SENATE BILL NO. 404–SENATORS PARKS, SEGERBLOM, SPEARMAN, WOODHOUSE, CANNIZZARO; DENIS, FARLEY, FORD, GOICOECHEA, MANENDO AND RATTI

MARCH 20, 2017

JOINT SPONSORS: ASSEMBLYMEN OHRENSCHALL, SPRINKLE, JOINER, CARLTON; AND BUSTAMANTE ADAMS

Referred to Committee on Commerce, Labor and Energy

SUMMARY—Revises provisions relating to health insurance coverage of certain cancer treatment drugs. (BDR 57-467)

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

CONTAINS UNFUNDED MANDATE (§ 13)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

AN ACT relating to insurance; prohibiting certain policies of health insurance and health care plans that cover treatment of certain types of cancer from limiting or excluding coverage for a drug by mandating that the insured first fail to respond successfully to a different drug or prove a history of failure of such drug; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires certain public and private health care plans and policies of insurance to provide coverage for certain uses of a drug approved by the United States Food and Drug Administration, including treatment received as part of a clinical trial or study, orally administered chemotherapy and treatment of cancer, under certain circumstances. (NRS 287.0278, 689A.04033, 689A.0404, 689A.0447, 689B.0306, 689B.0362, 689B.0365, 695B.1903, 695B.1908, 695B.1909, 695C.1693, 695C.1733, 695C.17335, 695G.167, 695G.173) This bill authorizes the use of a drug approved by the United States Food and Drug Administration for the treatment of metastatic cancer, including, without limitation, cancer identified as

advanced or stage four, without the insured having to first fail to respond successfully to a different drug or prove a history of failure of such drug.

Sections 2, 4, 5, 7, 8 and 11 of this bill require policies of individual health insurance, policies of group health insurance, health benefit plans for small employers, policies of health insurance issued by a nonprofit hospital or medical service corporation, health care plans of health maintenance organizations and health care plans issued by managed care organizations that provide coverage for the treatment of metastatic cancer not to limit or exclude coverage for a drug by mandating that the insured first be required to fail to respond successfully to a different drug or prove a history of failure of such drug.

Section 1 of this bill prohibits an insurer, carrier, hospital or medical services corporation, health maintenance organization and managed care organization from requiring prior authorization for the mandated benefits provided in **sections 2, 4, 5, 7, 8 and 11**.

Section 6 of this bill applies the mandated benefits provided in **section 5** to voluntary purchasing groups.

Sections 9 and 12 of this bill exclude the mandated benefits provided in **section 8** from applying to a health maintenance organization or managed care organization that provides health care services to certain recipients of Medicaid.

Sections 13 and 14 of this bill require local and state governments that provide coverage for the treatment of metastatic cancer not to limit or exclude coverage for a drug by mandating that the insured first be required to fail to respond successfully to a different drug or prove a history of failure of such drug.

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

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

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0413, 689A.044, 689A.0445, 689B.031, 689B.0313, 689B.0317, 689B.0374, 695B.1912, 695B.1914, 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1745, 695C.1751, 695G.170, 695G.171 and 695G.177, ***and sections 2, 4, 5, 7, 8 and 11 of this act,*** any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:

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

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

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

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

1. A policy of health insurance that provides coverage for the treatment of metastatic cancer must not limit or exclude coverage for a drug approved pursuant to subsection 2 by mandating that the insured first be required to fail to respond successfully to a different drug or to prove a history of failure of such drug.

2. A drug used for the treatment of metastatic cancer must be approved by the United States Food and Drug Administration, and the use of such drug must be:

(a) Consistent with evidence-based best practices for the treatment of metastatic cancer; and

(b) Supported by peer-reviewed medical literature.

3. A policy of health insurance subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after July 1, 2017, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) "Metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes or other parts of the body, and includes, without limitation, cancer identified as advanced or stage four.

