ASSEMBLY BILL NO. 436–COMMITTEE
ON COMMERCE AND LABOR

MARCH 26, 2021

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to vision insurance. (BDR 57-808)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
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; prohibiting an insurer from entering into a contract with a provider of vision care that contains certain provisions; requiring an insurer to provide certain information to a provider of vision care before entering into a contract to include the provider in the network of the insurer; prescribing certain requirements concerning the advertising and marketing of vision coverage; authorizing the imposition of an administrative penalty; limiting the rates that a provider of vision care may charge to patients for vision care provided out of network; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law prohibits certain unfair trade practices in the business of insurance. (NRS 686A.010-686A.280) **Section 1** of this bill prohibits an insurer from entering into a contract with a provider of vision care that places certain requirements on the provider of vision care, places certain limitations on coverage or provides for unreasonably low or nominal rates of reimbursement. **Section 1** also requires an insurer to provide to a provider of vision care a list of the rates of reimbursement that the insurer provides for covered vision care before entering into a contract to include the provider of vision care in the network of the insurer. **Section 1** additionally: (1) requires an insurer to disclose in any policy of vision insurance or related materials any ownership or other pecuniary interest of the insurer in a manufacturer of goods covered by the policy or in a provider of vision care; and (2) imposes certain restrictions on the manner in which an insurer may advertise a policy of insurance that covers vision care. **Sections 2 and 3** of this bill authorize the Commissioner of Insurance to enforce the requirements of **section 1**

in the same manner as other provisions governing the trade practices of insurers. Specifically, **section 2** authorizes the Commissioner to hold a hearing if he or she has cause to believe that a violation of **section 1** has occurred. If the Commissioner finds after that hearing that a violation has occurred and the insurer in violation knew or should have known of the violation, **section 3** authorizes the Commissioner to impose an administrative penalty or take action against the license of the insurer. **Sections 4-9** of this bill provide that certain entities that provide vision coverage, including local governments and the Public Employees' Benefits Program, are subject to the provisions of **section 1**.

Sections 10-12 of this bill prohibit a physician, osteopathic physician or optometrist from charging a patient who is covered by a policy of vision insurance for which the physician, osteopathic physician or optometrist is out-of-network for vision care an amount that exceeds the usual and customary rate that the physician, osteopathic physician or optometrist charges uninsured patients for that vision care. A physician, osteopathic physician or optometrist who willfully charges a patient a prohibited rate would be subject to professional discipline. (NRS 630.3065, 633.131, 636.295)

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

Section 1. Chapter 686A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer shall not enter into a contract with a provider of vision care that:

(a) Authorizes the insurer to set or limit the amount that the provider of vision care may charge for vision care that is not reimbursed under the contract;

(b) Requires the provider of vision care to participate in the network of providers of vision care of the insurer or any other insurer as a condition of including that provider of vision care in the network of providers of medical services of the insurer;

(c) Requires the provider of vision care to use a specific laboratory as the manufacturer of ophthalmic devices or materials provided to covered persons;

(d) Conditions any rate of reimbursement for vision care on the provider of vision care prescribing ophthalmic devices or materials in which the insurer has an ownership or other pecuniary interest or increases the rate of reimbursement if the provider of vision care prescribes such ophthalmic devices or materials; or

(e) Provides for unreasonably low or nominal rates of reimbursement for vision care.

2. Before entering into a contract with a provider of vision care to include the provider of vision care in the network of an insurer, the insurer must provide to the provider of vision care a

list of the rates of reimbursement for each service covered by the contract.

3. An insurer shall disclose in any policy of insurance that covers vision care or any description of benefits covered by such a policy, whether written or electronic, any ownership or other pecuniary interest of the insurer in a supplier of ophthalmic devices or materials or a provider of vision care. The disclosure must appear in a conspicuous and clear manner.

4. An insurer that does not provide reimbursement for specific vision care shall not claim in any advertisement or other material that the insurer covers that vision care, including, without limitation, by claiming that the insurer covers the vision care with a copayment or coinsurance in an amount that is in addition to the copayment or coinsurance that a covered person is typically required to pay for covered services.

5. An insurer shall not, in any advertisement or similar communication, place providers of vision care in tiers or similar designations designed to influence the choice of a covered person concerning a provider of vision care unless those designations are based on criteria related to quality of care that are expressly prescribed in the contract.

6. As used in this section:

(a) "Provider of vision care" means a physician who provides vision care or an optometrist.

(b) "Vision care" means:

(1) Services for the diagnosis, prevention, treatment, care or relief of a health condition, illness, injury or disease related to the eye.

(2) Ophthalmic devices or materials, including, without limitation, lenses, frames, mountings or other specially fabricated ophthalmic devices.

