Assembly Bill No. 155–Assemblymen Peters; Brown-May, Dickman, González, Hafen, Kasama, Nguyen, Orentlicher, Thomas and Watts

CHAPTER.....

AN ACT relating to health care; requiring policies of health insurance to include coverage of biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer in certain circumstances; establishing certain conditions relating to such required coverage; providing for a study of the cost-effectiveness of biomarker testing; making an appropriation and authorizing certain expenditures; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires public and private policies of insurance regulated under Nevada law to include certain coverage. (NRS 287.010, 287.04335, 422.2717-422.27248, 689A.04033-689A.0465, 689B.0303-689B.0379, 689C.1655-689C.169, 689C.194-689C.195, 689C.425, 695A.184-695A.1875, 695B.1901-695B.1949, 695C.050, 695C.1691-695C.176, 695G.162-695G.177) **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 medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer 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 for the diagnosis, treatment, management or ongoing monitoring of cancer or appealing a denial of coverage for such biomarker testing. **Sections 13-17, 19, 20, 22-25 and 27** additionally require such health plans to respond to any request for preauthorization for such biomarker testing within: (1) 24 hours for urgent requests; or (2) 72 hours for all other requests. **Sections 13-17, 19, 20, 22-25 and 27** clarify that an insurer is not required to cover biomarker testing for screening purposes or in certain circumstances. **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 **section 17, 19, 20, 22, 23 or 27** of this bill. (NRS 680A.200) **Section 28.5** of this bill appropriates and authorizes the expenditure of money for the Division of Health Care Financing and Policy of the Department of Health and Human Services to contract with a qualified person to determine the cost-effectiveness of providing coverage for biomarker testing under Medicaid for the diagnosis, treatment, management or ongoing monitoring of diseases or conditions other than cancer. **Section 29.5** of this bill requires the Joint Interim Standing Committee on Health and Human Services, in coordination with the Department of Health and Human

Services, to conduct a study during the 2023-2024 interim concerning the cost-effectiveness of biomarker testing.

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

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.

Secs. 2-10. (Deleted by amendment.)

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. (Deleted by amendment.)

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. Subject to the limitations prescribed by subsection 4, the Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer 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) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

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

(d) 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 for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such 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. The provisions of this section do not require the State Plan for Medicaid to include coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience; or

(c) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. 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:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

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

(c) "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.

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

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

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

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "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 risks 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.

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

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. Subject to the limitations prescribed by subsection 4, an insurer that issues a policy of health insurance shall include in the

policy coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer 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) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

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

(d) 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 for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such 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. The provisions of this section do not require an insurer to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that does not participate in the network plan of the insurer; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. 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.

6. 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:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

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

(c) "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.

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

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

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

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment

for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "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 risks 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.

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

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

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. Subject to the limitations prescribed by subsection 4, an insurer that issues a policy of group health insurance shall include in the policy coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer 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) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

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

(d) 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 for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such 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. The provisions of this section do not require an insurer to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that does not participate in the network plan of the insurer; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. 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.

6. 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:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

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

(c) "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.

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

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

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

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "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 risks 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.

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

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

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

1. Subject to the limitations prescribed by subsection 4, a carrier that issues a health benefit plan shall include in the plan coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer 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) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

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

(d) 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 for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such 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. The provisions of this section do not require a carrier to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that is not in the applicable network plan of the carrier; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. 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.

6. 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:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

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

(c) "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.

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

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

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

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "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 risks 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.

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

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. Subject to the limitations prescribed by subsection 4, a society that issues a benefit contract shall include in the contract coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer 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) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

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

(d) 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 for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such 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. The provisions of this section do not require a society to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that does not participate in the network plan of the society; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. 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.

6. 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:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A gene mutation or characteristic; and

(3) The expression of a protein.

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

(c) "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.

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

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

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

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "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 risks 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.

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

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

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

1. Subject to the limitations prescribed by subsection 4, a hospital or medical service corporation that issues a policy of health insurance shall include in the policy coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer 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) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

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

(d) 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 for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such 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. The provisions of this section do not require a hospital or medical service corporation to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that does not participate in the network plan of the hospital or medical service corporation; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. 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.

6. 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:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

(b) "Biomarker testing" means the analysis of the tissue, blood or other biospecimen of a patient for the presentation of a biomarker and includes, without limitation, single-analyte tests,

multiplex panel tests and whole genome, whole exome and whole transcriptome sequencing.

(c) "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.

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

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

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

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "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 risks 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.

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

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

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

1. Subject to the limitations prescribed by subsection 4, a health maintenance organization that issues a health care plan shall include in the plan coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer 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) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

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

(d) 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 for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such 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. The provisions of this section do not require a health maintenance organization to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that does not participate in the network plan of the health maintenance organization; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. 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.

6. 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:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

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

(c) "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.

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

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

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

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "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 risks 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.

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

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

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. Subject to the limitations prescribed by subsection 4, a managed care organization that issues a health care plan shall include in the plan coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer 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) The indicated tests for a drug that has been approved by the United States Food and Drug Administration or the warnings and precautions included on the label of such a drug;

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

(d) 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 for the diagnosis, treatment, management or ongoing monitoring of cancer; or

(2) Appeal a denial of coverage for such 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. The provisions of this section do not require a managed care organization to provide coverage of biomarker testing:

(a) For screening purposes;

(b) Conducted by a provider of health care for whom the biomarker testing is not within his or her scope of practice, training and experience;

(c) Conducted by a provider of health care or a facility that does not participate in the network plan of the managed care organization; or

(d) That has not been determined to be medically necessary by a provider of health care for whom such a determination is within his or her scope of practice, training and experience.

5. 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.

6. 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:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

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

(c) "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.

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

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

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

(3) Significant in guiding and informing the provider of health care in providing the most appropriate course of treatment for the patient in order to prevent, delay or lessen the magnitude of an adverse health outcome.

(e) "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 risks 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.

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

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

Sec. 28. (Deleted by amendment.)

Sec. 28.5. 1. There is hereby appropriated from the State General Fund to the Division of Health Care Financing and Policy of the Department of Health and Human Services the sum of $325,000 for the cost of contracting with a qualified person to determine the cost-effectiveness of providing coverage for biomarker testing under Medicaid for the diagnosis, treatment, management or ongoing monitoring of diseases or conditions other than cancer.

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.

3. Expenditure of $325,000 not appropriated from the State General Fund or State Highway Fund is hereby authorized during Fiscal Year 2023-2024 and Fiscal Year 2024-2025 by the Division of Health Care Financing and Policy of the Department of Health and Human Services for the same purpose as set forth in subsection 1.

4. 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:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

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

Sec. 29. (Deleted by amendment.)

Sec. 29.5. 1. During the 2023-2024 interim, the Joint Interim Standing Committee on Health and Human Services, in coordination with the Department of Health and Human Services, shall study the cost-effectiveness of biomarker testing, including, without limitation, the cost-effectiveness of biomarker testing:

(a) For the diagnosis, treatment, management or ongoing monitoring of specific diseases or conditions; and

(b) To screen for specific diseases or conditions or traits associated with specific diseases or conditions.

2. The Joint Interim Standing Committee on Health and Human Services shall submit a report of the results of the study, including any recommendations for legislation to the Director of the Legislative Counsel Bureau for transmission to the 83rd Session of the Nevada Legislature.

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:

(1) An interaction between a gene and a drug that is being used by or considered for use by the patient;

(2) A mutation or characteristic of a gene; and

(3) The expression of a protein.

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

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, and 28 to 29.5, inclusive, 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.

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