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AMENDMENT TO ASSEMBLY BILL 320
Proposed by Assemblywoman Barbara E. Buckley
May 7, 2003
Senate Committee on Judiciary

1. **Revocation of license for failure to pay 95 percent of claims within 30 days after date of approval -Section 3**. (Note: **Sections 12, 15, 17, 26, and 31** include similar provisions and should also be revised accordingly.)

   Delete the new subsections 8 and 9. Provide that repeated violations of the section require the Commissioner to consider revocation or suspension of the certificate of authority (or license, depending upon the section of NRS amended).

2. **Intervention in Rate Filing Process - Section 5.** The following language is proposed to replace "***any interested person or entity***" on lines 21 and 22 of page 6:

   "Any organization, entity or association of persons whose interests are affected"

3. **Continuity of Coverage - Section 9** (Note: **Sections 13, 24, 27, and 33** contain similar provisions and should be revised accordingly). Revise Section 9 as provided in **"Attachment B"**.

4. **Revisions to the Credentialing forms (Sections 10, 14, 16, 23, 25, 30, & 34** include the same provisions). A copy of **Section 10** is provided as **"Attachment A"** to present the following proposed changes:

   Delete the existing references to credentialing forms in the bill and reinsert the requirement for one credentialing form developed by the Insurance Commissioner into NRS Chapter 629 (Healing Arts Generally).

   In addition, authorize the Commissioner to develop a different form for different geographic areas of the state. Further, the Commissioner must:
   - Develop the forms through a public hearing process;
   - Ensure the forms meet accreditation standards;
   - Ensure the forms meet the needs of those who will be using the forms (health care plans, hospitals, third party administrators, etc.);
   - Develop forms that represent the most efficient method of credentialing (for example, no excessively long forms); and
   - Allow the use of supplemental forms to accommodate any new federal mandates that must be incorporated quickly until a new credentialing form can be developed.

5. **Revisions to Required Contract Provisions (Sections 10, 14, 16, 23, 25, 30, & 34** include the same provisions). A copy of **Section 10** is provided as **"Attachment A"** to present the following proposed changes:

Delete subsections 3 through 7. Replace these sections with the following concept:

> ***A provider contract may be modified at any time by mutual written agreement of the parties. The insurer may modify any provision of the provider contract upon thirty (30) days written notice to the provider. If the provider fails to object to such a modification in writing within the thirty (30) day notice period, then such modification shall become effective at the end of the notice period. If the provider objects in writing to any proposed modification within the thirty (30) day notice period, then such modification shall not take effect unless mutually agreed to in writing by both parties.***

6. **Required Disclosure of Certain Underwriting Decisions - Section 21** – Revise the language to specify that the insurance company must tell all of their insureds their base rate. Then, if the company is charging over that base rate to a physician, the company must tell the physician the reasons for the higher rate.

   The following changes are suggested to the existing language to accommodate this proposed amendment (see page 19, lines 33 through 41):

   > ***If an insurer, for a policy of insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of his professional duty toward a patient, sets the premium for the policy for the practitioner at a rate that is higher than the ~~applicable average rate determined pursuant to subsection 2,~~*** *standard base rate for such practitioner,* ***the insurer shall~~, upon the request of the practitioner,~~ disclose to the practitioner the reasons the insurer set the premium for the policy at ~~a~~*** *such* ***rate ~~that is higher than the applicable average rate determined pursuant to subsection 2~~.***

   Delete subsections 2 and 3 (bottom of page 19 and top of page 20) of Section 21.

7. **Notice of Withdrawal from Market in Nevada – Section 22**. Provide 120 days notice to both the Insurance Commissioner and the physician. Further, allow additional time if the withdrawal involves a specialty practice. To accommodate this proposed amendment, it is suggested to replace **Section 22** in Assembly Bill 320 (R1) with the language from Section 14 of Senate Bill 122 (R2), which addresses "essential medical specialties" and requires 120 days notice to an insured and to the Commissioner. Under Senate Bill 122, the Commissioner may require a delay of an additional 60 days in certain circumstances. In addition, add the following conceptual language:

   > ***Any insurer that issues a policy of insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631 or 633 of NRS for breach of his professional duty toward a patient who intends to withdraw from a particular class of such insureds shall notify the insureds and the commissioner at least 120 days before the effective date of the withdrawal.***

8. **Medicaid Exemptions – Section 28** – Remove new reference to NRS Chapter 686A.

ATTACHMENT A
CREDENTIALING FORMS & CONTRACT PROVISIONS

Section 10 of Assembly Bill 320(R1)
Proposed Changes

Sec. 1. NRS 689A.035 is hereby amended to read as follows:

689A.035 *1.* An insurer shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the insurer to its insureds.

2. An insurer shall not contract with a provider of health care to provide health care to an insured unless:

(a) The insurer uses the form prescribed by the Commissioner to obtain any information related to the credentials of the provider of health care; and

(b) The contract complies with the provisions of this section.

