ASSEMBLY BILL NO. 320–COMMITTEE ON JUDICIARY

MARCH 14, 2003

Referred to Committee on Judiciary

SUMMARY—Makes various changes regarding malpractice. (BDR 57-868)

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

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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 malpractice; requiring insurers and defendants to attend certain settlement conferences; providing for certain defendants in malpractice actions to receive specified information and independent counsel; requiring insurers to pay certain judgments in excess of policy limits; setting forth circumstances in which an insurer is deemed to have acted in bad faith; prohibiting certain organizations from charging a fee for including the name of a provider of health care on a panel of providers of health care under certain circumstances; requiring a contract with a provider of health care to include a schedule setting forth the payments required to be made to the provider of health care pursuant to the contract under certain circumstances; prohibiting a contract with a provider of health care from including various provisions relating to amendments to the terms of the contract; requiring the development and use of a uniform form for obtaining information regarding the credentials of providers of health care for the purposes of contracts; expanding the scope of certain deceptive trade practices to include health maintenance organizations; expanding the scope of statutorily defined unfair practices to include certain actions by managed care organizations; requiring revocation of the authority of certain insuring entities for failure to timely pay approved claims; authorizing intervention in certain insurance ratemaking proceedings;

requiring the Commissioner of Insurance to disapprove a proposed increase in rates for malpractice insurance under certain circumstances; prescribing procedures for withdrawal of certain insurers from the malpractice insurance market in this state; requiring disclosure of reasons for certain underwriting decisions; limiting rates and premiums and proposed increases in rates and premiums for certain malpractice 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 679A of NRS is hereby amended by adding thereto a new section to read as follows:

1. If an organization establishes a panel of providers of health care and makes the panel available for use by an insurer when offering health care services pursuant to chapter 689A, 689B, 689C, 695A, 695B or 695C of NRS, the organization shall not charge the insurer or a provider of health care a fee to include the name of the provider on the panel of providers of health care.

2. If an organization violates the provisions of subsection 1, the organization shall pay to the insurer or provider of health care, as appropriate, an amount that is equal to twice the fee charged to the insurer or provider of health care.

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

4. In addition to any relief granted pursuant to this section, if an organization violates the provisions of subsection 1, and if an insurer offering health care services pursuant to chapter 689A, 689B, 689C, 695A, 695B or 695C of NRS has a contract with or otherwise uses the services of the organization, the Division shall require the insurer to suspend its performance under the contract or discontinue using those services until the organization, as determined by the Division:

(a) Complies with the provisions of subsection 1; and

(b) Refunds to all providers of health care any fees obtained by the organization in violation of subsection 1.

Sec. 2. Chapter 683A of NRS is hereby amended by adding thereto a new section to read as follows:

If an administrator, managing general agent or producer of insurance, or a health maintenance organization when acting as an administrator pursuant to NRS 683A.0851 or a nonprofit corporation for hospital or medical services when acting as an administrator pursuant to NRS 683A.0852, contracts with a provider of health care to provide health care to an insured pursuant to this chapter, the administrator, managing general agent, producer of insurance, health maintenance organization or nonprofit corporation for hospital or medical services shall include in the contract a schedule setting forth the payments required to be made to the provider of health care pursuant to the contract.

Sec. 3. NRS 683A.0879 is hereby amended to read as follows:

683A.0879 1. Except as otherwise provided in subsection 2, an administrator shall approve or deny a claim relating to health insurance coverage within 30 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. Except as otherwise provided in this section, if the approved claim is not paid within that period, 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 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 administrator requires additional information to determine whether to approve or deny the claim, he shall notify the claimant of his request for the additional information within 20 days after he receives the claim. The administrator shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The administrator shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the administrator shall pay the claim within 30 days after he receives the additional information. If the approved claim is not paid within that period, the administrator shall pay interest on the claim in the manner prescribed in subsection 1.

3. 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. An administrator 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 administrator.

7. ***Except as otherwise provided in subsections 8 and 9:***

(a) 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 of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.]~~

(b) If the Commissioner determines that an administrator is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the administrator to pay an administrative fine in an amount to be determined by the Commissioner.

