ASSEMBLY BILL NO. 373–ASSEMBLYWOMAN SPIEGEL

MARCH 20, 2019

Referred to Committee on Health and Human Services

SUMMARY—Prohibits certain state and local governmental entities from restricting certain communications and services provided by a provider of health care to provide certain information and services to a patient. (BDR 40-941)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

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

AN ACT relating to health care; prohibiting certain state and local governmental entities from restricting certain communications and services provided by a provider of health care; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law provides for the licensure and regulation of medical facilities and facilities for the dependent by the Division of Public and Behavioral Health of the Department of Health and Human Services. (NRS 449.029-449.240) Existing law also creates local health officers and local boards of health to provide public health services in this State. (NRS 439.280-439.4905) **Section 1** of this bill prohibits the Division or any local health officer or board from: (1) requiring a provider of health care to provide to a patient any information that is not medically accurate or any service that is not medically appropriate for the patient; or (2) prohibiting a provider of health care from providing to a patient any information that is medically accurate and medically appropriate for the patient or any service that is evidence-based and medically appropriate for the patient. **Sections 3, 4, 6, 7 and 10-12** of this bill enact similar prohibitions applicable to local governing bodies, public insurance plans, including Medicaid, the Aging and Disability Services Division of the Department and health care licensing boards. **Sections 2, 8, 9, 13 and 14** of this bill make conforming changes.

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

Section 1. Chapter 439 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Division, a local board of health or a local health officer shall not, as a condition of licensure or certification or for any other purpose:

(a) Require a provider of health care to provide to a patient any information that is not medically accurate or any service that is not medically appropriate for the patient; or

(b) Prohibit a provider of health care from providing to a patient:

(1) Any information that is medically accurate and medically appropriate for the patient; or

(2) Any service that is evidence-based and medically appropriate for the patient and which the provider is properly qualified to perform.

2. As used in this section:

(a) "Evidence-based" means proven effective through empirical analysis.

(b) "Medically accurate" means information that is:

(1) Verified or supported by the weight of medical research conducted in compliance with accepted scientific methods;

(2) Recognized as correct and objective by the majority of national organizations of medical professionals who have relevant expertise; or

(3) Recommended by or affirmed in the medical practice guidelines adopted by a nationally recognized accrediting organization.

(c) "Medically appropriate" means a procedure or service that is determined to be appropriate for a patient in accordance with:

(1) The weight of medical research conducted in compliance with accepted scientific methods;

(2) The opinion of the majority of national organizations of medical professionals who have relevant expertise; or

(3) The medical practice guidelines adopted by a nationally recognized accrediting organization.

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

Sec. 2. 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 section 10 of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.621 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, other than the State Public Defender of the Office of State Public Defender who is appointed pursuant to NRS 180.010.

Sec. 3. Chapter 244 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 2, a board of county commissioners shall not, by ordinance, as a condition of entering into a contract with the city or town or in any other manner cause a provider of health care to engage in conduct contrary to that described in paragraph (a) or (b) of subsection 1 of section 1 of this act.

2. The provisions of this section must not be construed to require a board of county commissioners to pay for any service unless it is otherwise required by law.

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

Sec. 4. Chapter 268 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 2, the governing body of a city or town shall not, by ordinance, as a condition of entering into a contract with the city or town or in any other manner cause a provider of health care to engage in conduct contrary to that described in paragraph (a) or (b) of subsection 1 of section 1 of this act.

2. The provisions of this section must not be construed to require the governing body of a city or town to pay for any service unless it is otherwise required by law.

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

Sec. 5. Chapter 287 of NRS is hereby amended by adding thereto the provisions set forth as sections 6 and 7 of this act.

Sec. 6. ***1. Except as otherwise provided by subsection 2, the governing body of any county, school district, municipal***

corporation, political subdivision, public corporation or other local governmental agency shall not, as a condition of providing services covered by a policy of health insurance provided pursuant to NRS 287.010 for the benefit of the officers and employees of the county, school district, corporation, subdivision or agency cause a provider of health care to engage in conduct contrary to that described in paragraph (a) or (b) of subsection 1 of section 1 of this act.

