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ASSEMBLY BILL NO. 52—COMMITTEE  
ON COMMERCE AND LABOR

(ON BEHALF OF THE NEVADA COMMISSION  
ON MINORITY AFFAIRS)

PREFILED NOVEMBER 19, 2024

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Referred to Committee on Commerce and Labor

**SUMMARY**—Revises provisions relating to the payment of claims under policies of health insurance. (BDR 57-367)

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

CONTAINS UNFUNDED MANDATE (§ 20)  
(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.

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AN ACT relating to insurance; requiring the Commissioner of Insurance to establish programs to inform providers of health care and insureds under health insurance policies of certain information relating to the payment of claims; revising provisions governing the payment of claims under policies of health insurance; establishing certain administrative penalties; requiring a health carrier to provide certain information to participating providers of health care and covered persons; requiring a health carrier to establish certain procedures for challenging the denial of a claim; and providing other matters properly relating thereto.

**Legislative Counsel’s Digest:**

1 In most cases, existing law requires the administrators of health insurance plans  
2 and certain health insurers, including the Public Employees’ Benefits Program, to  
3 approve or deny a claim within 30 days after the insurer receives the claim. If the  
4 administrator or insurer approves the claim, existing law requires the administrator  
5 or insurer to pay the claim within 30 days after the claim is approved. If the  
6 administrator or insurer requires additional information to determine whether to  
7 approve or deny the claim, existing law requires the administrator or insurer to  
8 notify the claimant of its request for additional information within 20 days after the



9 administrator or insurer receives the claim. If the administrator or insurer approves  
10 the claim after receiving such additional information from the claimant, existing  
11 law requires the administrator or insurer to pay the claim within 30 days after  
12 receiving such information. Existing law requires an administrator or insurer that  
13 fails to pay a claim within the required time period to pay interest on the claim at a  
14 prescribed rate. (NRS 287.04335, 683A.0879, 689A.410, 689B.255, 689C.335,  
15 695A.188, 695B.2505, 695C.185, 695D.215, 695F.090)

16 **Sections 2, 5, 8-11, 14, 16, 20 and 22** of this bill replace those requirements  
17 with uniform requirements governing the time periods for the payment of health  
18 insurance claims that apply to administrators of health insurance plans and all  
19 public and private health insurers in this State, including Medicaid, insurance for  
20 employees of local governments and the Public Employees' Benefits Program.  
21 Specifically, **sections 2, 5, 8-11, 14, 16, 20 and 22** require each such administrator  
22 or insurer to approve or deny a claim and, if the claim is approved, pay the claim  
23 within: (1) fifteen working days after receiving the claim, if the claim is submitted  
24 electronically; or (2) thirty working days after receiving the claim, if the claim is  
25 not submitted electronically. **Sections 2, 5, 8-11, 14, 16, 20 and 22** require an  
26 administrator or insurer that needs additional information to determine whether to  
27 approve or deny a claim to request such information within 20 working days after  
28 receiving the claim. If, after receiving such additional information, the  
29 administrator or insurer approves the claim, **sections 2, 5, 8-11, 14, 16, 20 and 22**  
30 require the administrator or insurer, as applicable, to pay the claim within: (1)  
31 fifteen working days after receiving the additional information, if the additional  
32 information is submitted electronically; or (2) thirty working days after receiving  
33 the additional information, if the additional information is not submitted  
34 electronically. **Sections 2, 5, 8-11, 14, 16, 20 and 22** require an administrator or  
35 health insurer to annually report to the Commissioner of Insurance certain  
36 information relating to compliance with those requirements. **Section 25** of this bill  
37 repeals certain provisions applicable to health maintenance organizations that are  
38 no longer necessary because existing law makes the provisions of **section 16**  
39 applicable to all managed care organizations, including health maintenance  
40 organizations. (NRS 695C.055) **Sections 13 and 18** of this bill update references to  
41 a section repealed by **section 25** with a reference to **section 16**.

42 Existing law authorizes the Commissioner to: (1) impose an administrative  
43 penalty upon determining that the administrator of a health insurance plan or  
44 certain health insurers are not in substantial compliance with the provisions of  
45 existing law governing the schedule for paying claims; and (2) suspend or revoke  
46 the certificate of registration or authority of such an administrator or insurer upon a  
47 second or subsequent determination that such an administrator or insurer is not in  
48 substantial compliance with those provisions. (NRS 287.04335, 683A.0879,  
49 689A.410, 689B.255, 689C.335, 695B.2505, 695C.185, 695F.090) **Sections 10, 14**  
50 **and 16** of this bill extend those penalties to apply to fraternal benefit societies,  
51 issuers of plans for dental care and managed care organizations. **Sections 2, 5, 8-11,**  
52 **14 and 16** additionally authorize the Commissioner to: (1) impose an  
53 administrative penalty upon determining that the administrator of a health insurance  
54 plan or a health insurer has failed to approve or deny a claim or pay an approved  
55 claim within 60 working days after receiving the claim; and (2) suspend or revoke  
56 the certificate of registration or authority of an administrator or insurer upon a  
57 second or subsequent such determination. **Section 19** of this bill makes a  
58 conforming change to require the Director of the Department of Health and Human  
59 Services to administer the provisions of **section 22** in the same manner as other  
60 provisions governing Medicaid.

61 Existing law requires certain health insurers to provide certain notice to an  
62 insured within 10 days after denying coverage. (NRS 689A.755, 689B.0295,  
63 695B.400, 695G.230) **Sections 2, 6, 7, 9, 10, 12, 14, 15, 17, 18, 20 and 22** of this



64 bill require all public and private health insurers and administrators of health  
65 insurance plans to provide notice of the denial of a claim within 30 working days  
66 after receiving all information necessary to make a determination concerning the  
67 claim. **Sections 2, 6, 7, 9, 10, 12, 14, 15, 17, 18, 20 and 22** of this bill also require  
68 the inclusion of certain additional information in such a notice. **Sections 10, 14 and**  
69 **16** make certain other provisions relating to the payment of claims that currently  
70 apply to most health insurers also apply to fraternal benefit societies, organizations  
71 for dental care and managed care organizations so that the requirements governing  
72 the payment of claims are uniform for all health insurers.

73 Existing law requires a health carrier which offers or issues a network plan to  
74 notify each participating provider of health care in the network of the  
75 responsibilities of the provider of health care with respect to any applicable  
76 administrative policies and programs of the health carrier. (NRS 687B.730)  
77 **Sections 3 and 22** of this bill additionally require such a health carrier or the  
78 Medicaid Program to provide to each participating provider of health care and each  
79 covered person at least annually an explanation of the process by which the health  
80 carrier or Medicaid, as applicable, will provide remittances to or pay claims  
81 submitted by participating providers of health care.

82 Existing law requires a health carrier which offers or issues a network plan to  
83 establish procedures for the resolution of disputes between the health carrier and a  
84 participating provider of health care. (NRS 687B.820) **Section 4** of this bill requires  
85 those procedures to include an efficient process by which a participating provider  
86 of health care may challenge the denial by a health carrier of a claim. **Section 22**  
87 imposes a similar requirement on the Medicaid program. **Sections 20 and 21** of this  
88 bill make the provisions of **sections 3 and 4** applicable to local governments that  
89 provide health insurance for their employees and the Public Employees' Benefits  
90 Program, respectively. **Section 1** of this bill requires the Division of Insurance of  
91 the Department of Business and Industry to establish and carry out certain  
92 programs to facilitate public knowledge and use of the provisions of this bill.

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1 WHEREAS, Ensuring timely reimbursement for providers of  
2 health care will enhance the business environment in this State for  
3 providers of health care and improve access to health care for  
4 residents of this State; and

5 WHEREAS, Prompt payment of claims by health insurers will  
6 create a more stable and attractive landscape for new medical  
7 practices, thereby improving the health care infrastructure of this  
8 State; and

9 WHEREAS, Delayed payments by insurers have a  
10 disproportionate negative effect on minority communities, whose  
11 residents are less likely to have the means to pay out of pocket for  
12 health care services; now, therefore,

13  
14 THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN  
15 SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

16  
17 **Section 1.** NRS 679B.550 is hereby amended to read as  
18 follows:

19 679B.550 The Division shall:



1 1. Establish a toll-free telephone service for receiving inquiries  
2 and complaints from consumers of health care in this State  
3 concerning health care plans;

4 2. Provide answers to inquiries of consumers of health care  
5 concerning health care plans, or refer the consumers to the  
6 appropriate agency, department or other entity that is responsible for  
7 addressing the specific type of inquiry;

8 3. Refer consumers of health care to the appropriate agency,  
9 department or other entity that is responsible for addressing the  
10 specific type of complaint of the consumer;

11 4. Provide counseling and assistance to consumers of health  
12 care concerning health care plans;

13 5. Educate consumers of health care concerning health care  
14 plans in this State; ~~and~~

15 6. *Establish and carry out:*

16 (a) *A campaign to inform providers of health care and*  
17 *insureds of the provisions of NRS 683A.0879, 687B.730,*  
18 *687B.820, 689A.410, 689A.755, 689B.0295, 689B.255, 689C.335,*  
19 *695A.188, 695B.2505, 695B.400, 695D.215 and 695G.230 and*  
20 *sections 15 and 16 of this act; and*

21 (b) *A program to provide additional support and resources to*  
22 *assist providers of health care who operate small health care*  
23 *practices or are new to operating a health care practice in:*

24 (1) *Navigating the process for seeking reimbursement from*  
25 *insurers; and*

26 (2) *Ensuring that insurers comply with the requirements of*  
27 *NRS 683A.0879, 687B.730, 687B.820, 689A.410, 689A.755,*  
28 *689B.0295, 689B.255, 689C.335, 695A.188, 695B.2505, 695B.400,*  
29 *695D.215 and 695G.230 and sections 15 and 16 of this act; and*

30 7. Take such actions as are necessary to ensure public  
31 awareness of the existence and purpose of the services provided by  
32 the Division pursuant to this section.

