Amendment No. 426

Senate Amendment to Senate Bill No. 113	(BDR 57-333)
Proposed by: Senate Committee on Commerce and Labor	
Amends: Summary: Yes Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes	

Adoption of this amendment will MAINTAIN the unfunded mandate not requested by the affected local government to S.B. 113 (§ 10).

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) ***green bold italic underlining*** is new language proposed 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 that is proposed to be retained in this amendment; and (6) **green bold** is newly added transitory language.

WBD/TMC Date: 4/16/2007

S.B. No. 113—Requires certain policies of health insurance and health care plans to provide coverage for annual screenings for prostate cancer in certain circumstances. (BDR 57-333)

SENATE BILL NO. 113–SENATORS COFFIN, CARLTON, HORSFORD, LEE, MATHEWS, RAGGIO, RHOADS, SCHNEIDER, TITUS, TOWNSEND, WIENER AND WOODHOUSE (BY REQUEST)

FEBRUARY 19, 2007

JOINT SPONSORS: ASSEMBLYMEN PARKS, HORNE, BOBZIEN, HOGAN AND MARVEL

Referred to Committee on Commerce and Labor

SUMMARY—Requires certain policies of health insurance and health care plans to provide coverage for ~~[annual]~~ screenings for prostate cancer in certain circumstances. (BDR 57-333)

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

CONTAINS UNFUNDED MANDATE (§ 10)
(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 policies of health insurance and health care plans to provide coverage for ~~[annual]~~ screenings for prostate cancer in certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires certain public and private health care plans and policies of insurance to provide coverage for certain procedures **,** including colorectal cancer screenings, cytological screening tests and mammograms **,** in certain circumstances. (NRS 287.027, 287.04335, 689A.04042, 689A.0405, 689B.0367, 689B.0374, 695B.1907, 695B.1912, 695C.1731, 695C.1735, 695G.168) Existing law also requires employers to provide certain benefits to employees including coverage for the procedures required to be covered by insurers if the employer provides health benefits for its employees. (NRS 608.1555) **Sections 2-11** of this bill require those health care plans and policies of insurance, other than the State Plan for Medicaid, **that provide coverage for the treatment of prostate cancer** to also provide coverage for ~~[annual]~~ screenings for prostate cancer in certain circumstances. ~~[Sections 2, 4-6 and 9-11 also provide that such policies of health insurance and health care plans must not require prior authorization or charge a deductible, copayment or coinsurance for the provision of coverage for annual screenings for prostate cancer.]~~

Section 1 of this bill clarifies that policies of health insurance and health care plans which provide for such prostate cancer screenings must not require the insured to obtain prior authorization for the screening from the insurer or organization. (NRS 687B.225)

The provisions of this bill apply prospectively to any policy of insurance or health care plan issued or renewed on or after the effective date of the bill, October 1, 2007.

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

Section 1. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0413, 689B.031, 689B.0374, 695B.1912, 695B.1914, 695C.1713, 695C.1735 and 695G.170, ***and sections 2, 4, 5, 6, 9 and 10 of this act,*** any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:

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

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

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

Sec. 2. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. A policy of health insurance ~~*[must provide coverage for benefits payable for expenses incurred for an annual screening for prostate cancer for:*~~

~~*(a) Men 40 years of age or older; and*~~

~~*(b) Men 35 years of age or older who have a high risk of developing prostate cancer.*~~

~~*2. An annual screening for prostate cancer pursuant to subsection 1 must include a blood test to determine the amount of prostate-specific antigen in the blood and a digital rectal examination, regardless of the results of one of those tests.*~~

~~*3. For purposes of this section, a man has a high risk of developing prostate cancer if he has a definite or indeterminate family history of prostate cancer, if he is African American or if he is considered at high risk of developing prostate cancer according to the guidelines for the early detection of prostate cancer established by the National Alliance of State Prostate Cancer Coalitions or according to guidelines established or approved by the Task Force on Prostate Cancer created pursuant to NRS 457.310.*~~

~~*4. A policy of health insurance must not:*~~

~~*(a) Require an insured to obtain prior authorization for any service provided pursuant to subsection 1; or*~~

~~*(b) Charge a deductible, copayment or coinsurance for the provision of coverage required by subsection 1.*~~

~~*5.]*~~ ***that provides coverage for the treatment of prostate cancer must provide coverage for prostate cancer screening in accordance with:***

(a) The guidelines concerning prostate cancer screening which are published by the American Cancer Society; or

(b) Other guidelines or reports concerning prostate cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data.

2. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with subsection 1 is void.

Sec. 3. 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 section 2 of this act.***

Sec. 4. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A policy of group health insurance ~~[must provide coverage for benefits payable for expenses incurred for an annual screening for prostate cancer for:~~

~~(a) Men 40 years of age or older; and~~

~~(b) Men 35 years of age or older who have a high risk of developing prostate cancer.~~

~~2. An annual screening for prostate cancer pursuant to subsection 1 must include a blood test to determine the amount of prostate-specific antigen in the blood and a digital rectal examination, regardless of the results of one of those tests.~~

~~3. For purposes of this section, a man has a high risk of developing prostate cancer if he has a definite or indeterminate family history of prostate cancer, if he is African-American or if he is considered at high risk of developing prostate cancer according to the guidelines for the early detection of prostate cancer established by the National Alliance of State Prostate Cancer Coalitions or according to guidelines established or approved by the Task Force on Prostate Cancer created pursuant to NRS 457.310.~~

~~4. A policy of group health insurance must not:~~

~~(a) Require an insured to obtain prior authorization for any service provided pursuant to subsection 1; or~~

~~(b) Charge a deductible, copayment or coinsurance for the provision of coverage required by subsection 1.~~

~~5.] that provides coverage for the treatment of prostate cancer must provide coverage for prostate cancer screening in accordance with:

(a) The guidelines concerning prostate cancer screening which are published by the American Cancer Society; or

(b) Other guidelines or reports concerning prostate cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data.

2. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with subsection 1 is void.

Sec. 5. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A policy of health insurance issued by a hospital or medical service corporation ~~[must provide coverage for benefits payable for expenses incurred for an annual screening for prostate cancer for:~~

~~(a) Men 40 years of age or older; and~~

~~(b) Men 35 years of age or older who have a high risk of developing prostate cancer.~~

~~2. An annual screening for prostate cancer pursuant to subsection 1 must include a blood test to determine the amount of prostate-specific antigen in the blood and a digital rectal examination, regardless of the results of one of those tests.~~

~~3. For purposes of this section, a man has a high risk of developing prostate cancer if he has a definite or indeterminate family history of prostate cancer, if he is African-American or if he is considered at high risk of developing prostate cancer according to the guidelines for the early detection of prostate cancer established by the National Alliance of State Prostate Cancer Coalitions or according to guidelines established or approved by the Task Force on Prostate Cancer created pursuant to NRS 457.310.~~

~~4. A policy of health insurance issued by a hospital or medical service corporation must not:~~

~~(a) Require an insured to obtain prior authorization for any service provided pursuant to subsection 1; or~~

~~(b) Charge a deductible, copayment or coinsurance for the provision of coverage required by subsection 1.~~

~~5.]~~ *that provides coverage for the treatment of prostate cancer must provide coverage for prostate cancer screening in accordance with:*

(a) The guidelines concerning prostate cancer screening which are published by the American Cancer Society; or

(b) Other guidelines or reports concerning prostate cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data.

2. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with subsection 1 is void.

Sec. 6. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health care plan issued by a health maintenance ~~[plan must provide coverage for benefits payable for expenses incurred for an annual screening for prostate cancer for:~~

~~(a) Men 40 years of age or older; and~~

~~(b) Men 35 years of age or older who have a high risk of developing prostate cancer.~~

~~2. An annual screening for prostate cancer pursuant to subsection 1 must include a blood test to determine the amount of prostate-specific antigen in the blood and a digital rectal examination, regardless of the results of one of those tests.~~

~~3. For purposes of this section, a man has a high risk of developing prostate cancer if he has a definite or indeterminate family history of prostate cancer, if he is African-American or if he is considered at high risk of developing prostate cancer according to the guidelines for the early detection of prostate cancer established by the National Alliance of State Prostate Cancer Coalitions or according to guidelines established or approved by the Task Force on Prostate Cancer created pursuant to NRS 457.310.~~

~~4. A health maintenance plan must not:~~

~~(a) Require an insured to obtain prior authorization for any service provided pursuant to subsection 1; or~~

~~(b) Charge a deductible, copayment or coinsurance for the provision of coverage required by subsection 1.~~

~~*5. A policy]*~~ ***organization that provides coverage for the treatment of prostate cancer must provide coverage for prostate cancer screening in accordance with:***

(a) The guidelines concerning prostate cancer screening which are published by the American Cancer Society; or

(b) Other guidelines or reports concerning prostate cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data.