2. The provisions of this section must not be construed to require a policy of health insurance provided pursuant to NRS 287.010 to cover any service unless it is otherwise required by law.

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

Sec. 7. ***1. Except as otherwise provided in subsection 2, the Board shall not, as a condition of providing services covered by a plan of health insurance established pursuant to NRS 287.0433 cause a provider of health care to engage in conduct contrary to that described in paragraph (a) or (b) of subsection 1 of section 1 of this act.***

2. The provisions of this section must not be construed to require a plan of health insurance established pursuant to NRS 287.0433 to cover any service unless it is otherwise required by law.

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

Sec. 8. NRS 287.040 is hereby amended to read as follows:

287.040 The provisions of NRS 287.010 to 287.040, inclusive, ***and section 6 of this act*** do not make it compulsory upon any governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada, except as otherwise provided in NRS 287.021 or subsection 4 of NRS 287.023 or in an agreement entered into pursuant to subsection 3 of NRS 287.015, to pay any premiums, contributions or other costs for group insurance, a plan of benefits or medical or hospital services established pursuant to NRS 287.010, 287.015, 287.020 or paragraph (b), (c) or (d) of subsection 1 of NRS 287.025, for coverage under the Public Employees' Benefits Program, or to make any contributions to a trust fund established pursuant to NRS 287.017, or upon any officer or employee of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of this State to accept any such coverage or to assign his or her wages or salary in payment of premiums or contributions therefor.

Sec. 9. NRS 287.0402 is hereby amended to read as follows:

287.0402 As used in NRS 287.0402 to 287.049, inclusive, ***and section 7 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 287.0404 to 287.04064, inclusive, have the meanings ascribed to them in those sections.

Sec. 10. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 2, the Department and the Division shall not, as a condition of providing services pursuant to Medicaid or any other reason cause a provider of health care to engage in conduct contrary to that described in paragraph (a) or (b) of subsection 1 of section 1 of this act.

2. The provisions of this section must not be construed to require the State Plan for Medicaid to include coverage for any service unless it is otherwise required by law.

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

Sec. 11. Chapter 427A of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 2, the Division shall not, as a condition of employment with or entering into a contract with the Division or for any other reason cause a provider of health care to engage in conduct contrary to that described in paragraph (a) or (b) of subsection 1 of section 1 of this act.

2. The provisions of this section must not be construed to require the Division to pay for any service unless it is otherwise required by law.

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

Sec. 12. Chapter 629 of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health care licensing board shall not cause a provider of health care to engage in conduct contrary to that described in paragraph (a) or (b) of subsection 1 of section 1 of this act.

2. As used in this section, "health care licensing board" means:

(a) A board created pursuant to chapter 630, 630A, 631, 632, 633, 634, 634A, 635, 636, 637, 637B, 639, 640, 640A, 640B, 640C, 640D, 640E, 641, 641A, 641B or 641C of NRS.

(b) The Division of Public and Behavioral Health of the Department of Health and Human Services.

Sec. 13. NRS 687B.409 is hereby amended to read as follows:

687B.409 1. Every payment made pursuant to a policy of health insurance to pay for treatment relating solely to mental health

or the abuse of alcohol or drugs must be made directly to the provider of health care that provides the treatment if the provider:

(a) Is an out-of-network provider; and

(b) Has obtained and delivered to the insurer or an authorized representative of the insurer, including, without limitation, a third-party administrator, a written assignment of benefits pursuant to which the insured has assigned to the provider the insured's benefits under the policy of health insurance with regard to the treatment.

