S.B. 330

SENATE BILL NO. 330–SENATOR LANGE

MARCH 20, 2023

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions related to health care. (BDR 57-161)

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

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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; revising requirements for certain health insurance plans to provide certain benefits for preventative health care relating to breast cancer; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

1 Existing law requires most health insurance plans, including individual, group
2 and blanket health insurance policies, small employer plans, benefit contracts
3 provided by fraternal benefit societies, contracts for hospital or medical service,
4 health care plans of health maintenance organizations and plans issued by managed
5 care organizations to include coverage for mammograms. (NRS 689A.0405,
6 689B.0374, 689C.1674, 695A.1855, 695B.1912, 695C.1735, 695G.1713) **Sections**
7 **1-7** of this bill revise existing provisions requiring coverage for mammograms to
8 require such policies, plans and contracts of health care to additionally provide
9 coverage for imaging tests to screen for breast cancer and diagnostic imaging tests
10 for breast cancer for certain covered persons without requiring any deductible,
11 copayment, coinsurance or any other form of cost-sharing. **Section 8** of this bill
12 makes a conforming change to exclude the Public Employees' Benefits Program
13 from the requirement of this bill and, thus, the Program may, but is not required to,
14 provide the coverage set forth in this bill.

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

1 **Section 1.** NRS 689A.0405 is hereby amended to read as
2 follows:
3 689A.0405 1. A policy of health insurance must provide
4 coverage for benefits payable for expenses incurred for ~~[a]~~ ***:***

(a) A mammogram ~~[every 2 years, or]~~ ***to screen for breast cancer*** annually ~~[if ordered by a provider of health care,]~~ for ~~[women]~~ ***insureds who are*** 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of health insurance shall not:

(a) Require an insured to pay a ~~[higher]~~ deductible, ~~[any]~~ copayment ***,*** ~~[or]~~ coinsurance ***or any other form of cost-sharing*** or require a longer waiting period or other condition to obtain any benefit provided in the policy of health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, ~~[2018,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. 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) "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.

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

Sec. 2. NRS 689B.0374 is hereby amended to read as follows:

689B.0374 1. A policy of group health insurance must provide coverage for benefits payable for expenses incurred for ~~[a]~~ ***:***

(a) A mammogram ~~[every 2 years, or]~~ ***to screen for breast cancer*** annually ~~[if ordered by a provider of health care,]~~ for ~~[women]~~ ***insureds who are*** 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of group health insurance shall not:

(a) Require an insured to pay a ~~[higher]~~ deductible, ~~[any]~~ copayment ***,*** ~~[or]~~ coinsurance ***or any other form of cost-sharing*** or

1 require a longer waiting period or other condition to obtain any
2 benefit provided in the policy of group health insurance pursuant to
3 subsection 1;
4 (b) Refuse to issue a policy of group health insurance or cancel a
5 policy of group health insurance solely because the person applying
6 for or covered by the policy uses or may use any such benefit;
7 (c) Offer or pay any type of material inducement or financial
8 incentive to an insured to discourage the insured from obtaining any
9 such benefit;
10 (d) Penalize a provider of health care who provides any such
11 benefit to an insured, including, without limitation, reducing the
12 reimbursement of the provider of health care;
13 (e) Offer or pay any type of material inducement, bonus or other
14 financial incentive to a provider of health care to deny, reduce,
15 withhold, limit or delay access to any such benefit to an insured; or
16 (f) Impose any other restrictions or delays on the access of an
17 insured to any such benefit.
18 4. A policy subject to the provisions of this chapter which is
19 delivered, issued for delivery or renewed on or after January 1,
20 [2018,] ***2024,*** has the legal effect of including the coverage required
21 by subsection 1, and any provision of the policy or the renewal
22 which is in conflict with this section is void.
23 5. Except as otherwise provided in this section and federal law,
24 an insurer may use medical management techniques, including,
25 without limitation, any available clinical evidence, to determine the
26 frequency of or treatment relating to any benefit required by this
27 section or the type of provider of health care to use for such
28 treatment.
29 6. As used in this section:
30 (a) "Medical management technique" means a practice which is
31 used to control the cost or utilization of health care services or
32 prescription drug use. The term includes, without limitation, the use
33 of step therapy, prior authorization or categorizing drugs and
34 devices based on cost, type or method of administration.
35 (b) "Network plan" means a policy of group health insurance
36 offered by an insurer under which the financing and delivery of
37 medical care, including items and services paid for as medical care,
38 are provided, in whole or in part, through a defined set of providers
39 under contract with the insurer. The term does not include an
40 arrangement for the financing of premiums.
41 (c) "Provider of health care" has the meaning ascribed to it in
42 NRS 629.031.
43 **Sec. 3.** NRS 689C.1674 is hereby amended to read as follows:
44 689C.1674 1. A health benefit plan must provide coverage
45 for benefits payable for expenses incurred for [a] ***:***