(b) "Peer-reviewed medical literature" means:

(1) The most recent edition or supplement to the United States Pharmacopeia and the National Formulary, USP-NF, published by the United States Pharmacopeial Convention, or the AHFS-Drug Information, published by the American Society of Health-System Pharmacists; or

(2) At least two articles that report the results of scientific studies which:

(I) Support the use of the drug for treatment of metastatic cancer; and

(II) Are published in a scientific or medical journal, as defined in 21 C.F.R. § 99.3.

Sec. 3. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~.~~ ***, and section 2 of this act.***

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

1. A policy of group health insurance that provides coverage for the treatment of metastatic cancer must not limit or exclude coverage for a drug approved pursuant to subsection 2 by mandating that the insured first be required to fail to respond successfully to a different drug or to prove a history of failure of such drug.

2. A drug used for the treatment of metastatic cancer must be approved by the United States Food and Drug Administration, and the use of such drug must be:

(a) Consistent with evidence-based best practices for the treatment of metastatic cancer; and

(b) Supported by peer-reviewed medical literature.

3. A policy of group health insurance subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after July 1, 2017, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) "Metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes or other parts of the body, and includes, without limitation, cancer identified as advanced or stage four.

(b) "Peer-reviewed medical literature" means:

(1) The most recent edition or supplement to the United States Pharmacopeia and the National Formulary, USP-NF, published by the United States Pharmacopeial Convention, or the AHFS-Drug Information, published by the American Society of Health-System Pharmacists; or

(2) At least two articles that report the results of scientific studies which:

(I) Support the use of the drug for treatment of metastatic cancer; and

(II) Are published in a scientific or medical journal, as defined in 21 C.F.R. § 99.3.

Sec. 5. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health benefit plan that provides coverage for the treatment of metastatic cancer must not limit or exclude coverage for a drug approved pursuant to subsection 2 by mandating that the insured first be required to fail to respond successfully to a different drug or to prove a history of failure of such drug.

2. A drug used for the treatment of metastatic cancer must be approved by the United States Food and Drug Administration, and the use of such drug must be:

(a) Consistent with evidence-based best practices for the treatment of metastatic cancer; and

(b) Supported by peer-reviewed medical literature.

3. A health benefit plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after July 1, 2017, has the legal effect of including the coverage required by this section, and any provision of the health benefit plan or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) "Metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes or other parts of the body, and includes, without limitation, cancer identified as advanced or stage four.

(b) "Peer-reviewed medical literature" means:

(1) The most recent edition or supplement to the United States Pharmacopeia and the National Formulary, USP-NF, published by the United States Pharmacopeial Convention, or the AHFS-Drug Information, published by the American Society of Health-System Pharmacists; or

(2) At least two articles that report the results of scientific studies which:

(I) Support the use of the drug for treatment of metastatic cancer; and

(II) Are published in a scientific or medical journal, as defined in 21 C.F.R. § 99.3.

Sec. 6. 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 5 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. 7. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A policy of health insurance that provides coverage for the treatment of metastatic cancer must not limit or exclude coverage for a drug approved pursuant to subsection 2 by mandating that the insured first be required to fail to respond successfully to a different drug or to prove a history of failure of such drug.

2. A drug used for the treatment of metastatic cancer must be approved by the United States Food and Drug Administration, and the use of such drug must be:

(a) Consistent with evidence-based best practices for the treatment of metastatic cancer; and

(b) Supported by peer-reviewed medical literature.

3. A policy of health insurance subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after July 1, 2017, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) "Metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes or other parts of the body, and includes, without limitation, cancer identified as advanced or stage four.

(b) "Peer-reviewed medical literature" means:

(1) The most recent edition or supplement to the United States Pharmacopeia and the National Formulary, USP-NF, published by the United States Pharmacopeial Convention, or the AHFS-Drug Information, published by the American Society of Health-System Pharmacists; or

(2) At least two articles that report the results of scientific studies which:

(I) Support the use of the drug for treatment of metastatic cancer; and

(II) Are published in a scientific or medical journal, as defined in 21 C.F.R. § 99.3.

