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ASSEMBLY BILL 320
(First Reprint)

OVERVIEW BY TOPIC

Following is an overview of the topics included in the First Reprint of **Assembly Bill 320**. The topics are presented in the order in which they first appear in the bill.

PROHIBITION ON PANEL FEES AND OTHER FEES FOR ESTABLISHING A PROVIDER OF HEALTH CARE WITH AN ORGANIZATION

If an organization or a hospital establishes a panel of health care providers and makes the panel available for an insurer to use when offering health care services, or if an insurer establishes such a panel, **Assembly Bill 320** prohibits the organization or hospital from charging a fee to the insurer or the provider of health care for including the provider's name on the panel.[1] In addition, any other fees related to establishing a provider of health care as a provider for the organization or hospital (such as "credentialing fees") are also prohibited.

If an organization or hospital violates this prohibition, it must pay the insurer or provider of health care twice the amount of the fee. In addition, a court must award costs and attorney's fees to the prevailing party.

Finally, **Assembly Bill 320** specifies that, in addition to any other relief, if an organization or hospital violates these provisions and an insurer offering health care services has a contract with or uses the services of the organization or hospital, the Division of Insurance must require the insurer to suspend performance under the contract or stop using those services until the organization or hospital complies with the prohibition on charging panel fees and refunds the panel fees to the providers of health care.

> ***Sections of the bill:*** This provision is included under the following sections of **Assembly Bill 320**. The affected *Nevada Revised Statutes* (NRS) chapter is indicated in parentheses.
>
> - **Section 1** (NRS Chapter 679A – General Provisions for Title 57 [Insurance])
> - **Section 39.5** (NRS Chapter 449 – Medical and Other Related Facilities)
> - **Section 40** (NRS Chapter 616B – Industrial Insurance: Insurers; Liability for Provision of Coverage)

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[1] This section is similar to other prohibitions on panel fees under *Nevada Revised Statutes* (NRS) 689A.035 (Individual Health Insurance), 689B.015 (Group and Blanket Health Insurance), 689C.435 (Health Insurance for Small Employers), 695A.095 (Fraternal Benefit Societies), 695B.035 (Nonprofit Corporations for Hospital, Medical and Dental Services), 695C.125 (Health Maintenance Organizations), and 695G.270 (Managed Care).

CONTRACTS BETWEEN INSURERS AND PROVIDERS OF HEALTH CARE

With regard to schedules of payments, **Section 2** of **Assembly Bill 320** requires certain individuals and entities who contract with a provider of health care to provide health care to an insured under Chapter 683A (Administrators, Agents and Producers of Insurance) to:

1. If requested by the provider of health care at the time the contract is made, submit to the provider a copy of the schedule of payments applicable to the provider of health care; or
2. If requested by the provider of health care at any other time, submit to the provider the schedule of payments within 7 days after receiving the request.

This provision applies to an administrator; managing general agent or producer of insurance; and a health maintenance organization or nonprofit corporation for hospital or medical services authorized to act as an administrator of a program of health insurance. (These requirements are included in other sections of NRS under the following sections of the bill: **Sections 10, 14, 16, 23, 25, 30, and 34.**)

In addition, **Assembly Bill 320** prohibits insurers from contracting with providers of health care unless the following requirements are met:

- *Standard form for information regarding credentials*—The insurer must use the forms prescribed by the Commissioner of Insurance to obtain any information related to the credentials of a provider of health care.

- *Changes of material terms*—The contract must not contain any provision authorizing an insurer to amend the material terms of the contract unless the provider agrees to the amendment or the amendment is necessary to comply with state or federal law or accreditation requirements. If such an amendment is necessary, the provider may terminate the contract.

- *Advance notice of certain programs*—The contract must not contain any provision requiring the provider to comply with quality improvement or utilization management programs or procedures unless the requirement is fully disclosed to the provider 15 days before the contract is executed. An exception is also provided if the amendment is necessary to comply with state or federal law or accreditation requirements. If such an amendment is necessary, the provider may terminate the contract.

- *Patient information*—The contract must not contain any provision that requires or permits access to information related to an insured in violation of state or federal law concerning the confidentiality of such information.

Provisions waiving or conflicting with the above requirements are prohibited, and a contract that contains any provision in violation of the requirements is void.

Sections of the bill: These provisions are included under the following sections of **Assembly Bill 320**. The affected NRS chapter is indicated in parentheses.