33 **Sec. 2.** NRS 683A.0879 is hereby amended to read as follows:

34 683A.0879 1. Except as otherwise provided in subsection ~~2~~  
35 **3** and NRS 439B.754, an administrator shall approve or deny a  
36 claim relating to health insurance coverage *and, if the*  
37 *administrator:*

38 (a) *Approves the claim, pay the claim* within ~~30~~ :

39 (1) *Fifteen working* days after the administrator receives the  
40 claim ~~[. If the claim is approved, the administrator shall pay the~~  
41 ~~claim within 30 days after it is approved.]~~, *if the claim is submitted*  
42 *electronically; or*

43 (2) *Thirty working days after the administrator receives the*  
44 *claim, if the claim is not submitted electronically.*



1 (b) Denies the claim, notify the claimant in writing of the  
2 denial within 30 working days after the administrator receives the  
3 claim. The notice must include, without limitation:

4 (1) All reasons for denying the claim;

5 (2) The criteria by which the administrator determines  
6 whether to approve or deny the claim and a description of the  
7 manner in which the administrator applied those criteria to the  
8 claim;

9 (3) Any other legal or factual basis for denying the claim;  
10 and

11 (4) A summary of any applicable process established  
12 pursuant to NRS 687B.820 for challenging the denial of the claim.

13 2. Except as otherwise provided in this section, if the approved  
14 claim is not paid within ~~[that]~~ the period ~~[.]~~ specified in subsection  
15 1, the administrator shall pay interest on the claim at a rate of  
16 ~~[interest equal to the prime rate at the largest bank in Nevada, as~~  
17 ~~ascertained by the Commissioner of Financial Institutions, on~~  
18 ~~January 1 or July 1, as the case may be, immediately preceding the~~  
19 ~~date on which the payment was due, plus 6]~~ 10 percent ~~[.]~~ per  
20 annum. The interest must be calculated from ~~[30 days after]~~ the  
21 date on which *payment of* the claim is ~~[approved]~~ *due pursuant to*  
22 *subsection 1* until the date on which the claim is paid.

23 ~~[2.]~~ 3. If the administrator requires additional information to  
24 determine whether to approve or deny the claim, the administrator  
25 shall notify the claimant of the administrator's request for the  
26 additional information within 20 *working* days after receiving the  
27 claim. The administrator shall notify the ~~[provider of health care]~~  
28 *claimant* of all the specific reasons for the delay in approving or  
29 denying the claim. The administrator shall approve or deny the  
30 claim *and, if the administrator:*

31 (a) Approves the claim, pay the claim within ~~[30]~~ :

32 (1) Fifteen working days after receiving the additional  
33 information, if the information is submitted electronically; or

34 (2) Thirty working days after receiving the additional  
35 information ~~[. If the claim is approved, the administrator shall pay~~  
36 ~~the claim within 30 days after receiving the additional information.]~~  
37 , if the information is not submitted electronically.

38 (b) Denies the claim, provide notice of the denial in the  
39 manner prescribed in paragraph (b) of subsection 1 within 30  
40 working days after receiving the additional information.

41 4. If ~~[the]~~ a claim approved ~~[claim]~~ pursuant to subsection 3 is  
42 not paid within ~~[that]~~ the period ~~[.]~~ specified in that subsection, the  
43 administrator shall pay interest on the claim in the manner  
44 prescribed in subsection ~~[1.]~~ 2.



1 ~~§ 5.~~ 5. An administrator shall not request a claimant to  
2 resubmit information that the claimant has already provided to the  
3 administrator, unless the administrator provides a legitimate reason  
4 for the request and the purpose of the request is not to delay the  
5 payment of the claim, harass the claimant or discourage the filing of  
6 claims.

7 ~~§ 6.~~ 6. An administrator shall not pay only part of a claim that  
8 has been approved and is fully payable.

9 ~~§ 7.~~ 7. A court shall award costs and reasonable attorney's fees  
10 to the prevailing party in an action brought pursuant to this section.

11 ~~§ 8.~~ 8. The payment of interest provided for in this section for  
12 the late payment of an approved claim may be waived only if the  
13 payment was delayed because of an act of God or another cause  
14 beyond the control of the administrator.

15 ~~§ 9.~~ 9. The Commissioner may require an administrator to  
16 provide evidence which demonstrates that the administrator has  
17 substantially complied with the requirements set forth in this  
18 section, including, without limitation, payment within ~~§ 30 days~~ *the*  
19 *time periods specified by this section* of at least 95 percent of  
20 approved claims or at least 90 percent of the total dollar amount for  
21 approved claims.

22 ~~§ 10.~~ 10. If the Commissioner determines that an administrator  
23 is not in substantial compliance with the requirements set forth in  
24 this section ~~§~~ *or has failed to approve or deny a claim or pay an*  
25 *approved claim within 60 working days after receiving the claim,*  
26 the Commissioner may require the administrator to pay an  
27 administrative fine in an amount to be determined by the  
28 Commissioner. Upon a second or subsequent determination that an  
29 administrator is not in substantial compliance with the requirements  
30 set forth in this section ~~§~~ *or has failed to approve or deny a claim*  
31 *or pay an approved claim within 60 working days after receiving*  
32 *the claim,* the Commissioner may suspend or revoke the certificate  
33 of registration of the administrator.

34 *11. On or before February 1 of each year, an administrator*  
35 *that was responsible for the approval and denial of claims relating*  
36 *to health insurance coverage in this State during the immediately*  
37 *preceding calendar year shall submit to the Commissioner a report*  
38 *concerning the compliance of the administrator with the*  
39 *requirements of this section during that calendar year. The report*  
40 *must include, without limitation:*

41 *(a) The number of claims for which the administrator failed to*  
42 *comply with the requirements of subsections 1 and 3 during the*  
43 *immediately preceding calendar year; and*



1 *(b) The total amount of interest paid by the administrator*  
2 *pursuant to subsections 2 and 4 during the immediately preceding*  
3 *calendar year.*

4 **Sec. 3.** NRS 687B.730 is hereby amended to read as follows:

5 687B.730 A health carrier which offers or issues a network  
6 plan shall ~~notify~~:

7 *1. Notify* each participating provider of health care in the  
8 network of the responsibilities of the participating provider of health  
9 care with respect to any applicable administrative policies and  
10 programs of the health carrier including, without limitation, any  
11 applicable administrative policies and programs concerning:

12 ~~[1.]~~ (a) Terms of payment;

13 ~~[2.]~~ (b) Utilization review;

14 ~~[3.]~~ (c) Quality assessment and improvement;

15 ~~[4.]~~ (d) Credentialing;

16 ~~[5.]~~ (e) Procedures for grievances and appeals;

17 ~~[6.]~~ (f) Requirements for data reporting;

18 ~~[7.]~~ (g) Requirements for timely notice to the health carrier of  
19 changes in the practices of the participating provider of health care,  
20 such as discontinuance of accepting new patients;

21 ~~[8.]~~ (h) Requirements for confidentiality; and

22 ~~[9.]~~ (i) Any applicable federal or state programs.

23 *2. Provide to each participating provider of health care in the*  
24 *network and each covered person at least annually a detailed*  
25 *explanation of the process by which the health carrier will pay*  
26 *claims submitted by participating providers of health care,*  
27 *including, without limitation, the contact information for the*  
28 *department of the health carrier that is responsible for reviewing*  
29 *claims that have been denied in accordance with the process*  
30 *established pursuant to NRS 687B.820.*

31 **Sec. 4.** NRS 687B.820 is hereby amended to read as follows:

32 687B.820 A health carrier which offers or issues a network  
33 plan shall establish procedures for the resolution of administrative,  
34 payment or other disputes between a participating provider of health  
35 care in the network and the health carrier. *Those procedures must*  
36 *include, without limitation, an efficient process by which a*  
37 *participating provider of health care may challenge the denial of a*  
38 *claim by the health carrier. The process must allow for the clear*  
39 *resolution of each challenge within a reasonable time.*

40 **Sec. 5.** NRS 689A.410 is hereby amended to read as follows:

41 689A.410 1. Except as otherwise provided in subsection 2  
42 and NRS 439B.754, an insurer shall approve or deny a claim  
43 relating to a policy of health insurance within *15 working days after*  
44 *the insurer receives the claim, if the claim is submitted*  
45 *electronically, or 30 working* days after the insurer receives the



1 claim ~~[ ]~~, *if the claim is not submitted electronically*. If the claim is  
2 approved, the insurer shall *also* pay the claim within ~~[30 days after it~~  
3 ~~is approved.] that period~~. Except as otherwise provided in this  
4 section, if the approved claim is not paid within that period, the  
5 insurer shall pay interest on the claim at a rate of ~~[interest equal to~~  
6 ~~the prime rate at the largest bank in Nevada, as ascertained by the~~  
7 ~~Commissioner of Financial Institutions, on January 1 or July 1, as~~  
8 ~~the case may be, immediately preceding the date on which the~~  
9 ~~payment was due, plus 6] 10 percent [ ] per annum~~. The interest  
10 must be calculated from ~~[30 days after]~~ the date on which *payment*  
11 *of the claim is [approved] due pursuant to this subsection* until the  
12 date on which the claim is paid.

13 2. If the insurer requires additional information to determine  
14 whether to approve or deny the claim, it shall notify the claimant of  
15 its request for the additional information within 20 *working days*  
16 after it receives the claim. The insurer shall notify the ~~[provider of~~  
17 ~~health care] claimant~~ of all the specific reasons for the delay in  
18 approving or denying the claim. The insurer shall approve or deny  
19 the claim within *15 working days after receiving the additional*  
20 *information, if the additional information is submitted*  
21 *electronically, or 30 working days after receiving the additional*  
22 *information [ ] , if the additional information is not submitted*  
23 *electronically*. If the claim is approved, the insurer shall *also* pay the  
24 claim within ~~[30 days after it receives the additional information.]~~  
25 *that period*. If the approved claim is not paid within that period, the  
26 insurer shall pay interest on the claim in the manner prescribed in  
27 subsection 1.

