ASSEMBLY BILL NO. 155–ASSEMBLYMEN PETERS; AND ORENTLICHER

FEBRUARY 13, 2023

Referred to Committee on Health and Human Services

SUMMARY—Establishes provisions relating to biomarker testing. (BDR 40-305)

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

CONTAINS UNFUNDED MANDATE (§ 13)
(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 health care; establishing the Task Force on Precision Medicine and Biomarker Testing; prescribing the membership and duties of the Task Force; establishing March as Precision Medicine and Biomarker Testing Awareness Month; requiring policies of health insurance to include coverage of biomarker testing in certain circumstances; establishing certain conditions relating to such required coverage; making an appropriation; providing for a study of certain matters relating to precision medicine and biomarker testing; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law establishes certain programs to improve public health in this State. (NRS 439.4921-439.5297) **Section 12** of this bill defines the term "biomarker testing" to mean the analysis of the tissue, blood or other specimen of a patient for the presentation of a biomarker, which is further defined as an objectively measured characteristic that indicates certain biological processes. **Section 12** also: (1) establishes the month of March as Precision Medicine and Biomarker Testing Awareness Month in this State; and (2) requires the Governor to annually issue a proclamation calling upon certain entities to raise awareness of biomarker testing during the month of March.

Section 8 of this bill establishes the Task Force on Precision Medicine and Biomarker Testing within the Department of Health and Human Services and prescribes the membership of the Task Force. **Sections 2-7** of this bill define certain terms relating to the Task Force. **Sections 8 and 9** of this bill prescribe

certain requirements governing the operation of the Task Force. **Section 9** also authorizes the Task Force to establish subcommittees and solicit expert testimony. **Section 10** of this bill requires the Task Force to: (1) examine certain issues relating to the awareness, accessibility and use of biomarker testing; and (2) annually report its findings to the Director of the Department, the Commissioner of Insurance and the Legislature. **Section 31** of this bill terminates the Task Force on February 1, 2027.

Sections 13-15, 17, 19, 20, 22-25 and 27 of this bill require certain public and private health plans, including Medicaid and health plans for state and local government employees, to provide coverage for biomarker testing for the diagnosis, treatment, management and monitoring of a disease or condition when such biomarker testing is supported by medical and scientific evidence. **Sections 13-15, 17, 19, 20, 22-25 and 27** require such health plans to: (1) provide the required coverage in a manner that limits disruptions in care and the need for multiple specimens; and (2) establish a process for requesting an exception to a policy excluding coverage for biomarker testing or appealing a denial of coverage for biomarker testing. **Sections 13-17, 19, 20, 22-25 and 27** additionally require such health plans to respond to any request for preauthorization for biomarker testing within: (1) 24 hours for urgent requests; or (2) 72 hours for all other requests. **Sections 11, 18 and 21** of this bill make conforming changes to indicate the proper placement of **sections 15, 17 and 20**, respectively, in the Nevada Revised Statutes. **Section 26** 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 **section 24** of this bill. The Commissioner would also be authorized to take such action against other private health insurers who fail to comply with the requirements of **sections 17, 19, 20, 22, 23 or 27** of this bill. (NRS 680A.200)

Section 29 of this bill requires the Department to contract with a college or university or another qualified entity that conducts research in the field of public health and is located in this State to study the awareness of and access to precision medicine and biomarker testing in this State. **Section 29** requires the entity with which the Department enters into a contract to: (1) present its findings to the Joint Interim Standing Committee on Health and Human Services; and (2) submit a final report of the study to the Governor, the Director of the Department, the Commissioner of Insurance and the Legislature. **Section 28** of this bill appropriates money to the Department to pay the costs of the study.

WHEREAS, Precision medicine, also known as personalized health care or individualized medicine, is an evolving field in which providers of health care use the analysis of a specimen from a patient, known as biomarker testing, to determine which medical treatments will work best for the patient; and

WHEREAS, By combining the data from biomarker testing with the medical history, circumstances and values of a patient, a provider of health care is capable of directing a patient to a targeted treatment, benefitting both the patient and the health care system; and

WHEREAS, Precision medicine holds great promise in ensuring the delivery of the proper treatment to the proper patient at the proper time and avoiding treatment that is physically or financially harmful to the patient; and

WHEREAS, A significant number of treatments currently in preclinical development rely on the data from biomarker testing; and

WHEREAS, Biomedical science and the understanding of the characteristics of disease are evolving rapidly; and

WHEREAS, Providers of health care are increasingly using biomarker testing and other technologies to help identify gene mutations or aberrations and protein expressions specific to individual patients; and

