ASSEMBLY BILL NO. 261–ASSEMBLYMEN MABEY, GIBBONS, GRIFFIN, BROWN, BUCKLEY, ANGLE, CARPENTER, GEDDES, GOICOECHEA, HARDY, HETTRICK, KNECHT, MARVEL, MCCLEARY, PIERCE, SHERER AND WEBER

MARCH 7, 2003

Referred to Committee on Commerce and Labor

SUMMARY—Requires certain policies of health insurance and health care plans to provide coverage for continued medical treatment by provider of health care under certain circumstances. (BDR 57-814)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

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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 certain policies of health insurance and health care plans to provide coverage for continued medical treatment by a provider of health care under certain circumstances; revising the circumstances under which the Commissioner of Insurance may suspend or revoke a certificate of authority issued to a health maintenance organization; requiring certain public organizations that provide health insurance to provide coverage for continued medical treatment by a provider of health care under certain circumstances; and providing other matters properly relating thereto.

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

Section 1. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

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; and

(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.

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

(a) The 180th 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 incompetence or 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.

Sec. 2. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~[.]~~ ***, and section 1 of this act.***

Sec. 3. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. The provisions of this section apply to a policy of group 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; and

(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.

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

(a) The 180th 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 incompetence or 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.

Sec. 4. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. The provisions of this section apply to a policy of health insurance offered or issued by a hospital or medical service

corporation 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 hospital or medical service corporation.

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 hospital or medical service corporation 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; and

(b) The provider of health care is entitled to receive reimbursement from the hospital or medical service corporation 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.

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

(a) The 180th 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 hospital or medical service corporation and the hospital or medical service corporation terminated that contract because of the incompetence or misconduct of the provider of health care; and

(b) The hospital or medical service corporation 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.

Sec. 5. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. The provisions of this section apply to a health care plan offered or issued by a health maintenance organization if an

insured covered by the health care plan receives health care through a defined set of providers of health care who are under contract with the health maintenance organization.

2. Except as otherwise provided in this section, if an insured who is covered by a health care plan described in subsection 1 is receiving medical treatment for a medical condition from a provider of health care whose contract with the health maintenance organization is terminated during the course of the medical treatment, the health care plan 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; and

(b) The provider of health care is entitled to receive reimbursement from the health maintenance organization 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.

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

(a) The 180th 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 health maintenance organization and the health maintenance organization terminated that contract because of the incompetence or misconduct of the provider of health care; and

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

5. An evidence of coverage for a health care plan 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 evidence of coverage 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.

Sec. 6. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a

certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

4. The provisions of NRS 695C.110, 695C.170 to 695C.200, inclusive, 695C.250 and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care 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 Human Resources. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694 and 695C.1695 ***and section 5 of this act*** apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 7. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if he finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS ~~[695C.170]~~ ***695C.1694*** to 695C.200, inclusive, ~~[or 695C.1694, 695C.1695]~~ or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The State Board of Health certifies to the Commissioner that the health maintenance organization:

(1) Does not meet the requirements of subsection 2 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system for ***resolving*** complaints required by NRS 695C.260 in a manner reasonably to dispose of valid complaints;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees; ~~[or]~~

(j) ***The health maintenance organization fails to provide the coverage required by section 5 of this act; or***

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may **,** by written order **,** permit such further operation of the organization as he may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 8. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

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

2. Except as otherwise provided in this section, if an insured who is covered by a health care plan described in subsection 1 is receiving medical treatment for a medical condition from a provider of health care whose contract with the managed care organization is terminated during the course of the medical treatment, the health care plan 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; and

(b) The provider of health care is entitled to receive reimbursement from the managed care organization 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.

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

(a) The 180th 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 managed care organization and the managed care organization terminated that contract because of the incompetence or misconduct of the provider of health care; and

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

5. An evidence of coverage for a health care plan 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 evidence of coverage 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.

Sec. 9. 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 public 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 689B.030 to 689B.050, inclusive, ***and section 3 of this act*** and 689B.575 apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0359 do not apply to such coverage.

(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 public 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.

Sec. 10. 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 689B.255, ***section 8 of this act,*** 695G.150, 695G.160, 695G.170 and 695G.200 to 695G.230, inclusive, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 11. This act becomes effective upon passage and approval for the purpose of adopting regulations and on October 1, 2003, for all other purposes.

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