28 3. An insurer shall not request a claimant to resubmit  
29 information that the claimant has already provided to the insurer,  
30 unless the insurer provides a legitimate reason for the request and  
31 the purpose of the request is not to delay the payment of the claim,  
32 harass the claimant or discourage the filing of claims.

33 4. An insurer shall not pay only part of a claim that has been  
34 approved and is fully payable.

35 5. A court shall award costs and reasonable attorney's fees to  
36 the prevailing party in an action brought pursuant to this section.

37 6. The payment of interest provided for in this section for the  
38 late payment of an approved claim may be waived only if the  
39 payment was delayed because of an act of God or another cause  
40 beyond the control of the insurer.

41 7. The Commissioner may require an insurer to provide  
42 evidence which demonstrates that the insurer has substantially  
43 complied with the requirements set forth in this section, including,  
44 without limitation, payment within ~~[30 days]~~ *the time periods*





1 *specified by this section* of at least 95 percent of approved claims or  
2 at least 90 percent of the total dollar amount for approved claims.

3 8. If the Commissioner determines that an insurer is not in  
4 substantial compliance with the requirements set forth in this section  
5 ~~§~~ *or that the insurer has failed to approve or deny a claim or pay*  
6 *an approved claim within 60 working days after receiving the*  
7 *claim*, the Commissioner may require the insurer to pay an  
8 administrative fine in an amount to be determined by the  
9 Commissioner. Upon a second or subsequent determination that an  
10 insurer is not in substantial compliance with the requirements set  
11 forth in this section ~~§~~ *or has failed to approve or deny a claim or*  
12 *pay an approved claim within 60 working days after receiving the*  
13 *claim*, the Commissioner may suspend or revoke the certificate of  
14 authority of the insurer.

15 9. *On or before February 1 of each year, an insurer shall*  
16 *submit to the Commissioner a report concerning the compliance*  
17 *of the insurer with the requirements of this section during the*  
18 *immediately preceding calendar year. The report must include,*  
19 *without limitation:*

20 (a) *The number of claims for which the insurer failed to*  
21 *comply with the requirements of subsections 1 and 2 during the*  
22 *immediately preceding calendar year; and*

23 (b) *The total amount of interest paid by the insurer pursuant to*  
24 *subsections 1 and 2 during the immediately preceding calendar*  
25 *year.*

26 **Sec. 6.** NRS 689A.755 is hereby amended to read as follows:

27 689A.755 1. Following approval by the Commissioner, each  
28 insurer that issues a policy of health insurance in this State shall  
29 provide written notice to an insured, in clear and comprehensible  
30 language that is understandable to an ordinary layperson, explaining  
31 the right of the insured to file a written complaint. Such notice must  
32 be provided to an insured:

33 (a) At the time the insured receives his or her evidence of  
34 coverage;

35 (b) Any time that the insurer denies coverage of a health care  
36 service or limits coverage of a health care service to an insured; and

37 (c) Any other time deemed necessary by the Commissioner.

38 2. Any time that an insurer denies coverage of a health care  
39 service to an insured, including, without limitation, denying a claim  
40 relating to a policy of health insurance pursuant to NRS 689A.410,  
41 it shall notify the insured *and, if applicable, the provider of health*  
42 *care who submitted the claim*, in writing within *30 working days*  
43 *after the insurer receives all information necessary to make a*  
44 *determination concerning the claim or, if no claim is received,*



1 *within* 10 working days after ~~[(t)]~~ *the insurer* denies coverage of the  
2 health care service, of:

3 (a) ~~[(The reason)]~~ *All reasons* for denying coverage of the  
4 service;

5 (b) The criteria by which the insurer determines whether to  
6 authorize or deny coverage of the health care service ~~[(t)]~~ and *a*  
7 *description of the manner in which the insurer applied those*  
8 *criteria to the health care service;*

9 (c) *Any other legal or factual basis for denying coverage of the*  
10 *health care service;*

11 (d) *A summary of any applicable process established pursuant*  
12 *to NRS 687B.820 for challenging the denial of the claim; and*

13 (e) The right of the insured to file a written complaint and the  
14 procedure for filing such a complaint.

15 3. A written notice which is approved by the Commissioner  
16 shall be deemed to be in clear and comprehensible language that is  
17 understandable to an ordinary layperson.

18 **Sec. 7.** NRS 689B.0295 is hereby amended to read as follows:

19 689B.0295 1. Following approval by the Commissioner, each  
20 insurer that issues a policy of group health insurance in this State  
21 shall provide written notice to an insured, in clear and  
22 comprehensible language that is understandable to an ordinary  
23 layperson, explaining the right of the insured to file a written  
24 complaint. Such notice must be provided to an insured:

25 (a) At the time the insured receives his or her certificate of  
26 coverage or evidence of coverage;

27 (b) Any time that the insurer denies coverage of a health care  
28 service or limits coverage of a health care service to an insured; and

29 (c) Any other time deemed necessary by the Commissioner.

30 2. Any time that an insurer denies coverage of a health care  
31 service, including, without limitation, denying a claim relating to a  
32 policy of group health insurance or blanket insurance pursuant to  
33 NRS 689B.255, to an insured it shall notify the insured in writing  
34 within *30 working days after the insurer receives all information*  
35 *necessary to make a determination concerning the claim or, if no*  
36 *claim is received, within* 10 working days after ~~[(t)]~~ *the insurer*  
37 denies coverage of the health care service, of:

38 (a) ~~[(The reason)]~~ *All reasons* for denying coverage of the  
39 service;

40 (b) The criteria by which the insurer determines whether to  
41 authorize or deny coverage of the health care service ~~[(t)]~~ and *a*  
42 *description of the manner in which the insurer applied those*  
43 *criteria to the health care service;*

44 (c) *Any other legal or factual basis for denying coverage;*



1 *(d) A summary of any applicable process established pursuant*  
2 *to NRS 687B.820 for challenging the denial of the claim; and*

3 *(e) The right of the insured to file a written complaint and the*  
4 *procedure for filing such a complaint.*

5 3. A written notice which is approved by the Commissioner  
6 shall be deemed to be in clear and comprehensible language that is  
7 understandable to an ordinary layperson.

8 *4. If an insurer denies a claim submitted by a provider of*  
9 *health care, the insurer shall notify the provider of health care in*  
10 *writing of the denial within 30 working days after the insurer*  
11 *receives all information necessary to make a determination*  
12 *concerning the claim. The notice must include, without limitation:*

13 *(a) All reasons for denying the claim;*

14 *(b) The criteria by which the insurer determines whether to*  
15 *approve or deny the claim and a description of the manner in*  
16 *which the insurer applied those criteria to the claim;*

17 *(c) Any other legal or factual basis for denying the claim; and*

18 *(d) A summary of any applicable process established pursuant*  
19 *to NRS 687B.820 for challenging the denial of the claim.*

20 **Sec. 8.** NRS 689B.255 is hereby amended to read as follows:

21 689B.255 1. Except as otherwise provided in subsection 2  
22 and NRS 439B.754, an insurer shall approve or deny a claim  
23 relating to a policy of group health insurance or blanket insurance  
24 within *15 working days after the insurer receives the claim, if the*  
25 *claim is submitted electronically, or 30 working days after the*  
26 *insurer receives the claim* ~~[-]~~ *, if the claim is not submitted*  
27 *electronically. If the claim is approved, the insurer shall also pay the*  
28 *claim within* ~~[30 days after it is approved.]~~ *that period. Except as*  
29 *otherwise provided in this section, if the approved claim is not paid*  
30 *within that period, the insurer shall pay interest on the claim at a rate*  
31 *of* ~~[interest equal to the prime rate at the largest bank in Nevada, as~~  
32 ~~ascertained by the Commissioner of Financial Institutions, on~~  
33 ~~January 1 or July 1, as the case may be, immediately preceding the~~  
34 ~~date on which the payment was due, plus 6]~~ *10 percent* ~~[-]~~ *per*  
35 *annum. The interest must be calculated from* ~~[30 days after]~~ *the*  
36 *date on which* *payment of* the claim is ~~[approved]~~ *due pursuant to*  
37 *this subsection until the date on which the claim is paid.*

38 2. If the insurer requires additional information to determine  
39 whether to approve or deny the claim, it shall notify the claimant of  
40 its request for the additional information within 20 *working days*  
41 *after it receives the claim. The insurer shall notify the* ~~[provider of~~  
42 ~~health care]~~ *claimant of all the specific reasons for the delay in*  
43 *approving or denying the claim. The insurer shall approve or deny*  
44 *the claim within 15 working days after receiving the additional*  
45 *information, if the additional information is submitted*



1 *electronically, or 30 working* days after receiving the additional  
2 information ~~[ ]~~, *if the additional information is not submitted*  
3 *electronically.* If the claim is approved, the insurer shall *also* pay the  
4 claim within ~~[30 days after it receives the additional information.]~~  
5 *that period.* If the approved claim is not paid within that period, the  
6 insurer shall pay interest on the claim in the manner prescribed in  
7 subsection 1.

8 3. An insurer shall not request a claimant to resubmit  
9 information that the claimant has already provided to the insurer,  
10 unless the insurer provides a legitimate reason for the request and  
11 the purpose of the request is not to delay the payment of the claim,  
12 harass the claimant or discourage the filing of claims.

13 4. An insurer shall not pay only part of a claim that has been  
14 approved and is fully payable.

15 5. A court shall award costs and reasonable attorney's fees to  
16 the prevailing party in an action brought pursuant to this section.

17 6. The payment of interest provided for in this section for the  
18 late payment of an approved claim may be waived only if the  
19 payment was delayed because of an act of God or another cause  
20 beyond the control of the insurer.

21 7. The Commissioner may require an insurer to provide  
22 evidence which demonstrates that the insurer has substantially  
23 complied with the requirements set forth in this section, including,  
24 without limitation, payment within ~~[30 days]~~ *the time periods*  
25 *specified by this section* of at least 95 percent of approved claims or  
26 at least 90 percent of the total dollar amount for approved claims.