Revisions to Subsection 2: Delete these provisions from their current locations in the bill (Sections 10, 14, 16, 23, 24, 30, and 34). Reinsert the requirement to use the credentialing form developed by the Commissioner into NRS Chapter 629 (Healing Arts Generally).

In addition: Authorize the Commissioner to develop a different form for different geographic areas of the state. Further, the Commissioner must:

- *Develop the forms through a public hearing process;*
- *Ensure the forms meet any accreditation standards;*
- *Ensure the forms meet the needs of those who will be using the forms (health care plans, hospitals, third party administrators, etc.;*
- *Develop forms that represent the most efficient method of credentialing (The intent is to avoid excessively long forms, for example); and*
- *Allow the use of supplemental forms to accommodate any new federal mandates that must be incorporated quickly until a new credentialing form can be developed.*

~~*3. The contract must not contain any provision that authorizes an insurer to amend the material terms of the contract or any manual, policy or procedure document which is incorporated in or referenced by the contract unless:*~~

~~*(a) The provider of health care agrees to the amendment; or*~~

~~*(b) The amendment is necessary to comply with state or federal law or the accreditation requirements of a private accreditation organization. If an amendment is necessary pursuant to this paragraph, the provider of health care may terminate the contract.*~~

~~*4. The contract must not contain any provision that requires the provider of health care to comply with quality improvement or utilization management programs or procedures unless the requirement is:*~~

~~*(a) Fully disclosed to the provider of health care not later than 15 business days before the date the contract is executed; or*~~

~~*(b) Necessary to comply with accreditation requirements of state or federal law or a private accreditation organization. If an amendment is necessary pursuant to this paragraph, the provider of health care may terminate the contract.*~~

~~*5. The contract must not contain any provision that requires or permits access to information relating to an insured in violation of state or federal law concerning the confidentiality of such information.*~~

~~*6. The contract must not contain any provision that waives or conflicts with any provision of this section.*~~

~~*7. A contract that contains any provision in violation of this section is void.*~~

Suggested language to replace subsections 3 through 7: A provider contract may be modified at any time by mutual written agreement of the parties. The insurer may modify any provision of the provider contract upon thirty (30) days written notice to the provider. If the provider fails to object to such a modification in writing within thirty (30) day notice period, then such modification shall become effective at the end of the notice period. If the provider objects in writing to any proposed modification within the thirty (30) day notice period, then such modification shall not take effect unless mutually agreed to in writing by both parties.

8. The Commissioner shall develop the form required by subsection 2.

9. If an insurer contracts with a provider of health care to provide health care to an insured, the insurer shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

ATTACHMENT B
"CONTINUITY OF CARE"

Section 9 is first section the "continuity of care" provisions appear in Assembly Bill 320 (R1). The proposed changes are underlined. (**Sections 13, 24, 27, and 33** contain similar provisions and should be revised accordingly).

1. The provisions of this section apply to a policy of health insurance offered or issued by an insurer if an insured covered by the policy receives health care through a defined set of providers of health care who are under contract with the insurer.

2. Except as otherwise provided in this section, if an insured who is covered by a policy described in subsection 1 is receiving medical treatment for a medical condition from a provider of health care whose contract with the insurer is terminated during the course of the medical treatment, the policy must provide that:

(a) The insured may continue to obtain medical treatment for the medical condition from the provider of health care pursuant to this section, if:

(1) The insured is actively undergoing a medically necessary course of treatment; and

(2) The provider of health care and the insured agree that the continuity of care is desirable.

(b) The provider of health care is entitled to receive reimbursement from the insurer for the medical treatment he provides to the insured pursuant to this section, ~~at the same rate and under the same conditions as before the contract was terminated.~~ if the provider of health care agrees:

(1) To provide medical treatment under the terms of the contract between the provider of health care and the insurer with regard to the insured, including, without limitation, the rates of payment for providing medical service, as those terms existed before the termination of the contract between the provider of health care and the insurer; and

(2) Not to seek payment from the insured for any medical service provided by the provider of health care that the provider of health care could not have received from the insured were the provider of health care still under contract with the insurer.

3. The coverage required by subsection 2 must be provided until the later of:

(a) The ~~180th~~ 120th day after the date the contract is terminated; or

(b) If the medical condition is pregnancy, the 45th day after:

(1) The date of delivery; or

(2) If the pregnancy does not end in delivery, the date of the end of the pregnancy.

4. The requirements of this section do not apply to a provider of health care if:

(a) The provider of health care was under contract with the insurer and the insurer terminated that contract because of the medical incompetence or professional misconduct of the provider of health care; and

(b) The insurer did not enter into another contract with the provider of health care after the contract was terminated pursuant to paragraph (a).

5. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 2003, has the legal effect of including the coverage required by this section, and any provision of the policy or renewal thereof that is in conflict with this section is void.

6. The Commissioner shall adopt regulations to carry out the provisions of this section.