2. An out-of-network provider that receives payment pursuant to subsection 1:

(a) Shall, if a person paid the provider directly for the treatment described in subsection 1, refund to the person the amount that the person paid directly to the provider for the treatment, less any applicable deductible, copayment or coinsurance, not later than 45 days after the provider receives payment pursuant to subsection 1; and

(b) Must indemnify and hold harmless the insurer against any claim made against the insurer by the person who receives the treatment described in subsection 1 for any amount paid by the insurer to the provider in compliance with this section.

3. An assignment of benefits described in paragraph (b) of subsection 1 is irrevocable for the period:

(a) Beginning on the date the insured gives to the out-of-network provider the assignment of benefits; and

(b) Ending on the later of:

(1) The date on which the out-of-network provider receives from the insurer the final payment for the treatment; or

(2) The date of the final resolution, including, without limitation, by settlement or trial, of all claims relating to all payments which relate to the treatment.

4. Nothing in this section shall be construed to require an insurer to make a payment to an out-of-network provider:

(a) Who is not authorized by law to provide the treatment;

(b) Who provides the treatment in violation of any law; or

(c) In an amount which exceeds the amount required by the policy of health insurance to be paid for out-of-network treatment.

5. As used in this section:

(a) "Health care services" means services for the diagnosis, prevention, treatment, care or relief of a health condition, illness, injury or disease.

(b) "Insured" means a person who receives benefits pursuant to a policy of health insurance.

(c) "Insurer" means a person, including, without limitation, a governmental entity, who issues or otherwise provides a policy of health insurance.

(d) "Network plan" has the meaning ascribed to it in NRS 689B.570.

(e) "Out-of-network provider" means a provider of health care who:

(1) Provides health care services;

(2) Is paid, pursuant to a policy of health insurance, for providing the health care services; and

(3) Is not under contract to provide the health care services as part of any network plan associated with the policy of health insurance.

(f) "Policy of health insurance" includes, without limitation, a policy, contract, certificate, plan or agreement, as applicable, issued pursuant to or otherwise governed by NRS 287.0402 to 287.049, inclusive, ***and section 7 of this act*** or chapter 608, 689A, 689B, 689C, 695A, 695B, 695C, 695F or 695G of NRS for the provision of, delivery of, arrangement for, payment for or reimbursement for any of the costs of health care services.

(g) "Provider of health care" has the meaning ascribed to it in NRS 695G.070.

Sec. 14. NRS 689B.065 is hereby amended to read as follows:

689B.065 1. A policy of group health insurance issued to replace any discontinued policy or coverage for group health insurance must:

(a) Provide coverage for all persons who were covered under the previous policy or coverage on the date it was discontinued; and

(b) Except as otherwise provided in subsection 2, provide benefits which are at least as extensive as the benefits provided by the previous policy or coverage, except that benefits may be reduced or excluded to the extent that such a reduction or exclusion was permissible under the terms of the previous policy or coverage,

➥ if that replacement policy is issued within 60 days after the date on which the previous policy or coverage was discontinued.

2. If an employer obtains a replacement policy pursuant to subsection 1 to cover the employees of the employer, any benefits provided by the previous policy or coverage may be reduced if notice of the reduction is given to the employees of the employer pursuant to NRS 608.1577.

3. Any insurer which issues a replacement policy pursuant to subsection 1 may submit a written request to the insurer who provided the previous policy or coverage for a statement of benefits which were provided under that policy or coverage. Upon receiving such a request, the insurer who provided the previous policy or coverage shall give a written statement to the insurer providing the replacement policy which indicates what benefits were provided and

what exclusions or reductions were in effect under the previous policy or coverage.

4. The provisions of this section:

(a) Apply to a self-insured employer who provides health benefits to the employees of the employer and replaces those benefits with a policy of group health insurance.

(b) Do not apply to the Public Employees' Benefits Program established pursuant to NRS 287.0402 to 287.049, inclusive ~~.~~ ***, and section 7 of this act.***

Sec. 15. This act becomes effective upon passage and approval.

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