27 8. If the Commissioner determines that an insurer is not in  
28 substantial compliance with the requirements set forth in this section  
29 ~~[ ]~~ *or has failed to approve or deny a claim or pay an approved*  
30 *claim within 60 working days after receiving the claim,* the  
31 Commissioner may require the insurer to pay an administrative fine  
32 in an amount to be determined by the Commissioner. Upon a second  
33 or subsequent determination that an insurer is not in substantial  
34 compliance with the requirements set forth in this section ~~[ ]~~ *or has*  
35 *failed to approve or deny a claim or pay an approved claim within*  
36 *60 working days after receiving the claim,* the Commissioner may  
37 suspend or revoke the certificate of authority of the insurer.

38 9. *On or before February 1 of each year, an insurer shall*  
39 *submit to the Commissioner a report concerning the compliance*  
40 *of the insurer with the requirements of this section during the*  
41 *immediately preceding calendar year. The report must include,*  
42 *without limitation:*

43 *(a) The number of claims for which the insurer failed to*  
44 *comply with the requirements of subsections 1 and 2 during the*  
45 *immediately preceding calendar year; and*



1 (b) *The total amount of interest paid by the insurer pursuant to*  
2 *subsections 1 and 2 during the immediately preceding calendar*  
3 *year.*

4 **Sec. 9.** NRS 689C.335 is hereby amended to read as follows:  
5 689C.335 1. Except as otherwise provided in subsection ~~[2]~~ 3  
6 and NRS 439B.754, a carrier serving small employers and a carrier  
7 that offers a contract to a voluntary purchasing group shall approve  
8 or deny a claim relating to a policy of health insurance *and, if the*  
9 *carrier:*

10 (a) *Approves the claim, pay the claim* within ~~[30]~~ :

11 (1) *Fifteen working* days after the carrier receives the claim  
12 ~~[If the claim is approved, the carrier shall pay the claim within 30~~  
13 ~~days after it is approved.]~~, *if the claim is submitted electronically;*  
14 *or*

15 (2) *Thirty working days after the carrier receives the claim,*  
16 *if the claim is not submitted electronically.*

17 (b) *Denies the claim, notify the claimant in writing of the*  
18 *denial within 30 working days after the carrier receives the claim.*  
19 *The notice must include, without limitation:*

20 (1) *All reasons for denying the claim;*

21 (2) *The criteria by which the carrier determines whether to*  
22 *approve or deny the claim and a description of the manner in*  
23 *which the carrier applied those criteria to the claim;*

24 (3) *Any other legal or factual basis for denying the claim;*  
25 *and*

26 (4) *A summary of any applicable process established*  
27 *pursuant to NRS 687B.820 for challenging the denial of the claim.*

28 2. Except as otherwise provided in this section, if the approved  
29 claim is not paid within ~~[that]~~ the period ~~[.]~~ *specified in subsection*  
30 *1*, the carrier shall pay interest on the claim at a rate of ~~[interest~~  
31 ~~equal to the prime rate at the largest bank in Nevada, as ascertained~~  
32 ~~by the Commissioner of Financial Institutions, on January 1 or~~  
33 ~~July 1, as the case may be, immediately preceding the date on which~~  
34 ~~the payment was due, plus 6]~~ 10 percent ~~[.]~~ *per annum.* The interest  
35 must be calculated from ~~[30 days after]~~ the date on which *payment*  
36 *of the claim is [approved] due pursuant to subsection 1* until the  
37 date on which the claim is paid.

38 ~~[2.]~~ 3. If the carrier requires additional information to  
39 determine whether to approve or deny the claim, it shall notify the  
40 claimant of its request for the additional information within 20  
41 *working* days after it receives the claim. The carrier shall notify the  
42 ~~[provider of health care]~~ *claimant* of all the specific reasons for the  
43 delay in approving or denying the claim. The carrier shall approve or  
44 deny the claim *and, if the carrier:*

45 (a) *Approves the claim, pay the claim* within ~~[30]~~ :



1 *(1) Fifteen working days after receiving the additional*  
2 *information, if the information is submitted electronically; or*

3 *(2) Thirty working days after receiving the additional*  
4 *information. ~~[(If the claim is approved, the carrier shall pay the claim~~*  
5 *~~within 30 days after it receives the additional information.] , if the~~*  
6 *information is not submitted electronically.*

7 *(b) Denies the claim, provide notice of the denial in the*  
8 *manner prescribed in paragraph (b) of subsection 1 within 30*  
9 *working days after receiving the additional information.*

10 4. If ~~[(the approved)]~~ a claim *approved pursuant to subsection 3*  
11 *is not paid within ~~[(that)]~~ the period ~~[( )]~~ specified in that subsection,*  
12 *the carrier shall pay interest on the claim in the manner prescribed in*  
13 *subsection ~~[( )]~~ 2.*

14 ~~[( )]~~ 5. A carrier shall not request a claimant to resubmit  
15 information that the claimant has already provided to the carrier,  
16 unless the carrier provides a legitimate reason for the request and the  
17 purpose of the request is not to delay the payment of the claim,  
18 harass the claimant or discourage the filing of claims.

19 ~~[( )]~~ 6. A carrier shall not pay only part of a claim that has been  
20 approved and is fully payable.

21 ~~[( )]~~ 7. A court shall award costs and reasonable attorney's fees  
22 to the prevailing party in an action brought pursuant to this section.

23 ~~[( )]~~ 8. The payment of interest provided for in this section for  
24 the late payment of an approved claim may be waived only if the  
25 payment was delayed because of an act of God or another cause  
26 beyond the control of the carrier.

27 ~~[( )]~~ 9. The Commissioner may require a carrier to provide  
28 evidence which demonstrates that the carrier has substantially  
29 complied with the requirements set forth in this section, including,  
30 without limitation, payment within ~~[(30 days)]~~ *the time periods*  
31 *specified by this section* of at least 95 percent of approved claims or  
32 at least 90 percent of the total dollar amount for approved claims.

33 ~~[( )]~~ 10. If the Commissioner determines that a carrier is not in  
34 substantial compliance with the requirements set forth in this section  
35 ~~[( )]~~ *or has failed to approve or deny a claim or pay an approved*  
36 *claim within 60 working days after receiving the claim,* the  
37 Commissioner may require the carrier to pay an administrative fine  
38 in an amount to be determined by the Commissioner. Upon a second  
39 or subsequent determination that a carrier is not in substantial  
40 compliance with the requirements set forth in this section ~~[( )]~~ *or has*  
41 *failed to approve or deny a claim or pay an approved claim within*  
42 *60 working days after receiving the claim,* the Commissioner may  
43 suspend or revoke the certificate of authority of the carrier.

44 11. *On or before February 1 of each year, a carrier shall*  
45 *submit to the Commissioner a report concerning the compliance*



1 of the carrier with the requirements of this section during the  
2 immediately preceding calendar year. The report must include,  
3 without limitation:

4 (a) The number of claims for which the carrier failed to  
5 comply with the requirements of subsections 1 and 3 during the  
6 immediately preceding calendar year; and

7 (b) The total amount of interest paid by the carrier pursuant to  
8 subsections 2 and 4 during the immediately preceding calendar  
9 year.

10 **Sec. 10.** NRS 695A.188 is hereby amended to read as follows:

11 695A.188 1. Except as otherwise provided in subsection ~~[2]~~ 3  
12 and NRS 439B.754, a society shall approve or deny a claim relating  
13 to a certificate of health insurance *and, if the society:*

14 (a) *Approves the claim, pay the claim* within ~~[30]~~ :

15 (1) *Fifteen working* days after the society receives the claim  
16 ~~[. If the claim is approved, the society shall pay the claim within 30~~  
17 ~~days after it is approved. If]~~ , *if the claim is submitted*  
18 *electronically; or*

19 (2) *Thirty working days after the society receives the claim,*  
20 *if the claim is not submitted electronically.*

21 (b) *Denies the claim, notify the claimant in writing of the*  
22 *denial within 30 working days after the society receives the claim.*  
23 *The notice must include, without limitation:*

24 (1) *All reasons for denying the claim;*

25 (2) *The criteria by which the society determines whether to*  
26 *approve or deny the claim and a description of the manner in*  
27 *which the society applied those criteria to the claim;*

28 (3) *Any other legal or factual basis for denying the claim;*  
29 *and*

30 (4) *A summary of any applicable process established*  
31 *pursuant to NRS 687B.820 for challenging the denial of the claim.*

32 2. *Except as otherwise provided in this section, if* the  
33 approved claim is not paid within ~~[that]~~ *the* period ~~[.]~~ *specified by*  
34 *subsection 1,* the society shall pay interest on the claim at the rate of  
35 ~~[interest established pursuant to NRS 99.040 unless a different rate~~  
36 ~~of interest is established pursuant to an express written contract~~  
37 ~~between the society and the provider of health care.]~~ *10 percent per*  
38 *annum.* The interest must be calculated from ~~[30 days after]~~ the  
39 date on which *payment of* the claim is ~~[approved]~~ *due pursuant to*  
40 *subsection 1* until the claim is paid.

41 ~~[2.]~~ 3. If the society requires additional information to  
42 determine whether to approve or deny the claim, it shall notify the  
43 claimant of its request for the additional information within 20  
44 *working* days after it receives the claim. The society shall notify the  
45 ~~[provider of health care]~~ *claimant* of all the specific reasons for the



1 delay in approving or denying the claim. The society shall approve  
2 or deny the claim *and, if the society:*

3 (a) *Approves the claim, pay the claim* within ~~[30]~~ :

4 (1) *Fifteen working days after receiving the additional*  
5 *information, if the information is submitted electronically; or*

6 (2) *Thirty working days after receiving the additional*  
7 *information* ~~[. If the claim is approved, the society shall pay the~~  
8 ~~claim within 30 days after it receives the additional information.]~~, *if*  
9 *the information is not submitted electronically.*

10 (b) *Denies the claim, provide notice of the denial in the*  
11 *manner prescribed in paragraph (b) of subsection 1 within 30*  
12 *working days after receiving the additional information.*

13 4. If ~~[the approved]~~ a claim *approved pursuant to subsection 3*  
14 *is not paid within* ~~[that]~~ *the period* ~~[.]~~ *specified in that subsection,*  
15 *the society shall pay interest on the claim in the manner prescribed*  
16 *in subsection* ~~[.]~~ *2.*

17 ~~[3.]~~ 5. A society shall not request a claimant to resubmit  
18 information that the claimant has already provided to the society,  
19 unless the society provides a legitimate reason for the request and  
20 the purpose of the request is not to delay the payment of the claim,  
21 harass the claimant or discourage the filing of claims.