8. The Commissioner shall require an administrator to provide evidence which demonstrates that the administrator pays at least:

(a) Ninety-five percent of approved claims within 30 days after the date of approval; and

(b) Ninety percent of the total dollar amount for approved claims within 30 days after the date of approval.

9. If the Commissioner determines, after notice and a hearing, that an administrator is not in complete compliance with the requirements set forth in subsection 8, the Commissioner shall revoke the certificate of registration of the administrator. Notwithstanding any other provision of law, if revocation is required pursuant to this subsection, a lesser form of penalty, including, without limitation, a suspension or a fine, must not be substituted in lieu of the revocation.

Sec. 4. NRS 686A.310 is hereby amended to read as follows:

686A.310 1. Engaging in any of the following activities is considered to be an unfair practice:

(a) Misrepresenting to insureds or claimants pertinent facts or insurance policy provisions relating to any coverage at issue.

(b) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(c) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(d) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(e) Failing to effectuate prompt, fair and equitable settlements of claims in which liability of the insurer has become reasonably clear.

(f) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(g) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(h) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his representative, agent or broker.

(i) Failing, upon payment of a claim, to inform insureds or beneficiaries of the coverage under which payment is made.

(j) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(k) Delaying the investigation or payment of claims by requiring an insured or a claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(l) Failing to settle claims promptly, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(m) Failing to comply with the provisions of NRS 687B.310 to 687B.390, inclusive, or 687B.410.

(n) Failing to provide promptly to an insured a reasonable explanation of the basis in the insurance policy, with respect to the facts of the insured’s claim and the applicable law, for the denial of his claim or for an offer to settle or compromise his claim.

(o) Advising an insured or claimant not to seek legal counsel.

(p) Misleading an insured or claimant concerning any applicable statute of limitations.

(q) Failing to comply with the provisions of chapter 695G of NRS.

2. In addition to any rights or remedies available to the Commissioner, an insurer is liable to its insured for any damages sustained by the insured as a result of the commission of any act set forth in subsection 1 as an unfair practice.

Sec. 5. Chapter 686B of NRS is hereby amended by adding thereto a new section to read as follows:

If a filing made with the Commissioner pursuant to subsection 1 of NRS 686B.070 pertains to 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, any interested person or entity may intervene as a matter of right in any hearing or other proceeding conducted to determine whether the applicable rate or proposed increase thereto:

1. Complies with the standards set forth in NRS 686B.050.

2. Should be approved or disapproved.

Sec. 6. NRS 686B.020 is hereby amended to read as follows:

686B.020 As used in NRS 686B.010 to 686B.1799, inclusive, ***and section 5 of this act,*** unless the context otherwise requires:

1. "Advisory organization," except as limited by NRS 686B.1752, means any person or organization which is controlled by or composed of two or more insurers and which engages in activities related to rate making. For the purposes of this subsection, two or more insurers with common ownership or operating in this state under common ownership constitute a single insurer. An advisory organization does not include:

(a) A joint underwriting association;

(b) An actuarial or legal consultant; or

(c) An employee or manager of an insurer.

2. "Market segment" means any line or kind of insurance or, if it is described in general terms, any subdivision thereof or any class of risks or combination of classes.

3. "Rate service organization" means any person, other than an employee of an insurer, who assists insurers in rate making or filing by:

(a) Collecting, compiling and furnishing loss or expense statistics;

(b) Recommending, making or filing rates or supplementary rate information; or

(c) Advising about rate questions, except as an attorney giving legal advice.

4. "Supplementary rate information" includes any manual or plan of rates, statistical plan, classification, rating schedule, minimum premium, policy fee, rating rule, rule of underwriting relating to rates and any other information prescribed by regulation of the Commissioner.

Sec. 7. NRS 686B.040 is hereby amended to read as follows:

686B.040 ~~[The]~~

1. Except as otherwise provided in subsection 2, the Commissioner may by rule exempt any person or class of persons or any market segment from any or all of the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and section 5 of this act,*** if and to the extent that he finds their application unnecessary to achieve the purposes of those sections.