- **Section 10** (Chapter 689A – Individual Health Insurance)
- **Section 14** (Chapter 689B – Group and Blanket Health Insurance)
- **Section 16** (Chapter 689C – Health Insurance for Small Employers)
- **Section 23** (Chapter 695A – Fraternal Benefit Societies)
- **Section 25** (Chapter 695B – Nonprofit Corporations for Hospital, Medical and Dental Services)
- **Section 30** (Chapter 695C – Health Maintenance Organizations)
- **Section 34** (Chapter 695G – Managed Care) - **Note: Section 33.5 provides an exemption to this section for managed care organizations that provide 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.**

REVOCATION OF LICENSURE OR CERTIFICATION FOR FAILURE TO PAY CERTAIN PERCENTAGE OF CLAIMS

Under **Assembly Bill 320**, the Commissioner of Insurance must require evidence demonstrating that certain individuals or entities pay at least 95 percent of approved claims within 30 days after the date of approval and 90 percent of the total dollar amount for approved claims within the same time frame.

If the Commissioner, after a hearing, determines the individual or entity is not in compliance, the Commissioner must revoke their license or certificate of registration or authority. In addition, if revocation is required, a lesser form of penalty, such as a fine or a suspension, must not be substituted in lieu of the revocation.

Sections of the bill: This provision is added to existing statutes regarding the time frame for approval or denial of claims under the following sections of **Assembly Bill 320**. The affected NRS chapter is indicated in parentheses.

- **Section 3** (NRS Chapter 683A – Administrators, Agents and Producers of Insurance.)
- **Section 12** (NRS Chapter 689A – Individual Health Insurance)
- **Section 15** (NRS Chapter 689B – Group and Blanket Health Insurance)

- **Section 17** (NRS Chapter 689C – Health Insurance for Small Employers)
- **Section 26** (NRS Chapter 695B – Nonprofit Corporations for Hospital, Medical and Dental Services)
- **Section 31** (NRS Chapter 695C – Health Maintenance Organizations)

UNFAIR PRACTICES

Section 4 of **Assembly Bill 320** specifies that failing to comply with the provisions of NRS Chapter 695G (Managed Care) is considered to be an unfair practice under NRS Chapter 686A (Trade Practices and Frauds; Financing of Premiums).

INTERVENTION IN RATE FILING PROCESS

Currently, every authorized insurer must file with the Commissioner of Insurance all rates and proposed increases to those rates; the forms and policies to which the rates apply; supplementary rate information; and changes and amendments to that information (NRS 686B.070). **Section 5** of **Assembly Bill 320** provides that if such a filing is made that pertains to insurance covering the liability of certain health care practitioners[2], any interested person or entity may intervene as a matter of right in any hearing or proceeding conducted to determine whether the applicable rate or proposed increase complies with statutory standards and should be approved or disapproved.

In addition, **Section 7** of **Assembly Bill 320** prohibits the Commissioner of Insurance from exempting an insurer from certain rate-related provisions of Chapter 686B (Rates and Essential Insurance) with regard to insurance covering the liability of the health care practitioners.

APPROVAL OR DISAPPROVAL OF CHANGES IN INSURANCE RATES

Currently, NRS 686B.110 requires the Commissioner to consider each proposed increase or decrease in a line of insurance that is filed with the Division of Insurance. The Commissioner must disapprove the proposal if the Commissioner finds that a proposed increase will result in rates that do not comply with Nevada's standards for rates, including that those rates are not excessive, inadequate or unfairly discriminatory.

Section 8 of **Assembly Bill 320** revises these provisions to require the Commissioner to disapprove any proposal for an increase or decrease in rates that does not comply with Nevada's standards.

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[2] **Sections 5** and **7** apply to practitioners licensed under NRS Chapters 630 (Physicians, Physician Assistants and practitioners of Respiratory Care); 631 (Dentistry and Dental Hygiene); 632 (Nursing); or 633 (Osteopathic Medicine).

In addition, **Section 8** requires the Commissioner to disapprove proposals to increase the rate of insurance for certain licensed practitioners if the Commissioner finds the proposal is necessitated by any of the following:

- **Imprudent investment of money**—The insurer has experienced or is reasonably likely to experience capital losses, or diminished dividends, returns or income or any other financial loss as a result of the imprudent investment of money.

- **Fraud or willful misconduct**—The insurer, or any director, partner, officer, employee, agent or contractor of the insurer has engaged in:
  - Any fraudulent accounting practice;
  - Any form of corporate fraud or securities fraud; or
  - Any willful misconduct or wrongdoing that violates the laws or regulations of the United States, this state, or any other state.