Sec. 8. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health care plan that provides coverage for the treatment of metastatic cancer must not limit or exclude coverage for a drug approved pursuant to subsection 2 by mandating that the enrollee first be required to fail to respond successfully to a different drug or to prove a history of failure of such drug.

2. A drug used for the treatment of metastatic cancer must be approved by the United States Food and Drug Administration, and the use of such drug must be:

(a) Consistent with evidence-based best practices for the treatment of metastatic cancer; and

(b) Supported by peer-reviewed medical literature.

3. Any evidence of coverage subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after July 1, 2017, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

4. As used in this section:

(a) "Metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes or other parts of the body, and includes, without limitation, cancer identified as advanced or stage four.

(b) "Peer-reviewed medical literature" means:

(1) The most recent edition or supplement to the United States Pharmacopeia and the National Formulary, USP-NF, published by the United States Pharmacopeial Convention, or the AHFS-Drug Information, published by the American Society of Health-System Pharmacists; or

(2) At least two articles that report the results of scientific studies which:

(I) Support the use of the drug for treatment of metastatic cancer; and

(II) Are published in a scientific or medical journal, as defined in 21 C.F.R. § 99.3.

Sec. 9. 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.1735 to 695C.1755, 695C.176 to 695C.200, inclusive, and 695C.265 ***and section 8 of this act*** do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694, 695C.1695, 695C.1708, 695C.1731, 695C.17345 and 695C.1757 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. 10. 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 8 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;

(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. 11. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health care plan that provides coverage for the treatment of metastatic cancer must not limit or exclude coverage for a drug approved pursuant to subsection 2 by mandating that the insured first be required to fail to respond successfully to a different drug or to prove a history of failure of such drug.

2. A drug used for the treatment of metastatic cancer must be approved by the United States Food and Drug Administration, and the use of such drug must be:

(a) Consistent with evidence-based best practices for the treatment of metastatic cancer; and

(b) Supported by peer-reviewed medical literature.

3. An evidence of coverage for a health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after July 1, 2017, has the legal effect of including the coverage required by this section, and any provision

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

4. As used in this section:

(a) "Metastatic cancer" means cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes or other parts of the body, and includes, without limitation, cancer identified as advanced or stage four.

(b) "Peer-reviewed medical literature" means:

(1) The most recent edition or supplement to the United States Pharmacopeia or the National Formulary, USP-NF, published by the United States Pharmacopeial Convention, or the AHFS-Drug Information, published by the American Society of Health-System Pharmacists; or

(2) At least two articles that report the results of scientific studies which:

(I) Support the use of the drug for treatment of metastatic cancer; and

(II) Are published in a scientific or medical journal, as defined in 21 C.F.R. § 99.3.

Sec. 12. NRS 695G.090 is hereby amended to read as follows:

695G.090 1. Except as otherwise provided in subsection 3, the provisions of this chapter apply to each organization and insurer that operates as a managed care organization and may include, without limitation, an insurer that issues a policy of health insurance, an insurer that issues a policy of individual or group health insurance, a carrier serving small employers, a fraternal benefit society, a hospital or medical service corporation and a health maintenance organization.

2. In addition to the provisions of this chapter, each managed care organization shall comply with:

(a) The provisions of chapter 686A of NRS, including all obligations and remedies set forth therein; and

(b) Any other applicable provision of this title.

3. The provisions of NRS 695G.164, 695G.1645, 695G.167, 695G.200 to 695G.230, inclusive, and 695G.430 ***and section 8 of this act*** do not apply to a managed care organization that provides health care services 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 managed care organization from any provision of this chapter for services provided pursuant to any other contract.

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 687B.408, 689B.030 to 689B.050, inclusive, ***and section 4 of this act*** and 689B.287 apply to coverage provided pursuant to this paragraph.

(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 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177,

695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and section 11 of this act*** in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 15. 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. 16. This act becomes effective on July 1, 2017.

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