WHEREAS, Health outcomes are frequently improved through the use of precision medicine; and

WHEREAS, The National Academy of Medicine considers biomarker testing to be key to unlocking the promise of precision medicine; and

WHEREAS, Biomarker testing is available for an increasing range of conditions and diseases, but access of patients to biomarker testing is not keeping pace with the rate of innovation in the field; and

WHEREAS, A lack of awareness about biomarker testing among providers of health care and patients, a lack of common terminology in the field of biomarker testing and deficient coverage policies by public and private payers are preventing the effective adoption and integration of biomarker testing into precision medicine, particularly for historically marginalized communities and in nonacademic health care settings; and

WHEREAS, It is beneficial to promote appropriate awareness and education about the ways that biomarker testing may be used to support the diagnosis, treatment and monitoring of patients in a personalized way; now, therefore,

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 the provisions set forth as sections 2 to 10, inclusive, of this act.

Sec. 2. ***As used in sections 2 to 10, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 7, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"Biomarker testing" has the meaning ascribed to it in section 12 of this act.***

Sec. 4. ***"Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:***

1. Informed by a systemic review of evidence and an assessment of the costs and benefits of alternative options for care; and

2. Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

Sec. 5. *"Precision medicine" means the use of biomarker testing to determine the best medical treatment for a patient.*

Sec. 6. *"Provider of health care" has the meaning ascribed to it in NRS 629.031.*

Sec. 7. *"Task Force" means the Task Force on Precision Medicine and Biomarker Testing created by section 8 of this act.*

Sec. 8. *1. The Task Force on Precision Medicine and Biomarker Testing is hereby created within the Department.*

2. The Task Force consists of:

(a) The following four voting members appointed by the Governor:

(1) One representative of a medical school in this State that is conducting research on biomarker testing or precision medicine;

(2) One researcher in the field of molecular diagnostics or biomarker testing;

(3) One physician who specializes in the field of molecular pathology; and

(4) One provider of health care who uses biomarker testing to diagnose, treat or monitor patients;

(b) The following three voting members appointed by the Speaker of the Assembly:

(1) One researcher in the field of health technology who specializes in precision medicine;

(2) One representative of an organization that advocates for patients; and

(3) One representative of a reference laboratory, manufacturer of biomarker tests or other company involved in diagnostics;

(c) The following three voting members appointed by the Senate Majority Leader:

(1) One representative of an insurer, as defined in NRS 679B.540, or a health benefit plan, as defined in NRS 687B.470, for employees which provides coverage for biomarker testing;

(2) One representative of an organization or society that publishes nationally recognized clinical practice guidelines on biomarker testing or precision medicine; and

(3) One representative of a community impacted by health inequalities related to biomarker testing or precision medicine; and

(d) The Director or his or her designee as an ex officio, nonvoting member.

3. Members of the Task Force serve at the pleasure of the appointing authority. A vacancy in the membership of the Task Force must be filled in the same manner as the original appointment.

4. The members of the Task Force serve without compensation, except that each member is entitled, while engaged in the business of the Task Force and within the limits of available money, to the per diem allowance and travel expenses provided for state officers and employees generally.

5. Each member of the Task Force who is an officer or employee of this State or a political subdivision of this State must be relieved from his or her duties without loss of regular compensation so that the officer or employee may prepare for and attend meetings of the Task Force and perform any work necessary to carry out the duties of the Task Force in the most timely manner practicable. A state agency or political subdivision of this State shall not require an officer or employee who is a member of the Task Force to make up the time the officer or employee is absent from work to carry out duties as a member of the Task Force or use annual leave or compensatory time for the absence.

6. The Department may accept gifts, grants or donations from any source to support the activities of the Task Force.

Sec. 9. *1. The Speaker of the Assembly and the Majority Leader of the Senate, acting jointly, shall appoint the Chair of the Task Force from among the voting members of the Task Force. If the position of Chair becomes vacant, the Speaker of the Assembly and the Majority Leader of the Senate, acting jointly, shall appoint a Chair from among the voting members of the Task Force.*

2. The members of the Task Force shall meet at least once each quarter at the call of the Chair. The Task Force shall prescribe regulations for its own management and government.

3. A majority of the voting members of the Task Force constitutes a quorum, and a quorum may exercise all the powers conferred on the Task Force.