- **Certain decisions involving litigation**—The insurer has experienced or is reasonably likely to experience losses or expenses as a result of the insurer or any director, partner, officer, employee, agent or contract of the insurer having engaged in litigation unreasonably or vexatiously after one or more opposing parties have made a reasonable offer to settle.

- **Decisions to insure practitioners with multiple judgments**—The insurer has experienced losses or expenses as a result of providing insurance to certain practitioners for whom the insurer has paid not less than 10 judgments or settlements with regard to the practitioner's breach of duty to the patient and a total of $5 million with regard to the judgments and settlements involved in these cases.

The Commissioner must adopt regulations, as necessary to carry out the provisions governing the approval or disapproval of proposals for changes in rates.

CONTINUING COVERAGE FOR CERTAIN PATIENTS WHEN A PROVIDER'S CONTRACT IS TERMINATED

Assembly Bill 320 requires that policies of health insurance must include certain provisions allowing treatment for an insured's medical condition to continue when a health care provider's contract with the insurer is terminated. These provisions are the following:

- The insured may continue to obtain medical treatment for the medical condition from a health care provider; and

- The health care provider is entitled to receive reimbursement from the insurer for the treatment provided at the same rate and under the same conditions as before the contract was terminated.

- *Time frame for coverage*—The required coverage must be provided until the later of either: (1) the 180th day after the date the contract is terminated; or (2) if the medical condition is pregnancy, the 45th day after the date of delivery, or if the pregnancy does not end in delivery, the date of the end of the pregnancy.

- *Exceptions*—An exception is provided if the contract was terminated because of the incompetence or misconduct of the health care provider and the insurer did not enter into another contract with that provider after the contract was terminated for these reasons.

- *Applicability*—Policies delivered, issued, or renewed on or after October 1, 2003, have the legal effect of including this required coverage, and any provision under the policy or its renewal that is in conflict is void.

- *Regulations*—The Commissioner of Insurance must adopt regulations to carry out these provisions.

  Sections of the bill: This provision is included under the following sections of **Assembly Bill 320**. The affected NRS chapter is indicated in parentheses.

  - **Sections 9 and 11** (689A – Individual Health Insurance)
  - **Section 13** (Chapter 689B – Group and Blanket Health Insurance)
  - **Section 24** (Chapter 695B – Nonprofit Corporations for Hospital, Medical and Dental Services)
  - **Sections 27 and 32** (Chapter 695C – Health Maintenance Organizations)
  - **Section 33** (Chapter 695G – Managed Care) – **Note: Section 33.5 provides an exemption to this section for managed care organizations that provide 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.**
  - **Sections 38 and 39** (Chapter 287 – Programs for Public Employees)

PROHIBITIONS ON CANCELING, REFUSING TO RENEW, OR INCREASING THE PREMIUMS FOR RENEWAL BASED UPON CERTAIN CLAIMS UNDER THE POLICY

Sections 18 and 19 of **Assembly Bill 320** prohibits an insurer from canceling, refusing to renew, or increasing the premium for renewal of an insurance policy covering the liability of

certain practitioners[3] for a breach of professional duty toward a patient under specified circumstances. Such action is prohibited as a result of a claim against the practitioner if the insurer:

- o Makes a payment with respect to the claim in an amount that exceeds the limit of the coverage under the policy;
- o Had the opportunity to settle the claim for an amount equal to or less than the limit of coverage under the policy; and
- o Did not settle the claim for an amount equal to or less than the limit of coverage under the policy.

REQUIRED DISCLOSURE OF CERTAIN UNDERWRITING DECISIONS

Upon request, **Section 20** of **Assembly Bill 320** requires an insurer to disclose to a practitioner the reasons the insurer declined to issue a policy covering the practitioner's liability for breach of professional duty toward a patient.[4]

Section 21 requires an insurer to disclose, upon the request of the practitioner, the reasons an insurer sets a premium for a policy at a rate that is higher than the applicable average rate, as determined by the Commissioner of Insurance. The section requires the Commissioner of Insurance to determine the average rate for the premiums, and authorizes the Commissioner to determine different average rates applicable to different types of policies, types and specialties of practitioners, and geographic areas of the State. The Commissioner must review and update the average rates not less than once every two years.

NOTICE OF WITHDRAWAL FROM THE MARKET IN NEVADA

Section 22 of **Assembly Bill 320** requires an insurer with more than 40 percent of the market in Nevada for a particular category of practitioner to comply with certain requirements before withdrawing from the market. At least 120 days before withdrawing, the insurer must give written notice to the Commissioner of Insurance and each practitioner within the applicable category. The insurer must also submit a written plan to the Commissioner providing for the

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[3] **Section 19** applies to practitioners licensed under NRS Chapters 630 (Physicians, Physician Assistants and practitioners of Respiratory Care); 631 (Dentistry and Dental Hygiene); 632 (Nursing); or 633 (Osteopathic Medicine).

