis of the actual or perceived gender identity or expression of a person or a family member of the person;

2. Imposing a payment that is based on the actual or perceived gender identity or expression of a recipient of Medicaid or a family member of the recipient;

3. Designating the actual or perceived gender identity or expression of a person or a family member of the person as grounds to deny, cancel or limit participation or coverage; and

4. Denying, cancelling or limiting participation or coverage on the basis of actual or perceived gender identity or expression, including, without limitation, by limiting or denying payment or coverage for health care services that are:

(a) Related to gender transition, provided that there is coverage under Medicaid for the services when the services are not related to gender transition; or

(b) Ordinarily or exclusively available to persons of any sex.

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

Sec. 17. This act becomes effective on July 1, 2023.

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