(a) A mammogram ~~[every 2 years, or]~~ ***to screen for breast cancer*** annually ~~[if ordered by a provider of health care,]~~ for ~~[women]~~ ***insureds who are*** 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

2. A carrier must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier.

3. Except as otherwise provided in subsection 5, a carrier that offers or issues a health benefit plan shall not:

(a) Require an insured to pay a ~~[higher]~~ deductible, ~~[any]~~ copayment ***,*** ~~[or]~~ coinsurance ***or any other form of cost-sharing*** or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, ~~[2018,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques, including,

without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

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

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

Sec. 4. NRS 695A.1855 is hereby amended to read as follows:

695A.1855 1. A benefit contract must provide coverage for benefits payable for expenses incurred for [a] ***:***

(a) A mammogram [every 2 years, or] ***to screen for breast cancer*** annually [if ordered by a provider of health care,] for [women] ***insureds who are*** 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

2. A society must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society.

3. Except as otherwise provided in subsection 5, a society that offers or issues a benefit contract shall not:

(a) Require an insured to pay a [higher] deductible, [any] copayment ***,*** [or] coinsurance ***or any other form of cost-sharing*** or require a longer waiting period or other condition for coverage to

obtain any benefit provided in a benefit contract pursuant to subsection 1;

(b) Refuse to issue a benefit contract or cancel a benefit contract solely because the person applying for or covered by the contract uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A benefit contract subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, [2018,] ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the benefit contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. 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) "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.

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

Sec. 5. NRS 695B.1912 is hereby amended to read as follows:

695B.1912 1. An insurer that offers or issues a contract for hospital or medical service must provide coverage for benefits payable for expenses incurred for [a] ***:***

(a) A mammogram [every 2 years, or] *to screen for breast cancer* annually [if ordered by a provider of health care,] for [women] *insureds who are* 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the insured.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the insured's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a contract for hospital or medical service shall not:

(a) Require an insured to pay a [higher] deductible, [any] copayment *,* [or] coinsurance *or any other form of cost-sharing* or require a longer waiting period or other condition to obtain any benefit provided in a contract for hospital or medical service pursuant to subsection 1;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A contract for hospital or medical service subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, [2018,] *2024,* has the legal effect of including the coverage required by subsection 1, and any provision

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

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. 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) "Network plan" means a contract for hospital or medical service 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.

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

Sec. 6. NRS 695C.1735 is hereby amended to read as follows:

695C.1735 1. A health care plan of a health maintenance organization must provide coverage for benefits payable for expenses incurred for ~~[a]~~ ***:***

(a) A mammogram ~~[every 2 years, or]~~ ***to screen for breast cancer*** annually ~~[if ordered by a provider of health care,]~~ for ~~[women]~~ ***enrollees who are*** 40 years of age or older.

(b) An imaging test to screen for breast cancer on an interval and at the age deemed most appropriate, when medically necessary, as recommended by the enrollee's provider of health care based on personal or family medical history or additional factors that may increase the risk of breast cancer for the enrollee.

(c) A diagnostic imaging test for breast cancer at the age deemed most appropriate, when medically necessary, as recommended by the enrollee's provider of health care to evaluate an abnormality which is:

(1) Seen or suspected from a mammogram described in paragraph (a) or an imaging test described in paragraph (b); or

(2) Detected by other means of examination.

2. A health maintenance organization must ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.

3. Except as otherwise provided in subsection 5, a health maintenance organization that offers or issues a health care plan shall not:

(a) Require an enrollee to pay a ~~[higher]~~ deductible, ~~[any]~~ copayment ***,*** ~~[or]~~ coinsurance ***or any other form of cost-sharing*** or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any benefit provided in the health care plan pursuant to subsection 1;

(d) Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an enrollee; or

(f) Impose any other restrictions or delays on the access of an enrollee to any such benefit.

4. A health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, ~~[2018,]~~ ***2024,*** has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. 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) "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.