[4] **Sections 20 and 21** apply to practitioners licensed under NRS Chapters 630 (Physicians, Physician Assistants and practitioners of Respiratory Care); 631 (Dentistry and Dental Hygiene); 632 (Nursing); or 633 (Osteopathic Medicine).

insurer's orderly withdrawal from the market so as to minimize the effect of the withdrawal on the public generally and on the practitioners in the applicable category.

Assembly Bill 320 requires the Commissioner of Insurance to do the following under **Section 22**:

- o Adopt regulations prescribing the form, content, and method of submission for the insurer's plan for withdrawal;
- o Provide a procedure for determining the relative market share in Nevada among insurers with respect to policies of insurance issued to cover the liability of certain licensed practitioners[5] for a breach of professional duty toward a patient;
- o Specify the categories of licensed practitioners. Using data from the previous calendar year, the Commissioner must determine for each category the relative market share in Nevada among insurers. Such a determination is valid from April 1 to March 31 in the following year, without regard to any actual change in market share during that period.
- o Provide notice of the applicability of this section to each insurer whom the Commissioner determines to possess more than 40 percent of the market in Nevada within a category of practitioner.

<u>REQUIRE HEALTH MAINTENANCE ORGANIZATIONS TO COMPLY WITH LAWS GOVERNING TRADE PRACTICES, FRAUDS, AND FINANCING OF PREMIUMS</u>

Section 29 of **Assembly Bill 320** amends NRS 695C.055 to specify that Chapter 686A (Trade Practices and Frauds; Financing of Premiums) applies to a health maintenance organization.

<u>ACTIONS FOR DAMAGES FOR MALPRACTICE—DUTIES OF THE INSURER</u>

Section 36 of **Assembly Bill 320** requires the defendant and the insurer to attend any settlement conferences required in actions for damages for malpractice.

In addition, if the defendant receives a settlement demand that is equal to the limits of the defendant's insurance policy, the insurer must inform the defendant of any applicable rights and obligations possessed by the defendant. These rights include, without limitation, the right of the defendant to obtain independent counsel at the insurer's expense.

[5] **Section 22** applies to practitioners licensed under NRS Chapters 630 (Physicians, Physician Assistants and practitioners of Respiratory Care); 631 (Dentistry and Dental Hygiene); 632 (Nursing); or 633 (Osteopathic Medicine).

If the defendant notifies the judge within 15 days of receiving the settlement demand that the defendant wishes to have independent counsel, the judge must appoint independent counsel to represent the defendant within 15 days after receiving the notice. The insurer must pay the fees for the independent counsel.

Section 36 also requires the Commissioner of Insurance to prescribe a form that may be used by an insurer to fulfill the requirement of informing the defendant of any applicable rights and obligations after receiving a settlement demand.

IMPOSITION OF LIABILITY ON AN INSURER FOR DAMAGES AWARDED IN CERTAIN MALPRACTICE CASES

In an action for damages for medical or dental malpractice, **Section 37** of **Assembly Bill 320** provides that an insurer is liable for the entire amount of damages to the same extent the defendant is liable to the plaintiff if:

- The plaintiff made a settlement offer within the limits of coverage under the policy;
- The liability of the defendant was reasonably clear when the plaintiff made the settlement offer;
- The insurer, in contravention to the express instructions of the defendant, unreasonably rejected the settlement offer in light of all the surrounding facts and circumstances; and
- The court enters a judgment in favor of the plaintiff that imposes liability on the defendant for damages in an amount that exceeds the limits of coverage under the policy.

The court is authorized to determine the liability of the insurer in the underlying action for malpractice or in a separate proceeding.

Section 37 also specifies that an insurer found to be liable for the entire amount of damages to the same extent that the defendant is liable to the plaintiff is deemed to have acted in bad faith regarding its obligations to provide insurance coverage.

APPLICABILITY OF PROVISIONS AND EFFECTIVE DATE OF THE BILL

Assembly Bill 320 is effective on October 1, 2003. **Section 41** specifies that the amendatory provisions of the act apply to the following:

- A policy of insurance issued or renewed on or after October 1, 2003;
- An offer to issue a policy of insurance communicated to the applicant for the policy on or after October 1, 2003;
- A decision with regard to the issuance of a policy of insurance communicated to the applicant for the policy on or after October 1, 2003; and
- A cause of action that accrues on or after October 1, 2003.