4. The Task Force may establish subcommittees and solicit expert testimony as necessary to fulfill its duties.

Sec. 10. *1. The Task Force shall:*

(a) Review reports and studies on:

(1) The current status of precision medicine and biomarker testing;

(2) The evolution of science relating to precision medicine and biomarker testing;

(3) The experience of patients in accessing and receiving precision medicine and biomarker testing; and

(4) The experience of providers of health care in accessing and providing precision medicine and biomarker testing.

(b) Examine barriers to the use of biomarker testing with a focus on diagnosis, treatment decisions and the post-treatment monitoring of disease. Such barriers may include, without limitation:

(1) Lack of awareness of biomarker testing;

(2) The use of inconsistent terminology when discussing biomarker testing;

(3) A lack of reimbursement or low rates of reimbursement from third parties for biomarker testing;

(4) A lack of coverage of biomarker testing or restrictive medical management techniques imposed by third parties; and

(5) Low levels of understanding of the uses of biomarker testing in measuring indicators of normal biological processes, pathogenic processes or pharmacologic responses to a specific therapeutic intervention.

(c) Study the role of nationally recognized clinical practice guidelines in the making of decisions by providers of health care and third parties relating to biomarker testing, focusing on situations where evidence-based biomarker testing is available but nationally recognized clinical practice guidelines have not been developed.

(d) Identify opportunities to expand awareness, education, understanding and usefulness of precision medicine and biomarker testing to improve care and reduce spending on health care.

(e) On or before January 31 of each year:

(1) Compile a report of the findings and recommendations of the Task Force, which must include, without limitation, findings and recommendations to:

(I) Improve awareness, education and insurance coverage of precision medicine and biomarker testing; and

(II) Optimize the use of precision medicine and biomarker testing in this State; and

(2) Submit the report to the Director, the Commissioner of Insurance and the Director of the Legislative Counsel Bureau for transmittal to:

(I) In odd-numbered years, the next regular session of the Legislature; and

(II) In even-numbered years, the Joint Interim Standing Committee on Health and Human Services.

2. As used in this section:

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

(b) "Third party" means any insurer, governmental entity or other organization providing health coverage or benefits in accordance with state or federal law.

Sec. 11. 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 15 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. 12. Chapter 236 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The month of March of each year is designated as "Precision Medicine and Biomarker Testing Awareness Month" in the State of Nevada.

2. The Governor shall issue annually a proclamation encouraging the observance of "Precision Medicine and Biomarker Testing Awareness Month." The proclamation must, without limitation, call upon the news media, state and local officers, medical facilities, providers of health care and other public and private entities to bring public attention to the manner in which biomarker testing is useful to diagnose, treat and monitor patients in a personalized way.

3. As used in this section:

(a) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of a normal biological process, a pathogenic process or a pharmacological response to a specific therapeutic intervention and includes, without limitation, a gene mutation or the expression of a protein.

(b) "Biomarker testing" means the analysis of the tissue, blood or other specimen of a patient for the presentation of a biomarker and includes, without limitation, single-analyte tests, multi-plex panel tests and whole genome sequencing.

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 section 19 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 section 27 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. 15. Chapter 422 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for biomarker testing for the diagnosis, treatment, management and monitoring of a disease or condition when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(c) Nationally recognized clinical practice guidelines or consensus statements.

2. The Director shall:

(a) Ensure that the coverage required by subsection 1 is provided in a manner that limits disruptions in care and the need for multiple specimens.

(b) Include in the State Plan for Medicaid a clear and readily accessible process for a recipient of Medicaid or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing; or

(2) Appeal a denial of coverage for biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the Department.

3. If the State Plan for Medicaid requires a recipient of Medicaid to obtain prior authorization for a biomarker test described in subsection 1, the State Plan must require a response to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

4. As used in this section:

(a) "Biomarker testing" has the meaning ascribed to it in section 12 of this act.

(b) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(c) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the costs and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

Sec. 16. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0412, 689A.0413, 689A.044, 689A.0445, 689B.031, 689B.0313, 689B.0315, 689B.0317, 689B.0374, 689C.1675, 695A.1856, 695B.1912, 695B.1913, 695B.1914, 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1737, 695C.1745, 695C.1751, 695G.170, 695G.171, 695G.1714 and 695G.177, 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]~~ ***Unless a shorter time period is prescribed by a specific statute, including, without limitation, sections 17, 19, 20, 22, 23, 24 and 27 of this act, 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. 17. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer that issues a policy of health insurance shall include in the policy coverage for biomarker testing for the diagnosis, treatment, management and monitoring of a disease or condition when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(c) Nationally recognized clinical practice guidelines or consensus statements.

2. An insurer shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens.

(b) Establish a clear and readily accessible process for an insured or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing; or

(2) Appeal a denial of coverage for biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the insurer.