2. An evidence of coverage for a health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the ~~*[policy]*~~ ***evidence of coverage or the renewal which is in conflict with subsection 1 is void.***

Sec. 7. 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 to 695C.200, inclusive, ***and section 6 of this act,*** 695C.250 and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694, 695C.1695 and 695C.1731 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. 8. 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 he finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, ***and section 6 of this act,*** or 695C.207;

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

(d) The State Board of Health certifies to the Commissioner that the health maintenance organization:

(1) Does not meet the requirements of subsection 2 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 final adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

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

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

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

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

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

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as he 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. 9. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health care plan issued by a managed care organization ~~[must provide coverage for benefits payable for expenses incurred for an annual screening for prostate cancer for:~~

~~(a) Men 40 years of age or older; and~~

~~(b) Men 35 years of age or older who have a high risk of developing prostate cancer.~~

~~2. An annual screening for prostate cancer pursuant to subsection 1 must include a blood test to determine the amount of prostate specific antigen in the~~

~~*blood and a digital rectal examination, regardless of the results of one of those tests.*~~

~~*3. For purposes of this section, a man has a high risk of developing prostate cancer if he has a definite or indeterminate family history of prostate cancer, if he is African American or if he is considered at high risk of developing prostate cancer according to the guidelines for the early detection of prostate cancer established by the National Alliance of State Prostate Cancer Coalitions or according to guidelines established or approved by the Task Force on Prostate Cancer created pursuant to NRS 457.310.*~~

~~*4. A health care plan issued by a managed care organization must not:*~~

~~*(a) Require an insured to obtain prior authorization for any service provided pursuant to subsection 1; or*~~

~~*(b) Charge a deductible, copayment or coinsurance for the provision of coverage required by subsection 1.*~~

~~*5.*~~ *that provides coverage for the treatment of prostate cancer must provide coverage for prostate cancer screening in accordance with:*

(a) The guidelines concerning prostate cancer screening which are published by the American Cancer Society; or

(b) Other guidelines or reports concerning prostate cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data.

2. An evidence of coverage for a health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with subsection 1 is void.

Sec. 10. Chapter 287 of NRS is hereby amended by adding thereto a new section to read as follows:

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 an annual screening for prostate cancer for:*~~

~~*(a) Men 40 years of age or older; and*~~

~~*(b) Men 35 years of age or older who have a high risk of developing prostate cancer.*~~

~~*2. An annual screening for prostate cancer pursuant to subsection 1 must include a blood test to determine the amount of prostate-specific antigen in the blood and a digital rectal examination, regardless of the results of one of those tests.*~~

~~*3. For purposes of this section, a man has a high risk of developing prostate cancer if he has a definite or indeterminate family history of prostate cancer, if he is African American or if he is considered at high risk of developing prostate cancer according to the guidelines for the early detection of prostate cancer established by the National Alliance of State Prostate Cancer Coalitions or according to guidelines established or approved by the Task Force on Prostate Cancer created pursuant to NRS 457.310.*~~

~~*4. A plan of self-insurance described in subsection 1 must not:*~~

~~*(a) Require an insured to obtain prior authorization for any service provided pursuant to subsection 1; or*~~

~~*(b) Charge a deductible, copayment or coinsurance for the provision of coverage required by subsection 1.*~~

~~5.~~ *that provides coverage for the treatment of prostate cancer shall provide coverage for prostate cancer screening in accordance with:*

(a) The guidelines concerning prostate cancer screening which are published by the American Cancer Society; or

(b) Other guidelines or reports concerning prostate cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data.

2. A plan of self-insurance described in subsection 1 which is offered, delivered, issued for delivery or renewed on or after October 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the ~~*[evidence of coverage]*~~ *plan or the renewal which is in conflict with subsection 1 is void.*

Sec. 11. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 689B.255, 695G.150, 695G.160, 695G.164, 695G.170, 695G.173, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, *and section* ~~*[10]*~~ *9 of this act,* in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 12. 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.