2. The Commissioner may not, by rule or otherwise, exempt an insurer from the provisions of NRS 686B.010 to 686B.1799, inclusive, and section 5 of this act, with regard to 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.

Sec. 8. NRS 686B.110 is hereby amended to read as follows:

686B.110 1. The Commissioner shall consider each proposed increase or decrease in the rate of any kind or line of insurance or subdivision thereof ***that is*** filed with ~~[him]~~ ***the Commissioner*** pursuant to NRS 686B.070. ~~[If]~~

2. The Commissioner shall disapprove the proposal if the Commissioner finds that ~~[a proposed increase]~~ ***the proposal*** will result in a rate which is not in compliance with NRS 686B.050 **.** ~~[, he shall disapprove the proposal.]~~

3. In addition to the grounds for disapproval set forth in subsection 2, if the proposal will increase the rate 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, the Commissioner shall disapprove the proposal, or any constituent part thereof, if the Commissioner finds that the proposal, or the constituent part thereof, has been proposed or is necessitated because:

(a) 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;

(b) The insurer or any director, partner, officer, employee, agent or contractor of the insurer has engaged in:

(1) Any fraudulent accounting practice;

(2) Any form of corporate fraud or securities fraud; or

(3) Any willful misconduct or wrongdoing that violates the laws or regulations of the United States, this state or any other state;

(c) 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 contractor of the insurer having engaged in litigation unreasonably or vexatiously after one or more opposing parties have made a reasonable offer of settlement; or

(d) The insurer has experienced losses or expenses as a result of the insurer providing insurance to a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for whom the insurer has paid not less than:

(1) Ten judgments or settlements with regard to claims for breach of the practitioner's professional duty toward a patient; and

(2) A total of $5,000,000 with regard to the judgments and settlements identified in subparagraph (1).

4. The Commissioner shall approve or disapprove each proposal no later than 60 days after it is determined by him to be complete pursuant to subsection ~~[4.]~~ ***7.*** If the Commissioner fails to approve or disapprove the proposal within that period, the proposal shall be deemed approved.

~~[2.]~~ ***5.*** Whenever an insurer has no legally effective rates as a result of the Commissioner's disapproval of rates or other act, the Commissioner shall ***,*** on request ***,*** specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by him. When new rates become legally effective, the Commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis must not be required.

~~[3.]~~ ***6.*** If the Commissioner disapproves a proposed rate and an insurer requests a hearing to determine the validity of his action, the insurer has the burden of showing compliance with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive ~~[.]~~ ***, and section 5 of this act.*** Any such hearing must be held:

(a) Within 30 days after the request for a hearing has been submitted to the Commissioner; or

(b) Within a period agreed upon by the insurer and the Commissioner.

If the hearing is not held within the period specified in paragraph (a) or (b), or if the Commissioner fails to issue an order concerning the

proposed rate for which the hearing is held within 45 days after the hearing, the proposed rate shall be deemed approved.

~~[4.]~~ ***7.*** The Commissioner shall ~~[by regulation]~~ specify the documents or any other information which must be included in a proposal to increase or decrease a rate submitted to him pursuant to ~~[subsection 1.]~~ ***this section.*** Each such proposal shall be deemed complete upon its filing with the Commissioner, unless the Commissioner, within 15 business days after the proposal is filed with him, determines that the proposal is incomplete because the proposal does not comply with the regulations adopted by him pursuant to this ~~[subsection.]~~ ***section.***

8. The Commissioner shall adopt such regulations as are necessary to carry out the provisions of this section, including, without limitation, regulations which define words and terms used in this section.

Sec. 9. 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. 10. 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;

(b) The insurer includes in the contract a schedule setting forth the payments required to be made to the provider of health care pursuant to the contract; and

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

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.