3. If an insurer requires an insured to obtain prior authorization for a biomarker test described in subsection 1, the insurer shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

4. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2023, has the legal effect of including the coverage required by this section, and any provision of the policy

or renewal which is in conflict with the provisions of this section is void.

5. As used in this section:

(a) "Biomarker testing" has the meaning ascribed to it in section 12 of this act.

(b) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(c) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the costs and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

Sec. 18. 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 17 of this act.***

Sec. 19. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer that issues a policy of group health insurance shall include in the policy coverage for biomarker testing for the diagnosis, treatment, management and monitoring of a disease or condition when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(c) Nationally recognized clinical practice guidelines or consensus statements.

2. An insurer shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens.

(b) Establish a clear and readily accessible process for an insured or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing; or

(2) Appeal a denial of coverage for biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the insurer.

3. If an insurer requires an insured to obtain prior authorization for a biomarker test described in subsection 1, the insurer shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

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

5. As used in this section:

(a) "Biomarker testing" has the meaning ascribed to it in section 12 of this act.

(b) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(c) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the costs and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

Sec. 20. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A carrier that issues a health benefit plan shall include in the plan coverage for biomarker testing for the diagnosis, treatment, management and monitoring of a disease or condition when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(c) Nationally recognized clinical practice guidelines or consensus statements.

2. A carrier shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens.

(b) Establish a clear and readily accessible process for an insured or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing; or

(2) Appeal a denial of coverage for biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the carrier.

3. If a carrier requires an insured to obtain prior authorization for a biomarker test described in subsection 1, the carrier shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

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

5. As used in this section:

(a) "Biomarker testing" has the meaning ascribed to it in section 12 of this act.

(b) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(c) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the costs and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

Sec. 21. 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 section 20 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. 22. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. A society that issues a benefit contract shall include in the contract coverage for biomarker testing for the diagnosis, treatment, management and monitoring of a disease or condition when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(c) Nationally recognized clinical practice guidelines or consensus statements.

2. A society shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens.

(b) Establish a clear and readily accessible process for an insured or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing; or

(2) Appeal a denial of coverage for biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the society.

3. If a society requires an insured to obtain prior authorization for a biomarker test described in subsection 1, the society shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

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

5. As used in this section:

(a) "Biomarker testing" has the meaning ascribed to it in section 12 of this act.

(b) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(c) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the costs and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

Sec. 23. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A hospital or medical service corporation that issues a policy of health insurance shall include in the policy coverage for biomarker testing for the diagnosis, treatment, management and monitoring of a disease or condition when such biomarker testing

is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(c) Nationally recognized clinical practice guidelines or consensus statements.

2. A hospital or medical service corporation shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens.

(b) Establish a clear and readily accessible process for an insured or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing; or

(2) Appeal a denial of coverage for biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the hospital or medical service corporation.

3. If a hospital or medical service corporation requires an insured to obtain prior authorization for a biomarker test described in subsection 1, the hospital or medical service corporation shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

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

5. As used in this section:

(a) "Biomarker testing" has the meaning ascribed to it in section 12 of this act.

(b) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(c) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the costs and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

Sec. 24. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health maintenance organization that issues a health care plan shall include in the plan coverage for biomarker testing for the diagnosis, treatment, management and monitoring of a disease or condition when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(c) Nationally recognized clinical practice guidelines or consensus statements.

2. A health maintenance organization shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens.

(b) Establish a clear and readily accessible process for an enrollee or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing; or

(2) Appeal a denial of coverage for biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the health maintenance organization.

3. If a health maintenance organization requires an enrollee to obtain prior authorization for a biomarker test described in subsection 1, the health maintenance organization shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

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

5. As used in this section:

(a) "Biomarker testing" has the meaning ascribed to it in section 12 of this act.

(b) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(c) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the costs and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

Sec. 25. 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 section 24 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. 26. 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, ***and section 24 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 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. 27. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. A managed care organization that issues a health care plan shall include in the plan coverage for biomarker testing for the diagnosis, treatment, management and monitoring of a disease or condition when such biomarker testing is supported by medical and scientific evidence. Such evidence includes, without limitation:

(a) The labeled indications for a biomarker test or medication that has been approved or cleared by the United States Food and Drug Administration;

(b) A national coverage determination or local coverage determination, as those terms are defined in 42 C.F.R. § 400.202; or

(c) Nationally recognized clinical practice guidelines or consensus statements.