22 ~~[4.]~~ 6. A society shall not pay only part of a claim that has  
23 been approved and is fully payable.

24 ~~[5.]~~ 7. A court shall award costs and reasonable attorney's fees  
25 to the prevailing party in an action brought pursuant to this section.

26 8. *The payment of interest provided for in this section for the*  
27 *late payment of an approved claim may be waived only if the*  
28 *payment was delayed because of an act of God or another cause*  
29 *beyond the control of the society.*

30 9. *The Commissioner may require a society to provide*  
31 *evidence which demonstrates that the society has substantially*  
32 *complied with the requirements set forth in this section, including,*  
33 *without limitation, payment within the time periods specified by*  
34 *this section of at least 95 percent of approved claims or at least 90*  
35 *percent of the total dollar amount for approved claims.*

36 10. *If the Commissioner determines that a society is not in*  
37 *substantial compliance with the requirements set forth in this*  
38 *section or has failed to approve or deny a claim or pay an*  
39 *approved claim within 60 working days after receiving the claim,*  
40 *the Commissioner may require the society to pay an administrative*  
41 *fine in an amount to be determined by the Commissioner. Upon a*  
42 *second or subsequent determination that a society is not in*  
43 *substantial compliance with the requirements set forth in this*  
44 *section or has failed to approve or deny a claim or pay an*  
45 *approved claim within 60 working days after receiving the claim,*





1 *the Commissioner may suspend or revoke the certificate of*  
2 *authority of the society.*

3 *11. On or before February 1 of each year, a society shall*  
4 *submit to the Commissioner a report concerning the compliance*  
5 *of the society with the requirements of this section during the*  
6 *immediately preceding calendar year. The report must include,*  
7 *without limitation:*

8 *(a) The number of claims for which the society failed to*  
9 *comply with the requirements of subsections 1 and 3 during the*  
10 *immediately preceding calendar year; and*

11 *(b) The total amount of interest paid by the society pursuant to*  
12 *subsections 2 and 4 during the immediately preceding calendar*  
13 *year.*

14 **Sec. 11.** NRS 695B.2505 is hereby amended to read as  
15 follows:

16 695B.2505 1. Except as otherwise provided in subsection 2  
17 and NRS 439B.754, a corporation subject to the provisions of this  
18 chapter shall approve or deny a claim relating to a contract for  
19 dental, hospital or medical services within *15 working days after*  
20 *the corporation receives the claim, if the claim is submitted*  
21 *electronically, or 30 working days after the corporation receives the*  
22 *claim [-], if the claim is not submitted electronically.* If the claim is  
23 approved, the corporation shall *also* pay the claim within ~~30 days~~  
24 ~~after it is approved.] that period.~~ Except as otherwise provided in  
25 this section, if the approved claim is not paid within ~~that~~ *that*  
26 period, the corporation shall pay interest on the claim at a rate of  
27 ~~interest equal to the prime rate at the largest bank in Nevada, as~~  
28 ~~ascertained by the Commissioner of Financial Institutions, on~~  
29 ~~January 1 or July 1, as the case may be, immediately preceding the~~  
30 ~~date on which the payment was due, plus 6] 10 percent [-] per~~  
31 *annum.* The interest must be calculated from ~~30 days after~~ *the*  
32 *date on which the payment of the claim is [approved] due pursuant*  
33 *to this subsection* until the date on which the claim is paid.

34 2. If the corporation requires additional information to  
35 determine whether to approve or deny the claim, it shall notify the  
36 claimant of its request for the additional information within 20  
37 *working days* after it receives the claim. The corporation shall notify  
38 the ~~provider of dental, hospital or medical services] claimant~~ of all  
39 the specific reasons for the delay in approving or denying the claim.  
40 The corporation shall approve or deny the claim within *15 working*  
41 *days after receiving the additional information, if the additional*  
42 *information is submitted electronically, or 30 working days after*  
43 *receiving the additional information [-], if the information is not*  
44 *submitted electronically.* If the claim is approved, the corporation  
45 shall pay the claim within ~~30 days after it receives the additional~~



1 ~~information.]~~ *that period.* If the approved claim is not paid within  
2 that period, the corporation shall pay interest on the claim in the  
3 manner prescribed in subsection 1.

4 3. A corporation shall not request a claimant to resubmit  
5 information that the claimant has already provided to the  
6 corporation, unless the corporation provides a legitimate reason for  
7 the request and the purpose of the request is not to delay the  
8 payment of the claim, harass the claimant or discourage the filing of  
9 claims.

10 4. A corporation shall not pay only part of a claim that has  
11 been approved and is fully payable.

12 5. A court shall award costs and reasonable attorney's fees to  
13 the prevailing party in an action brought pursuant to this section.

14 6. The payment of interest provided for in this section for the  
15 late payment of an approved claim may be waived only if the  
16 payment was delayed because of an act of God or another cause  
17 beyond the control of the corporation.

18 7. The Commissioner may require a corporation to provide  
19 evidence which demonstrates that the corporation has substantially  
20 complied with the requirements set forth in this section, including,  
21 without limitation, payment within ~~[30 days]~~ *the time periods*  
22 *specified by this section* of at least 95 percent of approved claims or  
23 at least 90 percent of the total dollar amount for approved claims.

24 8. If the Commissioner determines that a corporation is not in  
25 substantial compliance with the requirements set forth in this section  
26 ~~[ ]~~ *or has failed to approve or deny a claim or pay an approved*  
27 *claim within 60 working days after receiving the claim,* the  
28 Commissioner may require the corporation to pay an administrative  
29 fine in an amount to be determined by the Commissioner. Upon a  
30 second or subsequent determination that a corporation is not in  
31 substantial compliance with the requirements set forth in this section  
32 ~~[ ]~~ *or has failed to approve or deny a claim or pay an approved*  
33 *claim within 60 working days after receiving the claim,* the  
34 Commissioner may suspend or revoke the certificate of authority of  
35 the corporation.

36 9. *On or before February 1 of each year, a corporation shall*  
37 *submit to the Commissioner a report concerning the compliance*  
38 *of the corporation with the requirements of this section during the*  
39 *immediately preceding calendar year. The report must include,*  
40 *without limitation:*

41 (a) *The number of claims for which the corporation failed to*  
42 *comply with the requirements of subsections 1 and 3 during the*  
43 *immediately preceding calendar year; and*



1 *(b) The total amount of interest paid by the corporation*  
2 *pursuant to subsections 1 and 2 during the immediately preceding*  
3 *calendar year.*

4 **Sec. 12.** NRS 695B.400 is hereby amended to read as follows:

5 695B.400 1. Following approval by the Commissioner, each  
6 insurer that issues a contract for hospital or medical services in this  
7 State shall provide written notice to an insured, in clear and  
8 comprehensible language that is understandable to an ordinary  
9 layperson, explaining the right of the insured to file a written  
10 complaint. Such notice must be provided to an insured:

11 (a) At the time the insured receives a certificate of coverage or  
12 evidence of coverage;

13 (b) Any time that the insurer denies coverage of a health care  
14 service or limits coverage of a health care service to an insured; and

15 (c) Any other time deemed necessary by the Commissioner.

16 2. Any time that an insurer denies coverage of a health care  
17 service to a beneficiary or subscriber, including, without limitation,  
18 denying a claim relating to a contract for dental, hospital or medical  
19 services pursuant to NRS 695B.2505, it shall notify the beneficiary  
20 or subscriber in writing within *30 working days after the insurer*  
21 *receives all information necessary to make a determination*  
22 *concerning the claim or, if no claim is received, within* 10 working  
23 days after ~~the~~ *the insurer* denies coverage of the health care service  
24 of:

25 (a) ~~The reason~~ *All reasons* for denying coverage of the  
26 service;

27 (b) The criteria by which the insurer determines whether to  
28 authorize or deny coverage of the health care service ~~the~~ *and the*  
29 *manner in which the insurer applied those criteria to the health*  
30 *care service;*

31 (c) *Any other legal or factual basis for denying coverage of the*  
32 *health care service;*

33 (d) *A summary of any applicable process established pursuant*  
34 *to NRS 687B.820 for challenging the denial of the claim;* and

35 ~~(e)~~ (e) The right of the beneficiary or subscriber to file a  
36 written complaint and the procedure for filing such a complaint.

37 3. A written notice which is approved by the Commissioner  
38 shall be deemed to be in clear and comprehensible language that is  
39 understandable to an ordinary layperson.

40 **Sec. 13.** NRS 695C.187 is hereby amended to read as follows:

41 695C.187 1. A health maintenance organization shall not:

42 (a) Enter into any contract or agreement, or make any other  
43 arrangements, with a provider for the provision of health care; or

44 (b) Employ a provider pursuant to a contract, an agreement or  
45 any other arrangement to provide health care,



1 ↪ unless the contract, agreement or other arrangement specifically  
2 provides that the health maintenance organization and provider  
3 agree to the schedule for the payment of claims set forth in ~~NRS~~  
4 ~~695C.185.~~ *section 16 of this act.*

5 2. Any contract, agreement or other arrangement between a  
6 health maintenance organization and a provider that is entered into  
7 or renewed on or after October 1, 2001, that does not specifically  
8 include a provision concerning the schedule for the payment of  
9 claims as required by subsection 1 shall be deemed to conform with  
10 the requirements of subsection 1 by operation of law.