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

Sec. 11. 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 9 of this act.***

Sec. 12. NRS 689A.410 is hereby amended to read as follows:

689A.410 1. Except as otherwise provided in subsection 2, an insurer shall approve or deny a claim relating to a policy of health insurance within 30 days after the insurer receives the claim. If the claim is approved, the insurer 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 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 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 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 days after it receives the claim. The insurer shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The insurer shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the insurer shall pay the claim within 30 days after it receives the additional information. 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. ***Except as otherwise provided in subsections 8 and 9:***

(a) 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 of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.]~~

(b) If the Commissioner determines that an insurer is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the insurer to pay an administrative fine in an amount to be determined by the Commissioner.

8. The Commissioner shall require an insurer to provide evidence which demonstrates that the insurer pays at least:

(a) Ninety-five percent of approved claims within 30 days after the date of approval; and

(b) Ninety percent of the total dollar amount for approved claims within 30 days after the date of approval.

9. If the Commissioner determines, after notice and a hearing, that an insurer is not in complete compliance with the requirements set forth in subsection 8, the Commissioner shall revoke the certificate of authority of the insurer. Notwithstanding any other provision of law, if revocation is required pursuant to this subsection, a lesser form of penalty, including, without limitation, a suspension or a fine, must not be substituted in lieu of the revocation.

Sec. 13. 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. 14. NRS 689B.015 is hereby amended to read as follows:

689B.015 ***1.*** An insurer that issues a policy of group health insurance 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 specified in subsection 1 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;

(b) The insurer includes in the contract a schedule setting forth the payments required to be made to the provider of health care pursuant to the contract; and

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

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.

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

Sec. 15. NRS 689B.255 is hereby amended to read as follows:

689B.255 1. Except as otherwise provided in subsection 2, an insurer shall approve or deny a claim relating to a policy of group health insurance or blanket insurance within 30 days after the insurer receives the claim. If the claim is approved, the insurer 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 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 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 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 days after it receives the claim. The insurer shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The insurer shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the insurer shall pay the claim within 30 days after it receives the additional information. 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. ***Except as otherwise provided in subsections 8 and 9:***

(a) 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 of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.]~~

(b) If the Commissioner determines that an insurer is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the insurer to pay an administrative fine in an amount to be determined by the Commissioner.

8. The Commissioner shall require an insurer to provide evidence which demonstrates that the insurer pays at least:

(a) Ninety-five percent of approved claims within 30 days after the date of approval; and

(b) Ninety percent of the total dollar amount for approved claims within 30 days after the date of approval.

9. If the Commissioner determines, after notice and a hearing, that an insurer is not in complete compliance with the requirements set forth in subsection 8, the Commissioner shall revoke the certificate of authority of the insurer. Notwithstanding any other provision of law, if revocation is required pursuant to this subsection, a lesser form of penalty, including, without limitation, a suspension or a fine, must not be substituted in lieu of the revocation.

Sec. 16. NRS 689C.435 is hereby amended to read as follows:

689C.435 ***1.*** A carrier serving small employers and a carrier that offers a contract to a voluntary purchasing group 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 carrier to its insureds.

2. A carrier specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless:

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

(b) The carrier includes in the contract a schedule setting forth the payments required to be made to the provider of health care pursuant to the contract; and

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

3. The contract must not contain any provision that authorizes a carrier 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.

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

Sec. 17. NRS 689C.485 is hereby amended to read as follows:

689C.485 1. Except as otherwise provided in subsection 2, 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 within 30 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. Except as otherwise provided in this section, if the approved claim is not paid within that period, 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 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 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 days after it receives the claim. The carrier shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The carrier shall approve or deny the claim within 30 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 approved claim is not paid within that period, the carrier shall pay interest on the claim in the manner prescribed in subsection 1.

3. 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. A carrier 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 carrier.

7. ***Except as otherwise provided in subsections 8 and 9:***

(a) 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 of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.]~~

(b) If the Commissioner determines that a carrier is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the carrier to pay an administrative fine in an amount to be determined by the Commissioner.

8. The Commissioner shall require a carrier to provide evidence which demonstrates that the carrier pays at least:

(a) Ninety-five percent of approved claims within 30 days after the date of approval; and

(b) Ninety percent of the total dollar amount for approved claims within 30 days after the date of approval.

