ASSEMBLY BILL NO. 52–COMMITTEE
ON COMMERCE AND LABOR

(ON BEHALF OF THE NEVADA COMMISSION
ON MINORITY AFFAIRS)

PREFILED NOVEMBER 19, 2024

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.

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:

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

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

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

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

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

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

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

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

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

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

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

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

Section 1. NRS 679B.550 is hereby amended to read as follows:

679B.550 The Division shall:

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

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

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

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

5. Educate consumers of health care concerning health care plans in this State; ~~[and]~~

6. ***Establish and carry out:***

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

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

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

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

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

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

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

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

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

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

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

(1) All reasons for denying the claim;

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

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

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

2. Except as otherwise provided in this section, if the approved claim is not paid within ~~[that]~~ ***the*** period ~~[,]~~ ***specified in subsection 1,*** the administrator 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]~~ ***10*** percent ~~[.]~~ ***per annum.*** The interest must be calculated from ~~[30 days after]~~ the date on which ***payment of*** the claim is ~~[approved]~~ ***due pursuant to subsection 1*** until the date on which the claim is paid.

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

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

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

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

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

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

~~[3.]~~ ***5.*** An administrator shall not request a claimant to resubmit information that the claimant has already provided to the administrator, unless the administrator 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.]~~ ***6.*** An administrator shall not pay only part of a claim that has been approved and is fully payable.

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

~~[6.]~~ ***8.*** 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 administrator.

~~[7.]~~ ***9.*** The Commissioner may require an administrator to provide evidence which demonstrates that the administrator has substantially complied with the requirements set forth in this section, including, without limitation, payment within ~~[30 days]~~ ***the time periods specified by this section*** of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

~~[8.]~~ ***10.*** If the Commissioner determines that an administrator is not in substantial compliance with the requirements set forth in this section ~~[,]~~ ***or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,*** the Commissioner may require the administrator to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that an administrator is not in substantial compliance with the requirements set forth in this section ~~[,]~~ ***or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,*** the Commissioner may suspend or revoke the certificate of registration of the administrator.

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

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

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

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

687B.730 A health carrier which offers or issues a network plan shall ~~[notify]~~ ***:***

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

claim ~~[.]~~ ***, if the claim is not submitted electronically.*** If the claim is approved, the insurer shall ***also*** pay the claim within ~~[30 days after it is approved.]~~ ***that period.*** Except as otherwise provided in this section, if the approved claim is not paid within that period, the insurer 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]~~ ***10*** percent ~~[.]~~ ***per annum.*** The interest must be calculated from ~~[30 days after]~~ the date on which ***payment of*** the claim is ~~[approved]~~ ***due pursuant to this subsection*** until the date on which the claim is paid.

2. If the insurer 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 ***working*** days after it receives the claim. The insurer shall notify the ~~[provider of health care]~~ ***claimant*** of all the specific reasons for the delay in approving or denying the claim. The insurer shall approve or deny the claim within ***15 working days after receiving the additional information, if the additional information is submitted electronically, or*** 30 ***working*** days after receiving the additional information ~~[.]~~ ***, if the additional information is not submitted electronically.*** If the claim is approved, the insurer shall ***also*** pay the claim within ~~[30 days after it receives the additional information.]~~ ***that period.*** If the approved claim is not paid within that period, the insurer shall pay interest on the claim in the manner prescribed in subsection 1.

3. An insurer shall not request a claimant to resubmit information that the claimant has already provided to the insurer, unless the insurer 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. An insurer 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 insurer.

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

specified by this section 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 an insurer is not in substantial compliance with the requirements set forth in this section ~~[,]~~ ***or that the insurer has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,*** the Commissioner may require the insurer to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that an insurer is not in substantial compliance with the requirements set forth in this section ~~[,]~~ ***or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,*** the Commissioner may suspend or revoke the certificate of authority of the insurer.