Sec. 2. NRS 686A.160 is hereby amended to read as follows:

686A.160 If the Commissioner has cause to believe that any person has been engaged or is engaging, in this state, in any unfair method of competition or any unfair or deceptive act or practice prohibited by NRS 686A.010 to 686A.310, inclusive, ***and section 1 of this act*** and that a proceeding by the Commissioner in respect thereto would be in the interest of the public, the Commissioner may issue and serve upon such person a statement of the charges and a notice of the hearing to be held thereon. The statement of charges and notice of hearing shall comply with the requirements of NRS 679B.320 and shall be served upon such person directly or by certified or registered mail, return receipt requested.

Sec. 3. NRS 686A.183 is hereby amended to read as follows:

686A.183 1. After the hearing provided for in NRS 686A.160, the Commissioner shall issue an order on hearing pursuant to NRS 679B.360. If the Commissioner determines that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice in violation of NRS 686A.010 to 686A.310, inclusive, ***and section 1 of this act,*** the Commissioner shall order the person to cease and desist from engaging in that method of competition, act or practice, and may order one or both of the following:

(a) If the person knew or reasonably should have known that he or she was in violation of NRS 686A.010 to 686A.310, inclusive, ***and section 1 of this act,*** payment of an administrative fine of not more than $5,000 for each act or violation, except that as to licensed agents, brokers, solicitors and adjusters, the administrative fine must not exceed $500 for each act or violation.

(b) Suspension or revocation of the person's license if the person knew or reasonably should have known that he or she was in violation of NRS 686A.010 to 686A.310, inclusive ~~[.]~~ ***, and section 1 of this act.***

2. Until the expiration of the time allowed for taking an appeal, pursuant to NRS 679B.370, if no petition for review has been filed within that time, or, if a petition for review has been filed within that time, until the official record in the proceeding has been filed with the court, the Commissioner may, at any time, upon such notice and in such manner as the Commissioner deems proper, modify or set aside, in whole or in part, any order issued by him or her under this section.

3. After the expiration of the time allowed for taking an appeal, if no petition for review has been filed, the Commissioner may at any time, after notice and opportunity for hearing, reopen and alter, modify or set aside, in whole or in part, any order issued by him or her under this section whenever in the opinion of the Commissioner conditions of fact or of law have so changed as to require such action or if the public interest so requires.

Sec. 4. NRS 686A.520 is hereby amended to read as follows:

686A.520 1. The provisions of NRS 683A.341, 683A.451, 683A.461 and 686A.010 to 686A.310, inclusive, ***and section 1 of this act*** apply to companies.

2. For the purposes of subsection 1, unless the context requires that a section apply only to insurers, any reference in those sections to "insurer" must be replaced by a reference to "company."

Sec. 5. NRS 695B.320 is hereby amended to read as follows:

695B.320 1. Nonprofit hospital and medical or dental service corporations are subject to the provisions of this chapter, and to the

provisions of chapters 679A and 679B of NRS, NRS 686A.010 to 686A.315, inclusive, ***and section 1 of this act,*** 687B.010 to 687B.040, inclusive, 687B.070 to 687B.140, inclusive, 687B.150, 687B.160, 687B.180, 687B.200 to 687B.255, inclusive, 687B.270, 687B.310 to 687B.380, inclusive, 687B.410, 687B.420, 687B.430, 687B.500 and chapters 692B, 692C, 693A and 696B of NRS, to the extent applicable and not in conflict with the express provisions of this chapter.

2. For the purposes of this section and the provisions set forth in subsection 1, a nonprofit hospital and medical or dental service corporation is included in the meaning of the term "insurer."

Sec. 6. NRS 695C.300 is hereby amended to read as follows:

695C.300 1. No health maintenance organization or representative thereof may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading or any form of evidence of coverage which is deceptive. For purposes of this chapter:

(a) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan.

(b) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan if such benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist.

(c) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format as well as language, shall be such as to cause a reasonable person not possessing special knowledge regarding health care plans and evidences of coverage therefor to expect benefits, services, charges or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

2. NRS 686A.010 to 686A.310, inclusive, ***and section 1 of this act*** shall be construed to apply to health maintenance organizations, health care plans and evidences of coverage except to the extent that the nature of health maintenance organizations, health care plans

and evidences of coverage render the sections therein clearly inappropriate.

3. An enrollee may not be cancelled or not renewed except for the failure to pay the charge for such coverage or for cause as determined in the master contract.

4. No health maintenance organization, unless licensed as an insurer, may use in its name, contracts, or literature any of the words "insurance," "casualty," "surety," "mutual" or any other words descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this State.

5. No person not certificated under this chapter shall use in its name, contracts or literature the phrase "health maintenance organization" or the initials "HMO."

Sec. 7. NRS 695F.090 is hereby amended to read as follows:

695F.090 1. Prepaid limited health service organizations are subject to the provisions of this chapter and to the following provisions, to the extent reasonably applicable:

(a) NRS 687B.310 to 687B.420, inclusive, concerning cancellation and nonrenewal of policies.