9. If the Commissioner determines, after notice and a hearing, that a carrier is not in complete compliance with the requirements set forth in subsection 8, the Commissioner shall revoke the certificate of authority of the carrier. Notwithstanding any other provision of law, if revocation is required pursuant to this subsection, a lesser form of penalty, including, without limitation, a suspension or a fine, must not be substituted in lieu of the revocation.

Sec. 18. Chapter 690B of NRS is hereby amended by adding thereto the provisions set forth as sections 19 to 22, inclusive, of this act.

Sec. 19. ***An insurer shall not cancel, refuse to renew or increase the premium for renewal of 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 as a result of a claim against the practitioner pursuant to the policy if the insurer:***

1. Makes a payment with respect to the claim in an amount that exceeds the limit of the coverage under the policy;

2. Had the opportunity to settle the claim for an amount equal to or less than the limit of the coverage under the policy: and

3. Did not settle the claim for an amount equal to or less than the limit of the coverage under the policy.

Sec. 20. *If an insurer declines to issue to a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS a policy of insurance covering the liability of the practitioner for a breach of his professional duty toward a patient, the insurer shall, upon the request of the practitioner, disclose to the practitioner the reasons the insurer declined to issue the policy.*

Sec. 21. *1. 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, 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 rate that is higher than the applicable average rate determined pursuant to subsection 2.*

2. For the purposes of this section, the Commissioner shall determine an average rate for the premium 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. The Commissioner may determine different average rates applicable to different:

(a) Types of policies, including, without limitation, policies of claims-made insurance and policies of occurrence-based insurance;

(b) Types and specialties of practitioners; and

(c) Geographic areas of this state within which a practitioner may practice.

3. The Commissioner shall review and update the average rates determined pursuant to subsection 2 not less than once every 2 years.

Sec. 22. *1. The Commissioner shall, on or before April 1 of each year:*

(a) Specify for the purposes of this section, by regulation, categories of practitioners licensed pursuant to chapter 630, 631, 632 or 633 of NRS;

(b) Determine for each category of practitioner specified pursuant to paragraph (a), using data applicable to the previous calendar year, the relative market share in this state among insurers with respect to policies of insurance issued to cover the liability of the practitioners within the category for breach of professional duty toward a patient; and

(c) Provide notice of the applicability of this section to each insurer whom the Commissioner determines, pursuant to paragraph (b), possesses more than 40 percent of the market in this state within a category of practitioner.

2. A determination by the Commissioner pursuant to subsection 1 that an insurer possesses more than 40 percent of the market in this state within a category of practitioner is valid for the period beginning on April 1 of the year in which the determination is made and ending on March 31 of the following year, without regard to any actual change in market share during that period.

3. During any period specified in subsection 2 for which an insurer is determined by the Commissioner pursuant to subsection 1 to possess more than 40 percent of the market in this state within a category of practitioner, the insurer shall, before withdrawing from that market, comply with the provisions of subsections 4 and 5.

4. An insurer described in subsection 3 shall, at least 120 days before withdrawing:

(a) Give written notice of its intent to withdraw to the Commissioner and to each practitioner within the applicable category whom the insurer insures against liability for a breach of his professional duty toward a patient; and

(b) Submit to the Commissioner a written plan providing for the insurer's orderly withdrawal from the market so as to minimize the effect of the withdrawal on the public generally and on the practitioners within the applicable category whom the insurer insures against liability for a breach of professional duty toward a patient.

5. After complying with the requirements set forth in subsection 4, an insurer described in subsection 3:

(a) Shall not take any action toward withdrawal until the Commissioner determines that the written plan required pursuant to paragraph (b) of subsection 4 complies with the regulations adopted pursuant to paragraph (a) of subsection 7.

(b) Shall ensure that any action it takes toward withdrawal is in compliance with the written plan required pursuant to paragraph (b) of subsection 4.

6. The Commissioner has the final authority to determine whether a particular action taken by an insurer is in compliance with the written plan required pursuant to paragraph (b) of subsection 4.