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

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

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

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

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

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

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

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

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

within 10 working days after ~~[it]~~ ***the insurer*** denies coverage of the health care service **,** of:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) All reasons for denying the claim;

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

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

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

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

689B.255 1. Except as otherwise provided in subsection 2 and NRS 439B.754, an insurer shall approve or deny a claim relating to a policy of group health insurance or blanket insurance within ***15 working days after the insurer receives the claim, if the claim is submitted electronically, or*** 30 ***working*** days after the insurer receives the claim ~~[.]~~ ***, if the claim is not submitted electronically.*** If the claim is approved, the insurer shall ***also*** pay the claim within ~~[30 days after it is approved.]~~ ***that period.*** Except as otherwise provided in this section, if the approved claim is not paid within that period, the insurer 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]~~ ***10*** percent ~~[.]~~ ***per annum.*** The interest must be calculated from ~~[30 days after]~~ the date on which ***payment of*** the claim is ~~[approved]~~ ***due pursuant to this subsection*** until the date on which the claim is paid.

2. If the insurer 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 ***working*** days after it receives the claim. The insurer shall notify the ~~[provider of health care]~~ ***claimant*** of all the specific reasons for the delay in approving or denying the claim. The insurer shall approve or deny the claim within ***15 working days after receiving the additional information, if the additional information is submitted***

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

3. An insurer shall not request a claimant to resubmit information that the claimant has already provided to the insurer, unless the insurer 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. An insurer 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 insurer.

7. The Commissioner may require an insurer to provide evidence which demonstrates that the insurer has substantially complied with the requirements set forth in this section, including, without limitation, payment within ~~[30 days]~~ ***the time periods specified by this section*** 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 an insurer is not in substantial compliance with the requirements set forth in this section ~~[,]~~ ***or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,*** the Commissioner may require the insurer to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that an insurer is not in substantial compliance with the requirements set forth in this section ~~[,]~~ ***or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,*** the Commissioner may suspend or revoke the certificate of authority of the insurer.

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

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

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

Sec. 9. NRS 689C.335 is hereby amended to read as follows:

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

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

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

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

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

(1) All reasons for denying the claim;

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

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

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

2. Except as otherwise provided in this section, if the approved claim is not paid within ~~[that]~~ ***the*** period ~~[,]~~ ***specified in subsection 1,*** the carrier 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]~~ ***10*** percent ~~[.]~~ ***per annum.*** The interest must be calculated from ~~[30 days after]~~ the date on which ***payment of*** the claim is ~~[approved]~~ ***due pursuant to subsection 1*** until the date on which the claim is paid.

~~[2.]~~ ***3.*** If the carrier 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 ***working*** days after it receives the claim. The carrier shall notify the ~~[provider of health care]~~ ***claimant*** of all the specific reasons for the delay in approving or denying the claim. The carrier shall approve or deny the claim ***and, if the carrier:***

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

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

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

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

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

~~[3.]~~ ***5.*** A carrier shall not request a claimant to resubmit information that the claimant has already provided to the carrier, unless the carrier 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.]~~ ***6.*** A carrier shall not pay only part of a claim that has been approved and is fully payable.

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

~~[6.]~~ ***8.*** 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 carrier.

~~[7.]~~ ***9.*** The Commissioner may require a carrier to provide evidence which demonstrates that the carrier has substantially complied with the requirements set forth in this section, including, without limitation, payment within ~~[30 days]~~ ***the time periods specified by this section*** of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

~~[8.]~~ ***10.*** If the Commissioner determines that a carrier is not in substantial compliance with the requirements set forth in this section ~~[,]~~ ***or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,*** the Commissioner may require the carrier to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that a carrier is not in substantial compliance with the requirements set forth in this section ~~[,]~~ ***or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,*** the Commissioner may suspend or revoke the certificate of authority of the carrier.

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

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

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

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

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

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

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

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

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

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

(1) All reasons for denying the claim;

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

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

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

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

~~[2.]~~ ***3.*** If the society 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 ***working*** days after it receives the claim. The society shall notify the ~~[provider of health care]~~ ***claimant*** of all the specific reasons for the

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

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

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

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

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

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

~~[3.]~~ ***5.*** A society shall not request a claimant to resubmit information that the claimant has already provided to the society, unless the society 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.]~~ ***6.*** A society shall not pay only part of a claim that has been approved and is fully payable.

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

8. 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 society.

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

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

the Commissioner may suspend or revoke the certificate of authority of the society.