(b) NRS 687B.122 to 687B.128, inclusive, concerning readability of policies.

(c) The requirements of NRS 679B.152.

(d) The fees imposed pursuant to NRS 449.465.

(e) NRS 686A.010 to 686A.310, inclusive, ***and section 1 of this act*** concerning trade practices and frauds.

(f) The assessment imposed pursuant to NRS 679B.700.

(g) Chapter 683A of NRS.

(h) To the extent applicable, the provisions of NRS 689B.340 to 689B.580, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance.

(i) NRS 689A.035, 689A.0463, 689A.410, 689A.413 and 689A.415.

(j) NRS 680B.025 to 680B.039, inclusive, concerning premium tax, premium tax rate, annual report and estimated quarterly tax payments. For the purposes of this subsection, unless the context otherwise requires that a section apply only to insurers, any reference in those sections to "insurer" must be replaced by a reference to "prepaid limited health service organization."

(k) Chapter 692C of NRS, concerning holding companies.

(l) NRS 689A.637, concerning health centers.

2. For the purposes of this section and the provisions set forth in subsection 1, a prepaid limited health service organization is included in the meaning of the term "insurer."

Sec. 8. 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, 689B.287 and 689B.500 ***and section 1 of this act*** 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. 9. 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 687B.409, 689B.255, 695G.150, 695G.155, 695G.160, 695G.162,

695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.174, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and section 1 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. 10. Chapter 630 of NRS is hereby amended by adding thereto a new section to read as follows:

1. A physician shall not charge a patient who is covered by a policy of vision insurance for vision care that is not included in the policy an amount which exceeds the usual and customary rate that the physician charges uninsured patients for the same care.

2. As used in this section:

(a) "Policy of vision insurance" means a policy of insurance or other arrangement whereby a third party agrees to reimburse the costs of vision care provided to a patient.

(b) "Third party" means:

(1) An insurer, as that term is defined in NRS 679B.540;

(2) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for vision care;

(3) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance that covers vision care for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; or

(4) Any other insurer or organization providing coverage of vision care in accordance with state or federal law.

(c) "Vision care" means:

(1) Services for the diagnosis, prevention, treatment, care or relief of a health condition, illness, injury or disease related to the eye.

(2) Ophthalmic devices or materials, including, without limitation, lenses, frames, mountings or other specially fabricated ophthalmic devices.

Sec. 11. Chapter 633 of NRS is hereby amended by adding thereto a new section to read as follows:

1. An osteopathic physician shall not charge a patient who is covered by a policy of vision insurance for vision care that is not included in the policy an amount which exceeds the usual and customary rate that the osteopathic physician charges uninsured patients for the same care.

2. As used in this section:

(a) "Policy of vision insurance" means a policy of insurance or other arrangement whereby a third party agrees to reimburse the costs of vision care provided to a patient.

(b) "Third party" means:

(1) An insurer, as that term is defined in NRS 679B.540;

(2) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for vision care;

(3) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance that covers vision care for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; or

(4) Any other insurer or organization providing coverage of vision care in accordance with state or federal law.

(c) "Vision care" means:

(1) Services for the diagnosis, prevention, treatment, care or relief of a health condition, illness, injury or disease related to the eye.

(2) Ophthalmic devices or materials, including, without limitation, lenses, frames, mountings or other specially fabricated ophthalmic devices.

Sec. 12. Chapter 636 of NRS is hereby amended by adding thereto a new section to read as follows:

1. An optometrist shall not charge a patient who is covered by a policy of vision insurance for vision care that is not included in the policy an amount which exceeds the usual and customary rate that the optometrist charges uninsured patients for the same care.

2. As used in this section:

(a) "Policy of vision insurance" means a policy of insurance or other arrangement whereby a third party agrees to reimburse the costs of vision care provided to a patient.

(b) "Third party" means:

(1) An insurer, as that term is defined in NRS 679B.540;

(2) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for vision care;

(3) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance that covers vision care for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; or

(4) Any other insurer or organization providing coverage of vision care in accordance with state or federal law.

(c) "Vision care" means:

(1) Services for the diagnosis, prevention, treatment, care or relief of a health condition, illness, injury or disease related to the eye.

(2) Ophthalmic devices or materials, including, without limitation, lenses, frames, mountings or other specially fabricated ophthalmic devices.

Sec. 13. The provisions of section 1 of this act do not apply to any contract existing on October 1, 2021, between an insurer and a provider of vision care until the contract is renewed.

Sec. 14. Notwithstanding the provisions of NRS 218D.430 and 218D.435, a committee, other than the Assembly Standing Committee on Ways and Means and the Senate Standing Committee on Finance, may vote on this act before the expiration of the period prescribed for the return of a fiscal note in NRS 218D.475. This section applies retroactively from and after March 22, 2021.

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