11 **Sec. 14.** NRS 695D.215 is hereby amended to read as follows:

12 695D.215 1. Except as otherwise provided in subsection ~~[2,]~~  
13 **3**, an organization for dental care shall approve or deny a claim  
14 relating to a plan for dental care *and, if the organization for dental*  
15 *care:*

16 (a) *Approves the claim, pay the claim* within ~~[30]~~ :

17 (1) *Fifteen working* days after the organization for dental  
18 care receives the claim ~~[. If the claim is approved, the organization~~  
19 ~~for dental care shall pay the claim within 30 days after it is~~  
20 ~~approved. If]~~ , *if the claim is submitted electronically; or*

21 (2) *Thirty working days after the organization for dental*  
22 *care receives the claim, if the claim is not submitted electronically.*

23 (b) *Denies the claim, notify the claimant in writing of the*  
24 *denial within 30 working days after the organization for dental*  
25 *care receives the claim. The notice must include, without*  
26 *limitation:*

27 (1) *All reasons for denying the claim;*

28 (2) *The criteria by which the organization for dental care*  
29 *determines whether to approve or deny the claim and a description*  
30 *of the manner in which the organization for dental care applied*  
31 *those criteria to the claim;*

32 (3) *Any other legal or factual basis for denying the claim;*  
33 *and*

34 (4) *A summary of any applicable process established*  
35 *pursuant to NRS 687B.820 for challenging the denial of the claim.*

36 2. *Except as otherwise provided in this section, if* the  
37 approved claim is not paid within ~~[that]~~ the period ~~[.]~~ *specified by*  
38 *subsection 1*, the organization for dental care shall pay interest on  
39 the claim at the rate of ~~[interest established pursuant to NRS~~  
40 ~~99.040.]~~ *10 percent per annum.* The interest must be calculated  
41 from the date the payment *of the claim* is due *pursuant to*  
42 *subsection 1* until the claim is paid.

43 ~~[2.]~~ 3. If the organization for dental care requires additional  
44 information to determine whether to approve or deny the claim, it  
45 shall notify the claimant of its request for the additional information



1 within 20 *working* days after it receives the claim. The organization  
2 for dental care shall notify the ~~[provider of dental care]~~ *claimant* of  
3 the reason for the delay in approving or denying the claim. The  
4 organization for dental care shall approve or deny the claim *and, if*  
5 *the organization for dental care:*

6 (a) *Approves the claim, pay the claim* within ~~[30]~~ :

7 (1) *Fifteen working days after receiving the additional*  
8 *information, if the information is submitted electronically; or*

9 (2) *Thirty working* days after receiving the additional  
10 information ~~[. If the claim is approved, the organization for dental~~  
11 ~~care shall pay the claim within 30 days after it receives the~~  
12 ~~additional information.]~~ , *if the information is not submitted*  
13 *electronically.*

14 (b) *Denies the claim, provide notice of the denial in the*  
15 *manner prescribed in paragraph (b) of subsection 1 within 30*  
16 *working days after receiving the additional information.*

17 4. If ~~[the approved]~~ a claim approved pursuant to subsection 3  
18 is not paid within ~~[that]~~ the period ~~[,]~~ specified in that subsection,  
19 the organization for dental care shall pay interest on the claim in the  
20 manner prescribed in subsection ~~[1.]~~ 2.

21 5. *An organization for dental care shall not request a*  
22 *claimant to resubmit information that the claimant has already*  
23 *provided to the organization for dental care, unless the*  
24 *organization for dental care provides a legitimate reason for the*  
25 *request and the purpose of the request is not to delay the payment*  
26 *of the claim, harass the claimant or discourage the filing of*  
27 *claims.*

28 6. *An organization for dental care shall not pay only part of a*  
29 *claim that has been approved and is fully payable.*

30 7. *A court shall award costs and reasonable attorney's fees to*  
31 *the prevailing party in an action brought pursuant to this section.*

32 8. *The payment of interest provided for in this section for the*  
33 *late payment of an approved claim may be waived only if the*  
34 *payment was delayed because of an act of God or another cause*  
35 *beyond the control of the organization for dental care.*

36 9. *The Commissioner may require an organization for dental*  
37 *care to provide evidence which demonstrates that the organization*  
38 *for dental care has substantially complied with the requirements*  
39 *set forth in this section, including, without limitation, payment*  
40 *within the time periods specified by this section of at least 95*  
41 *percent of approved claims or at least 90 percent of the total dollar*  
42 *amount for approved claims.*

43 10. *If the Commissioner determines that an organization for*  
44 *dental care is not in substantial compliance with the requirements*  
45 *set forth in this section or has failed to approve or deny a claim or*



1 *pay an approved claim within 60 working days after receiving the*  
2 *claim, the Commissioner may require the organization for dental*  
3 *care to pay an administrative fine in an amount to be determined*  
4 *by the Commissioner. Upon a second or subsequent determination*  
5 *that an organization for dental care is not in substantial*  
6 *compliance with the requirements set forth in this section or has*  
7 *failed to approve or deny a claim or pay an approved claim within*  
8 *60 working days after receiving the claim, the Commissioner may*  
9 *suspend or revoke the certificate of authority of the organization*  
10 *for dental care.*

11 *11. On or before February 1 of each year, an organization*  
12 *for dental care shall submit to the Commissioner a report*  
13 *concerning the compliance of the organization for dental care*  
14 *with the requirements of this section during the immediately*  
15 *preceding calendar year. The report must include, without*  
16 *limitation:*

17 *(a) The number of claims for which the organization for*  
18 *dental care failed to comply with the requirements of subsections 1*  
19 *and 3 during the immediately preceding calendar year; and*

20 *(b) The total amount of interest paid by the organization for*  
21 *dental care pursuant to subsections 2 and 4 during the*  
22 *immediately preceding calendar year.*

23 **Sec. 15.** Chapter 695F of NRS is hereby amended by adding  
24 thereto a new section to read as follows:

25 *If a prepaid limited health service organization denies a claim,*  
26 *the prepaid limited health service organization shall notify the*  
27 *claimant in writing of the denial within 30 working days after the*  
28 *prepaid limited health service organization receives all*  
29 *information necessary to make a determination concerning the*  
30 *claim. The notice must include, without limitation:*

31 *1. All reasons for denying the claim;*

32 *2. The criteria by which the prepaid limited health service*  
33 *organization determines whether to approve or deny the claim and*  
34 *a description of the manner in which the prepaid limited health*  
35 *service organization applied those criteria to the claim;*

36 *3. Any other legal or factual basis for denying the claim; and*

37 *4. A summary of any applicable process established pursuant*  
38 *to NRS 687B.820 for challenging the denial of the claim.*

39 **Sec. 16.** Chapter 695G of NRS is hereby amended by adding  
40 thereto a new section to read as follows:

41 *1. Except as otherwise provided in subsection 2 and NRS*  
42 *439B.754, a managed care organization shall approve or deny a*  
43 *claim within 15 working days after the managed care organization*  
44 *receives the claim, if the claim is submitted electronically, or 30*  
45 *working days after the managed care organization receives the*



1 *claim, if the claim is not submitted electronically. If the claim is*  
2 *approved, the managed care organization shall also pay the claim*  
3 *within that period. Except as otherwise provided in this section, if*  
4 *the approved claim is not paid within that period, the managed*  
5 *care organization shall pay interest on the claim at a rate of 10*  
6 *percent per annum. The interest must be calculated from the date*  
7 *on which payment of the claim is due pursuant to this subsection*  
8 *until the date on which the claim is paid.*

9 2. *If the managed care organization requires additional*  
10 *information to determine whether to approve or deny the claim, it*  
11 *shall notify the claimant of its request for the additional*  
12 *information within 20 working days after it receives the claim. The*  
13 *managed care organization shall notify the claimant of all the*  
14 *specific reasons for the delay in approving or denying the claim.*  
15 *The managed care organization shall approve or deny the claim*  
16 *within 15 working days after receiving the additional information,*  
17 *if the additional information is submitted electronically, or 30*  
18 *working days after receiving the additional information, if the*  
19 *additional information is not submitted electronically. If the claim*  
20 *is approved, the managed care organization shall also pay the*  
21 *claim within that period. If the approved claim is not paid within*  
22 *that period, the managed care organization shall pay interest on*  
23 *the claim in the manner prescribed in subsection 1.*

24 3. *A managed care organization shall not request a claimant*  
25 *to resubmit information that the claimant has already provided to*  
26 *the managed care organization, unless the managed care*  
27 *organization provides a legitimate reason for the request and the*  
28 *purpose of the request is not to delay the payment of the claim,*  
29 *harass the claimant or discourage the filing of claims.*

30 4. *A managed care organization shall not pay only part of a*  
31 *claim that has been approved and is fully payable.*

32 5. *A court shall award costs and reasonable attorney's fees to*  
33 *the prevailing party in an action brought pursuant to this section.*

34 6. *The payment of interest provided for in this section for the*  
35 *late payment of an approved claim may be waived only if the*  
36 *payment was delayed because of an act of God or another cause*  
37 *beyond the control of the managed care organization.*

38 7. *The Commissioner may require a managed care*  
39 *organization to provide evidence which demonstrates that the*  
40 *managed care organization has substantially complied with the*  
41 *requirements set forth in this section, including, without*  
42 *limitation, payment within the time periods specified by this*  
43 *section of at least 95 percent of approved claims or at least 90*  
44 *percent of the total dollar amount for approved claims.*



1       8. *If the Commissioner determines that a managed care*  
2 *organization is not in substantial compliance with the*  
3 *requirements set forth in this section or has failed to approve or*  
4 *deny a claim or pay an approved claim within 60 working days*  
5 *after receiving the claim, the Commissioner may require the*  
6 *managed care organization to pay an administrative fine in an*  
7 *amount to be determined by the Commissioner. Upon a second or*  
8 *subsequent determination that a managed care organization is not*  
9 *in substantial compliance with the requirements set forth in this*  
10 *section or has failed to approve or deny a claim or pay an*  
11 *approved claim within 60 working days after receiving the claim,*  
12 *the Commissioner may suspend or revoke the certificate of*  
13 *authority of the managed care organization.*

14       9. *On or before February 1 of each year, a managed care*  
15 *organization shall submit to the Commissioner a report*  
16 *concerning the compliance of the managed care organization with*  
17 *the requirements of this section during the immediately preceding*  
18 *calendar year. The report must include, without limitation:*

19       (a) *The number of claims for which the managed care*  
20 *organization failed to comply with the requirements of subsections*  
21 *1 and 2 during the immediately preceding calendar year; and*

22       (b) *The total amount of interest paid by the managed care*  
23 *organization pursuant to subsections 1 and 2 during the*  
24 *immediately preceding calendar year.*

25       **Sec. 17.** NRS 695G.090 is hereby amended to read as follows:

26       695G.090 1. Except as otherwise provided in subsection 3,  
27 the provisions of this chapter apply to each organization and insurer  
28 that operates as a managed care organization and may include,  
29 without limitation, an insurer that issues a policy of health  
30 insurance, an insurer that issues a policy of individual or group  
31 health insurance, a carrier serving small employers, a fraternal  
32 benefit society, a hospital or medical service corporation and a  
33 health maintenance organization.