1 (c) "Provider of health care" has the meaning ascribed to it in
2 NRS 629.031.
3 **Sec. 7.** NRS 695G.1713 is hereby amended to read as follows:
4 695G.1713 1. A health care plan issued by a managed care
5 organization must provide coverage for benefits payable for
6 expenses incurred for [a] ***:***
7 ***(a) A*** mammogram [every 2 years, or] ***to screen for breast***
8 ***cancer*** annually [if ordered by a provider of health care,] for
9 [women] ***insureds who are*** 40 years of age or older.
10 ***(b) An imaging test to screen for breast cancer on an interval***
11 ***and at the age deemed most appropriate, when medically***
12 ***necessary, as recommended by the insured's provider of health***
13 ***care based on personal or family medical history or additional***
14 ***factors that may increase the risk of breast cancer for the insured.***
15 ***(c) A diagnostic imaging test for breast cancer at the age***
16 ***deemed most appropriate, when medically necessary, as***
17 ***recommended by the insured's provider of health care to evaluate***
18 ***an abnormality which is:***
19 ***(1) Seen or suspected from a mammogram described in***
20 ***paragraph (a) or an imaging test described in paragraph (b); or***
21 ***(2) Detected by other means of examination.***
22 2. A managed care organization must ensure that the benefits
23 required by subsection 1 are made available to an insured through a
24 provider of health care who participates in the network plan of the
25 managed care organization.
26 3. Except as otherwise provided in subsection 5, a managed
27 care organization that offers or issues a health care plan which
28 provides coverage for prescription drugs shall not:
29 (a) Require an insured to pay a [higher] deductible, [any]
30 copayment ***,*** [or] coinsurance ***or any other form of cost-sharing*** or
31 require a longer waiting period or other condition to obtain any
32 benefit provided in the health care plan pursuant to subsection 1;
33 (b) Refuse to issue a health care plan or cancel a health care plan
34 solely because the person applying for or covered by the plan uses
35 or may use any such benefit;
36 (c) Offer or pay any type of material inducement or financial
37 incentive to an insured to discourage the insured from obtaining any
38 such benefit;
39 (d) Penalize a provider of health care who provides any such
40 benefit to an insured, including, without limitation, reducing the
41 reimbursement of the provider of health care;
42 (e) Offer or pay any type of material inducement, bonus or other
43 financial incentive to a provider of health care to deny, reduce,
44 withhold, limit or delay access to any such benefit to an insured; or

1 (f) Impose any other restrictions or delays on the access of an
2 insured to any such benefit.
3 4. A health care plan subject to the provisions of this chapter
4 that is delivered, issued for delivery or renewed on or after
5 January 1, [2018,] ***2024,*** has the legal effect of including the
6 coverage required by subsection 1, and any provision of the plan or
7 the renewal which is in conflict with this section is void.
8 5. Except as otherwise provided in this section and federal law,
9 a managed care organization may use medical management
10 techniques, including, without limitation, any available clinical
11 evidence, to determine the frequency of or treatment relating to any
12 benefit required by this section or the type of provider of health care
13 to use for such treatment.
14 6. As used in this section:
15 (a) "Medical management technique" means a practice which is
16 used to control the cost or utilization of health care services or
17 prescription drug use. The term includes, without limitation, the use
18 of step therapy, prior authorization or categorizing drugs and
19 devices based on cost, type or method of administration.
20 (b) "Network plan" means a health care plan offered by a
21 managed care organization under which the financing and delivery
22 of medical care, including items and services paid for as medical
23 care, are provided, in whole or in part, through a defined set of
24 providers under contract with the managed care organization. The
25 term does not include an arrangement for the financing of
26 premiums.
27 (c) "Provider of health care" has the meaning ascribed to it in
28 NRS 629.031.
29 **Sec. 8.** NRS 287.04335 is hereby amended to read as follows:
30 287.04335 If the Board provides health insurance through a
31 plan of self-insurance, it shall comply with the provisions of NRS
32 686A.135, 687B.352, 687B.409, 687B.723, 687B.725, 689B.0353,
33 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162,
34 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167,
35 695G.1675, 695G.170 to ***695G.1712, inclusive, 695G.1714 to***
36 695G.174, inclusive, 695G.176, 695G.177, 695G.200 to 695G.230,
37 inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, in the
38 same manner as an insurer that is licensed pursuant to title 57 of
39 NRS is required to comply with those provisions.
40 **Sec. 9.** This act becomes effective on January 1, 2024.