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

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

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

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

695B.2505 1. Except as otherwise provided in subsection 2 and NRS 439B.754, a corporation subject to the provisions of this chapter shall approve or deny a claim relating to a contract for dental, hospital or medical services within ***15 working days after the corporation receives the claim, if the claim is submitted electronically, or*** 30 ***working*** days after the corporation receives the claim ~~[.]~~ ***, if the claim is not submitted electronically.*** If the claim is approved, the corporation shall ***also*** pay the claim within ~~[30 days after it is approved.]~~ ***that period.*** Except as otherwise provided in this section, if the approved claim is not paid within ~~[that]~~ ***that*** period, the corporation 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]~~ ***10*** percent ~~[.]~~ ***per annum.*** The interest must be calculated from ~~[30 days after]~~ the date on which the ***payment of the*** claim is ~~[approved]~~ ***due pursuant to this subsection*** until the date on which the claim is paid.

2. If the corporation 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 ***working*** days after it receives the claim. The corporation shall notify the ~~[provider of dental, hospital or medical services]~~ ***claimant*** of all the specific reasons for the delay in approving or denying the claim. The corporation shall approve or deny the claim within ***15 working days after receiving the additional information, if the additional information is submitted electronically, or*** 30 ***working*** days after receiving the additional information ~~[.]~~ ***, if the information is not submitted electronically.*** If the claim is approved, the corporation shall pay the claim within ~~[30 days after it receives the additional~~

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

3. A corporation shall not request a claimant to resubmit information that the claimant has already provided to the corporation, unless the corporation 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 corporation 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 corporation.

7. The Commissioner may require a corporation to provide evidence which demonstrates that the corporation has substantially complied with the requirements set forth in this section, including, without limitation, payment within ~~[30 days]~~ ***the time periods specified by this section*** 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 corporation is not in substantial compliance with the requirements set forth in this section ~~[,]~~ ***or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,*** the Commissioner may require the corporation to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that a corporation is not in substantial compliance with the requirements set forth in this section ~~[,]~~ ***or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,*** the Commissioner may suspend or revoke the certificate of authority of the corporation.

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

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

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

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

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

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

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

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

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

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

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

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

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

~~[(c)]~~ ***(e)*** The right of the beneficiary or subscriber to file a written complaint and the procedure for filing such a complaint.

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) All reasons for denying the claim;

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

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

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

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

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

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

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

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

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

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

5. An organization for dental care shall not request a claimant to resubmit information that the claimant has already provided to the organization for dental care, unless the organization for dental care 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.

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

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

8. 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 organization for dental care.

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

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

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

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

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

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

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

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

1. All reasons for denying the claim;

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

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

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

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

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

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

2. If the managed care 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 working days after it receives the claim. The managed care organization shall notify the claimant of all the specific reasons for the delay in approving or denying the claim. The managed care organization shall approve or deny the claim within 15 working days after receiving the additional information, if the additional information is submitted electronically, or 30 working days after receiving the additional information, if the additional information is not submitted electronically. If the claim is approved, the managed care organization shall also pay the claim within that period. If the approved claim is not paid within that period, the managed care organization shall pay interest on the claim in the manner prescribed in subsection 1.

3. A managed care organization shall not request a claimant to resubmit information that the claimant has already provided to the managed care organization, unless the managed care 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 managed care 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 managed care organization.

7. The Commissioner may require a managed care organization to provide evidence which demonstrates that the managed care organization has substantially complied with the requirements set forth in this section, including, without limitation, payment within the time periods specified by this section 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 managed care organization is not in substantial compliance with the requirements set forth in this section or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim, the Commissioner may require the managed care organization to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that a managed care organization is not in substantial compliance with the requirements set forth in this section or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim, the Commissioner may suspend or revoke the certificate of authority of the managed care organization.

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

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

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

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

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

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

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

(b) Any other applicable provision of this title.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) The right of the insured to:

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

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

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

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

~~[(d)]~~ ***(f)*** The telephone number of the Office for Consumer Health Assistance.

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

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

(a) All reasons for denying the claim;

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

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

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

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

232.320 1. The Director:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. If the Department 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 working days after it receives the claim. The Department shall notify the claimant of all the specific reasons for the delay in approving or denying the claim. The Department shall approve or deny the claim within 15 working days after receiving the additional information, if the additional information is submitted electronically, or 30 working days after receiving the additional

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

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

(a) All reasons for denying the claim;

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

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

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

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

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

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

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

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

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

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

TEXT OF REPEALED SECTIONS

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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