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

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

38       (b) Any other applicable provision of this title.

39       3. The provisions of NRS 695G.127, 695G.1639, 695G.164,  
40 695G.1645, 695G.167 , ~~and~~ 695G.200 ~~to 695G.230, inclusive,~~  
41 *695G.210 and 695G.220 and subsections 1, 2 and 3 of NRS*  
42 *695G.230* do not apply to a managed care organization that provides  
43 health care services to recipients of Medicaid under the State Plan  
44 for Medicaid or insurance pursuant to the Children's Health  
45 Insurance Program pursuant to a contract with the Division of





1 Health Care Financing and Policy of the Department of Health and  
2 Human Services.

3 4. The provisions of NRS 695C.1735 and 695G.1639 do not  
4 apply to a managed care organization that provides health care  
5 services to members of the Public Employees' Benefits Program.

6 5. Subsections 3 and 4 do not exempt a managed care  
7 organization from any provision of this chapter for services  
8 provided pursuant to any other contract.

9 **Sec. 18.** NRS 695G.230 is hereby amended to read as follows:

10 695G.230 1. After approval by the Commissioner, each  
11 health carrier shall provide a written notice to an insured, in clear  
12 and comprehensible language that is understandable to an ordinary  
13 layperson, explaining the right of the insured to file a written  
14 complaint and to obtain an expedited review pursuant to NRS  
15 695G.210. Such a notice must be provided to an insured:

16 (a) At the time the insured receives his or her certificate of  
17 coverage or evidence of coverage;

18 (b) Any time that the health carrier denies coverage of a health  
19 care service or limits coverage of a health care service to an insured;  
20 and

21 (c) Any other time deemed necessary by the Commissioner.

22 2. If a health carrier denies coverage of a health care service to  
23 an insured, including, without limitation, a ~~health maintenance~~  
24 *managed care* organization that denies a claim related to a health  
25 care plan pursuant to ~~NRS 695C.185,~~ *section 16 of this act*, it  
26 shall notify the insured *and, if applicable, the provider of health*  
27 *care who submitted the claim*, in writing within *30 working days*  
28 *after the health carrier receives all information necessary to make*  
29 *a determination concerning the claim or, if no claim is received,*  
30 *within 10 working days after ~~it~~ the health carrier* denies coverage  
31 of the health care service of:

32 (a) ~~The reason~~ *All reasons* for denying coverage of the  
33 service;

34 (b) The criteria by which the health carrier or insurer determines  
35 whether to authorize or deny coverage of the health care service ~~it~~  
36 *and a description of the manner in which the health carrier*  
37 *applied those criteria to the health care service;*

38 (c) *Any other legal or factual basis for denying coverage of the*  
39 *health care service;*

40 (d) *A summary of any applicable process established pursuant*  
41 *to NRS 687B.820 for challenging the denial of the claim;*

42 (e) The right of the insured to:

43 (1) File a written complaint and the procedure for filing such  
44 a complaint;



1 (2) Appeal an adverse determination pursuant to NRS  
2 695G.241 to 695G.310, inclusive;

3 (3) Receive an expedited external review of an adverse  
4 determination if the health carrier receives proof from the insured's  
5 provider of health care that failure to proceed in an expedited  
6 manner may jeopardize the life or health of the insured, including  
7 notification of the procedure for requesting the expedited external  
8 review; and

9 (4) Receive assistance from any person, including an  
10 attorney, for an external review of an adverse determination; and

11 ~~(d)~~ (f) The telephone number of the Office for Consumer  
12 Health Assistance.

13 3. A written notice which is approved by the Commissioner  
14 shall be deemed to be in clear and comprehensible language that is  
15 understandable to an ordinary layperson.

16 4. *If a health carrier denies a claim submitted by a provider*  
17 *of health care, the health carrier shall notify the provider of health*  
18 *care in writing of the denial within 30 working days after the*  
19 *health carrier receives all information necessary to make a*  
20 *determination concerning the claim. The notice must include,*  
21 *without limitation:*

22 (a) *All reasons for denying the claim;*

23 (b) *The criteria by which the health carrier determines*  
24 *whether to approve or deny the claim and a description of the*  
25 *manner in which the health carrier applied those criteria to the*  
26 *claim;*

27 (c) *Any other legal or factual basis for denying the claim; and*

28 (d) *A summary of any applicable process established pursuant*  
29 *to NRS 687B.820 for challenging the denial of the claim.*

30 **Sec. 19.** NRS 232.320 is hereby amended to read as follows:

31 232.320 1. The Director:

32 (a) Shall appoint, with the consent of the Governor,  
33 administrators of the divisions of the Department, who are  
34 respectively designated as follows:

35 (1) The Administrator of the Aging and Disability Services  
36 Division;

37 (2) The Administrator of the Division of Welfare and  
38 Supportive Services;

39 (3) The Administrator of the Division of Child and Family  
40 Services;

41 (4) The Administrator of the Division of Health Care  
42 Financing and Policy; and

43 (5) The Administrator of the Division of Public and  
44 Behavioral Health.



1 (b) Shall administer, through the divisions of the Department,  
2 the provisions of chapters 63, 424, 425, 427A, 432A to 442,  
3 inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS  
4 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, *and*  
5 *section 22 of this act*, 422.580, 432.010 to 432.133, inclusive,  
6 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive,  
7 and 445A.010 to 445A.055, inclusive, and all other provisions of  
8 law relating to the functions of the divisions of the Department, but  
9 is not responsible for the clinical activities of the Division of Public  
10 and Behavioral Health or the professional line activities of the other  
11 divisions.

12 (c) Shall administer any state program for persons with  
13 developmental disabilities established pursuant to the  
14 Developmental Disabilities Assistance and Bill of Rights Act of  
15 2000, 42 U.S.C. §§ 15001 et seq.

16 (d) Shall, after considering advice from agencies of local  
17 governments and nonprofit organizations which provide social  
18 services, adopt a master plan for the provision of human services in  
19 this State. The Director shall revise the plan biennially and deliver a  
20 copy of the plan to the Governor and the Legislature at the  
21 beginning of each regular session. The plan must:

22 (1) Identify and assess the plans and programs of the  
23 Department for the provision of human services, and any  
24 duplication of those services by federal, state and local agencies;

25 (2) Set forth priorities for the provision of those services;

26 (3) Provide for communication and the coordination of those  
27 services among nonprofit organizations, agencies of local  
28 government, the State and the Federal Government;

29 (4) Identify the sources of funding for services provided by  
30 the Department and the allocation of that funding;

31 (5) Set forth sufficient information to assist the Department  
32 in providing those services and in the planning and budgeting for the  
33 future provision of those services; and

34 (6) Contain any other information necessary for the  
35 Department to communicate effectively with the Federal  
36 Government concerning demographic trends, formulas for the  
37 distribution of federal money and any need for the modification of  
38 programs administered by the Department.

39 (e) May, by regulation, require nonprofit organizations and state  
40 and local governmental agencies to provide information regarding  
41 the programs of those organizations and agencies, excluding  
42 detailed information relating to their budgets and payrolls, which the  
43 Director deems necessary for the performance of the duties imposed  
44 upon him or her pursuant to this section.

45 (f) Has such other powers and duties as are provided by law.



1 2. Notwithstanding any other provision of law, the Director, or  
2 the Director's designee, is responsible for appointing and removing  
3 subordinate officers and employees of the Department.

4 **Sec. 20.** NRS 287.010 is hereby amended to read as follows:

5 287.010 1. The governing body of any county, school  
6 district, municipal corporation, political subdivision, public  
7 corporation or other local governmental agency of the State of  
8 Nevada may:

9 (a) Adopt and carry into effect a system of group life, accident  
10 or health insurance, or any combination thereof, for the benefit of its  
11 officers and employees, and the dependents of officers and  
12 employees who elect to accept the insurance and who, where  
13 necessary, have authorized the governing body to make deductions  
14 from their compensation for the payment of premiums on the  
15 insurance.

16 (b) Purchase group policies of life, accident or health insurance,  
17 or any combination thereof, for the benefit of such officers and  
18 employees, and the dependents of such officers and employees, as  
19 have authorized the purchase, from insurance companies authorized  
20 to transact the business of such insurance in the State of Nevada,  
21 and, where necessary, deduct from the compensation of officers and  
22 employees the premiums upon insurance and pay the deductions  
23 upon the premiums.