2. A managed care organization shall:

(a) Provide the coverage required by subsection 1 in a manner that limits disruptions in care and the need for multiple specimens.

(b) Establish a clear and readily accessible process for an insured or provider of health care to:

(1) Request an exception to a policy excluding coverage for biomarker testing; or

(2) Appeal a denial of coverage for biomarker testing; and

(c) Make the process described in paragraph (b) available on an Internet website maintained by the managed care organization.

3. If a managed care organization requires an insured to obtain prior authorization for a biomarker test described in subsection 1, the managed care organization shall respond to a request for such prior authorization:

(a) Within 24 hours after receiving an urgent request; or

(b) Within 72 hours after receiving any other request.

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

5. As used in this section:

(a) "Biomarker testing" has the meaning ascribed to it in section 12 of this act.

(b) "Consensus statement" means a statement aimed at a specific clinical circumstance that is:

(1) Made for the purpose of optimizing the outcomes of clinical care;

(2) Made by an independent, multidisciplinary panel of experts that has established a policy to avoid conflicts of interest;

(3) Based on scientific evidence; and

(4) Made using a transparent methodology and reporting procedure.

(c) "Nationally recognized clinical practice guidelines" means evidence-based guidelines establishing standards of care that include, without limitation, recommendations intended to optimize care of patients and are:

(1) Informed by a systemic review of evidence and an assessment of the costs and benefits of alternative options for care; and

(2) Developed using a transparent methodology and reporting procedure by an independent organization or society of medical professionals that has established a policy to avoid conflicts of interest.

Sec. 28. 1. There is hereby appropriated from the State General Fund to the Department of Health and Human Services the sum of $500,000 for the purpose of entering into a contract with a college or university or another qualified entity that conducts research in the field of public health for the purposes described in section 29 of this act.

2. Any remaining balance of the appropriation made by subsection 1 must not be committed for expenditure after June 30, 2025, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 19, 2025, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 19, 2025.

Sec. 29. 1. The Department of Health and Human Services shall use a competitive bidding process conducted in accordance with the provisions of chapter 333 of NRS to enter into a contract with a college or university or another qualified entity that conducts research in the field of public health and is located in this State to study the awareness of and access to precision medicine and biomarker testing in this State. The study must include, without limitation:

(a) The collection of information on the policies of third parties concerning coverage of precision medicine and biomarker testing, including, without limitation, evidentiary standards of clinical utility used by third parties. Information must be collected for, at a minimum, Medicaid, the Public Employees' Benefits Program, the

three largest plans regulated under chapter 689A of NRS and the three largest plans regulated under chapter 689C of NRS.

(b) Statewide surveys to determine levels of understanding among providers of health care about the availability and usefulness of biomarker testing to diagnose diseases and direct therapies.

(c) The compilation of published guidelines relating to precision medicine and biomarker testing that are commonly used by providers of health care and third parties in this State.

(d) Recommendations to promote equity in access to precision medicine and biomarker testing for use in making clinical decisions.

(e) Recommendations on policy changes to:

(1) Improve awareness of and access to precision medicine and biomarker testing; and

(2) Increase the use of data science in health care.

2. The entity with which the Department enters into a contract pursuant to subsection 1 shall:

(a) On or before August 1, 2024, present the findings from the study conducted pursuant to subsection 1 and any recommendations for legislation resulting from that study at a meeting of the Joint Interim Standing Committee on Health and Human Services.

(b) On or before December 31, 2024, submit a final report of the study conducted pursuant to subsection 1 and any recommendations resulting from that study to the Governor, the Director of the Department of Health and Human Services, the Commissioner of Insurance and the Director of the Legislative Counsel Bureau for transmittal to the 83rd Regular Session of the Legislature.

3. The Department of Health and Human Services shall provide any support or assistance necessary for the entity with which the Department enters into a contract pursuant to subsection 1 to perform the duties described in subsections 1 and 2.

4. As used in this section:

(a) "Biomarker testing" has the meaning ascribed to it in section 12 of this act.

(b) "Precision medicine" has the meaning ascribed to it in section 5 of this act.

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

(d) "Third party" has the meaning ascribed to it in section 10 of this act.

Sec. 30. 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. 31. 1. This section becomes effective upon passage and approval.

2. Sections 1 to 10, inclusive, 12, 28 and 29 of this act become effective on July 1, 2023.

3. Sections 11, 13 to 27, inclusive, and 30 of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On October 1, 2023, for all other purposes.

4. Sections 2 to 10, inclusive, of this act expire by limitation on February 1, 2027.

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