ASSEMBLY BILL NO. 225–COMMITTEE
ON COMMERCE AND LABOR

FEBRUARY 21, 2019

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to health insurance. (BDR 57-937)

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 insurance; prohibiting health carriers from retroactively denying a claim under certain circumstances; requiring health carriers, under certain circumstances, to treat deductible, copayment or coinsurance paid by the covered person for medically necessary emergency services as if the expenses were paid to a participating health care provider for the purposes of determining certain annual maximum payments; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law sets forth requirements for a health benefit plan, which includes a policy, contract, certificate, plan or agreement offered or issued for the provision of, delivery of, arrangement for, payment for or reimbursement for any of the costs of health care services. (NRS 687B.600-687B.850) Existing law sets forth certain requirements for contracts for payment of the costs of medical or dental care which require prior authorization of care. (NRS 687B.225) **Sections 2 and 3** of this bill define the terms used in this bill. **Section 4** of this bill requires that a health carrier must treat any deductible, copayment or coinsurance paid by a covered person to an out-of-network provider of health care for medically necessary emergency services as if the payments were made to a participating provider of health care services for the purposes of determining the annual maximums that the covered person must pay.

Section 5 of this bill prohibits a health carrier from retroactively denying a claim for payment for health care services because of the ineligibility of the covered person if the health carrier provided prior authorization for the health care services and an authorization number authorizing the health care services. **Section**

6 of this bill requires the issuance of an authorization number when prior authorization is provided for health care services.

Sections 7-9 of this bill make conforming changes.

Sections 10 and 11 of this bill include the requirements contained in **sections 4 and 5** of this bill in provisions governing insurance coverage for state and local government employees.

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

Section 1. Chapter 687B of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 5, inclusive, of this act.

Sec. 2. ***"Medically necessary emergency services" means health care services that are provided to a covered person by a provider of health care after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:***

1. Serious jeopardy to the health of a covered person;

2. Serious jeopardy to the health of an unborn child;

3. Serious impairment of a bodily function; or

4. Serious dysfunction of any bodily organ or part.

Sec. 3. ***"Out-of-network provider of health care" means a provider of health care who:***

1. Provides health care services; and

2. Is not a participating provider of health care in the network plan of the covered person.

Sec. 4. ***A health carrier which issues a network plan must treat any deductible, copayment or coinsurance paid by a covered person to an out-of-network provider of health care for medically necessary emergency services as if the deductible, copayment or coinsurance were paid to a participating provider of health care for the purposes of determining the annual maximum deductible, copayment or coinsurance that the covered person must pay pursuant to the network plan.***

Sec. 5. ***A health carrier may not retroactively deny a claim for payment for health care services because of the covered person's ineligibility at any time if the health carrier provided an authorization number pursuant to NRS 687B.225 authorizing the health care services.***

Sec. 6. 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 section 5 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 ~~[.]~~ ***; and***

(c) If the care is approved, provide to the insured or member an authorization number authorizing that care.

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

Sec. 7. NRS 687B.600 is hereby amended to read as follows:

687B.600 As used in NRS 687B.600 to 687B.850, inclusive, ***and sections 2 to 5, inclusive, of this act,*** unless the context otherwise requires, the words and terms defined in NRS 687B.605 to 687B.665, inclusive, ***and sections 2 and 3 of this act*** have the meanings ascribed to them in those sections.

Sec. 8. NRS 687B.670 is hereby amended to read as follows:

687B.670 If a health carrier offers or issues a ***health benefit plan, including, without limitation, a*** network plan, the health carrier shall, with regard to that ~~[network]~~ ***health benefit*** plan:

1. Comply with all applicable requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~[;]~~ ***, and sections 2 to 5, inclusive, of this act;***

2. As applicable, ***if the health benefit plan is a network plan,*** ensure that each contract entered into for the purposes of the network plan between a participating provider of health care and the health carrier complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ***,*** ~~[;]~~ and ***sections 2 to 5, inclusive, of this act; and***

3. As applicable, ensure that the ~~[network]~~ ***health benefit*** plan complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~[.]~~ ***, and sections 2 to 5, inclusive, of this act.***

Sec. 9. NRS 687B.850 is hereby amended to read as follows:

687B.850 The Commissioner may adopt any regulations necessary to carry out the purposes and provisions of NRS 687B.600 to 687B.850, inclusive ~~[.]~~ ***, and sections 2 to 5, inclusive, of this act.***

Sec. 10. 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 689B.287 ***and sections 4 and 5 of this act*** 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. 11. 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.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 sections 4 and 5 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. 12. This act becomes effective upon passage and approval for the purpose of adopting regulations and performing any preliminary administrative tasks that are necessary to carry out the provisions of this act, and on January 1, 2020, for all other purposes.

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