24 (c) Provide group life, accident or health coverage through a  
25 self-insurance reserve fund and, where necessary, deduct  
26 contributions to the maintenance of the fund from the compensation  
27 of officers and employees and pay the deductions into the fund. The  
28 money accumulated for this purpose through deductions from the  
29 compensation of officers and employees and contributions of the  
30 governing body must be maintained as an internal service fund as  
31 defined by NRS 354.543. The money must be deposited in a state or  
32 national bank or credit union authorized to transact business in the  
33 State of Nevada. Any independent administrator of a fund created  
34 under this section is subject to the licensing requirements of chapter  
35 683A of NRS, and must be a resident of this State. Any contract  
36 with an independent administrator must be approved by the  
37 Commissioner of Insurance as to the reasonableness of  
38 administrative charges in relation to contributions collected and  
39 benefits provided. The provisions of NRS 439.581 to 439.597,  
40 inclusive, 686A.135, 687B.352, 687B.408, 687B.692, 687B.723,  
41 687B.725, **687B.730**, 687B.805, **subsection 4 of NRS 689B.0295**,  
42 689B.030 to 689B.0317, inclusive, paragraphs (b) and (c) of  
43 subsection 1 of NRS 689B.0319, subsections 2, 4, 6 and 7 of NRS  
44 689B.0319, 689B.033 to 689B.0369, inclusive, 689B.0375 to  
45 689B.050, inclusive, 689B.0675, **689B.255**, 689B.265, 689B.287



1 and 689B.500 apply to coverage provided pursuant to this  
2 paragraph, except that the provisions of NRS 689B.0378,  
3 689B.03785 and 689B.500 only apply to coverage for active officers  
4 and employees of the governing body, or the dependents of such  
5 officers and employees.

6 (d) Defray part or all of the cost of maintenance of a self-  
7 insurance fund or of the premiums upon insurance. The money for  
8 contributions must be budgeted for in accordance with the laws  
9 governing the county, school district, municipal corporation,  
10 political subdivision, public corporation or other local governmental  
11 agency of the State of Nevada.

12 2. If a school district offers group insurance to its officers and  
13 employees pursuant to this section, members of the board of trustees  
14 of the school district must not be excluded from participating in the  
15 group insurance. If the amount of the deductions from compensation  
16 required to pay for the group insurance exceeds the compensation to  
17 which a trustee is entitled, the difference must be paid by the trustee.

18 3. In any county in which a legal services organization exists,  
19 the governing body of the county, or of any school district,  
20 municipal corporation, political subdivision, public corporation or  
21 other local governmental agency of the State of Nevada in the  
22 county, may enter into a contract with the legal services  
23 organization pursuant to which the officers and employees of the  
24 legal services organization, and the dependents of those officers and  
25 employees, are eligible for any life, accident or health insurance  
26 provided pursuant to this section to the officers and employees, and  
27 the dependents of the officers and employees, of the county, school  
28 district, municipal corporation, political subdivision, public  
29 corporation or other local governmental agency.

30 4. If a contract is entered into pursuant to subsection 3, the  
31 officers and employees of the legal services organization:

32 (a) Shall be deemed, solely for the purposes of this section, to be  
33 officers and employees of the county, school district, municipal  
34 corporation, political subdivision, public corporation or other local  
35 governmental agency with which the legal services organization has  
36 contracted; and

37 (b) Must be required by the contract to pay the premiums or  
38 contributions for all insurance which they elect to accept or of which  
39 they authorize the purchase.

40 5. A contract that is entered into pursuant to subsection 3:

41 (a) Must be submitted to the Commissioner of Insurance for  
42 approval not less than 30 days before the date on which the contract  
43 is to become effective.

44 (b) Does not become effective unless approved by the  
45 Commissioner.



1 (c) Shall be deemed to be approved if not disapproved by the  
2 Commissioner within 30 days after its submission.

3 6. As used in this section, "legal services organization" means  
4 an organization that operates a program for legal aid and receives  
5 money pursuant to NRS 19.031.

6 **Sec. 21.** NRS 287.04335 is hereby amended to read as  
7 follows:

8 287.04335 If the Board provides health insurance through a  
9 plan of self-insurance, it shall comply with the provisions of NRS  
10 439.581 to 439.597, inclusive, 686A.135, 687B.352, 687B.409,  
11 687B.692, 687B.723, 687B.725, **687B.730**, 687B.805, **687B.820**,  
12 **subsection 4 of NRS 689B.0295**, 689B.0353, 689B.255,  
13 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162,  
14 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167,  
15 695G.1675, 695G.170 to 695G.1712, inclusive, 695G.1714 to  
16 695G.174, inclusive, 695G.176, 695G.177, 695G.200 to 695G.230,  
17 inclusive, 695G.241 to 695G.310, inclusive, 695G.405 and  
18 695G.415, **and section 16 of this act** in the same manner as an  
19 insurer that is licensed pursuant to title 57 of NRS is required to  
20 comply with those provisions.

21 **Sec. 22.** Chapter 422 of NRS is hereby amended by adding  
22 thereto a new section to read as follows:

23 **1. Except as otherwise provided in subsection 2, the**  
24 **Department shall approve or deny a claim for reimbursement on a**  
25 **fee-for-service basis under Medicaid or the Children's Health**  
26 **Insurance Program within 15 working days after the Department**  
27 **receives the claim, if the claim is submitted electronically, or 30**  
28 **working days after the Department receives the claim, if the claim**  
29 **is not submitted electronically. If the claim is approved, the**  
30 **Department shall also pay the approved reimbursement within that**  
31 **period. Except as otherwise provided in this section, if the**  
32 **approved reimbursement is not paid within that period, the**  
33 **Department shall pay interest on the claim at a rate of 10 percent**  
34 **per annum. The interest must be calculated from the date on**  
35 **which payment is due pursuant to this subsection until the date on**  
36 **which the reimbursement is paid.**

37 **2. If the Department requires additional information to**  
38 **determine whether to approve or deny the claim, it shall notify the**  
39 **claimant of its request for the additional information within 20**  
40 **working days after it receives the claim. The Department shall**  
41 **notify the claimant of all the specific reasons for the delay in**  
42 **approving or denying the claim. The Department shall approve or**  
43 **deny the claim within 15 working days after receiving the**  
44 **additional information, if the additional information is submitted**  
45 **electronically, or 30 working days after receiving the additional**



1 *information, if the additional information is not submitted*  
2 *electronically. If the claim is approved, the Department shall also*  
3 *pay the approved reimbursement within that period. If the*  
4 *approved reimbursement is not paid within that period, the*  
5 *Department shall pay interest on the claim in the manner*  
6 *prescribed in subsection 1.*

7 *3. If the Department denies a claim for reimbursement on a*  
8 *fee-for-service basis under Medicaid or the Children's Health*  
9 *Insurance Program, the Department shall notify the claimant in*  
10 *writing of the denial within 30 working days after the Department*  
11 *receives all information necessary to make a determination*  
12 *concerning the claim. The notice must include, without limitation:*

13 *(a) All reasons for denying the claim;*

14 *(b) The criteria by which the Department determines whether*  
15 *to approve or deny the claim and a description of the manner in*  
16 *which the Department applied those criteria to the claim;*

17 *(c) Any other legal or factual basis for denying the claim; and*

18 *(d) A description of the process established pursuant to*  
19 *subsection 4 for challenging the denial of the claim.*

20 *4. The Department shall establish an efficient process by*  
21 *which a provider of health care who participates in Medicaid or*  
22 *the Children's Health Insurance Program may challenge the*  
23 *denial by the Department of a claim for reimbursement on a fee-*  
24 *for-service basis. The process must allow for the clear resolution*  
25 *of each challenge within a reasonable time.*

26 *5. The Department shall provide to each provider of health*  
27 *care who receives reimbursement on a fee-for-service basis*  
28 *through Medicaid or the Children's Health Insurance Program,*  
29 *each recipient of Medicaid who receives services on a fee-for-*  
30 *service basis and the parent or guardian of each child who*  
31 *receives coverage under the Children's Health Insurance*  
32 *Program and receives services on a fee-for-service basis at least*  
33 *annually an explanation of the process by which the Department*  
34 *will provide remittances to participating providers of health care.*

35 **Sec. 23.** 1. The amendatory provisions of this act do not  
36 supersede the provisions of any contract entered into or policy  
37 issued before July 1, 2025, but apply to any renewal of such a  
38 contract or policy.

39 2. The amendatory provisions of this act do not apply to any  
40 claim under a policy of health insurance or other program that  
41 provides health coverage submitted before July 1, 2025, but, except  
42 as otherwise provided in subsection 1, apply to such claims  
43 submitted on or after that date.



1     **Sec. 24.** The provisions of NRS 354.599 do not apply to any  
2 additional expenses of a local government that are related to the  
3 provisions of this act.

4     **Sec. 25.** NRS 695C.128 are 695C.185 are hereby repealed.

5     **Sec. 26.** This act becomes effective on July 1, 2025.

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**TEXT OF REPEALED SECTIONS**

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**695C.128 Contracts to provide services pursuant to certain state programs: Payment of interest on claims.** Any contract or other agreement entered into or renewed by a health maintenance organization on or after October 1, 2001:

1. To provide health care services through managed care to recipients of Medicaid under the state plan for Medicaid; or

2. With the Division of Health Care Financing and Policy of the Department of Health and Human Services to provide insurance pursuant to the Children's Health Insurance Program,

↳ must require the health maintenance organization to pay interest to a provider of health care services on a claim that is not paid within the time provided in the contract or agreement at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

**695C.185 Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements; imposition of administrative fine or suspension or revocation of certificate of authority for failure to comply.**

1. Except as otherwise provided in subsection 2 and NRS 439B.754, a health maintenance organization shall approve or deny a claim relating to a health care plan within 30 days after the health maintenance organization receives the claim. If the claim is approved, the health maintenance organization shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the health maintenance organization shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the





date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

2. If the health maintenance organization requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for the additional information within 20 days after it receives the claim. The health maintenance organization shall notify the provider of health care services of all the specific reasons for the delay in approving or denying the claim. The health maintenance organization shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the health maintenance organization shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the health maintenance organization shall pay interest on the claim in the manner prescribed in subsection 1.

3. A health maintenance organization shall not request a claimant to resubmit information that the claimant has already provided to the health maintenance organization, unless the health maintenance organization provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. A health maintenance organization shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may be waived only if the payment was delayed because of an act of God or another cause beyond the control of the health maintenance organization.

7. The Commissioner may require a health maintenance organization to provide evidence which demonstrates that the health maintenance organization has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

8. If the Commissioner determines that a health maintenance organization is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the health maintenance organization to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that a health maintenance organization is not in substantial compliance with the requirements set forth in this



section, the Commissioner may suspend or revoke the certificate of authority of the health maintenance organization.

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