7. The Commissioner shall adopt regulations:

(a) Prescribing the form, content and method of submission of a written plan required pursuant to paragraph (b) of subsection 4.

(b) Providing a procedure for determining, pursuant to subsection 1, the relative market share in this state among insurers with respect to policies of insurance issued to cover 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.

Sec. 23. NRS 695A.095 is hereby amended to read as follows:

695A.095 ***1.*** A society 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 society to its insureds.

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

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

(b) The society includes in the contract a schedule setting forth the payments required to be made to the provider of health care pursuant to the contract; and

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

3. The contract must not contain any provision that authorizes a society 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.

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

Sec. 24. 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. 25. NRS 695B.035 is hereby amended to read as follows:

695B.035 ***1.*** A corporation subject to the provisions of this chapter 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 corporation to its insureds.

2. A corporation specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless:

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

(b) The corporation includes in the contract a schedule setting forth the payments required to be made to the provider of health care pursuant to the contract; and

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

3. The contract must not contain any provision that authorizes a corporation 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.

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

Sec. 26. NRS 695B.2505 is hereby amended to read as follows:

695B.2505 1. Except as otherwise provided in subsection 2, 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 30 days after the corporation receives the claim. If the claim is approved, the corporation 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 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 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 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 days after it receives the claim. The corporation shall notify the provider of dental, hospital or medical services of all the specific reasons for the delay in approving or denying the claim. The corporation shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the corporation shall pay the claim within 30 days after it receives the additional information. 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. ***Except as otherwise provided in subsections 8 and 9:***

(a) 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 of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.]~~

(b) If the Commissioner determines that a corporation is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the corporation to pay an administrative fine in an amount to be determined by the Commissioner.

8. The Commissioner shall require a corporation to provide evidence which demonstrates that the corporation pays at least:

(a) Ninety-five percent of approved claims within 30 days after the date of approval; and

(b) Ninety percent of the total dollar amount for approved claims within 30 days after the date of approval.

9. If the Commissioner determines, after notice and a hearing, that a corporation is not in complete compliance with the requirements set forth in subsection 8, the Commissioner shall revoke the certificate of authority of the corporation. Notwithstanding any other provision of law, if revocation is required pursuant to this subsection, a lesser form of penalty, including, without limitation, a suspension or a fine, must not be substituted in lieu of the revocation.

Sec. 27. 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. 28. 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 27 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. 29. NRS 695C.055 is hereby amended to read as follows:

695C.055 1. The provisions of NRS 449.465, 679B.700, subsections 2, 4, 18, 19 and 32 of NRS 680B.010, NRS 680B.025 to 680B.060, inclusive, and ~~[chapter]~~ ***chapters 686A and*** 695G of NRS apply to a health maintenance organization.

2. For the purposes of subsection 1, unless the context requires that a provision apply only to insurers, any reference in those sections to "insurer" must be replaced by "health maintenance organization."

Sec. 30. NRS 695C.125 is hereby amended to read as follows:

695C.125 ***1.*** A health maintenance organization 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 health maintenance organization to its enrollees.

2. A health maintenance organization shall not contract with a provider of health care to provide health care to an insured unless:

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

(b) The health maintenance organization includes in the contract a schedule setting forth the payments required to be made to the provider of health care pursuant to the contract; and

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

3. The contract must not contain any provision that authorizes a health maintenance organization 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.

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

Sec. 31. NRS 695C.185 is hereby amended to read as follows:

695C.185 1. Except as otherwise provided in subsection 2, 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. ***Except as otherwise provided in subsections 8 and 9:***

(a) 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.]~~

(b) 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.

8. The Commissioner shall require a health maintenance organization to provide evidence which demonstrates that the health maintenance organization pays at least:

(a) Ninety-five percent of approved claims within 30 days after the date of approval; and

(b) Ninety percent of the total dollar amount for approved claims within 30 days after the date of approval.

9. If the Commissioner determines, after notice and a hearing, that a health maintenance organization is not in complete compliance with the requirements set forth in subsection 8, the Commissioner shall revoke the certificate of authority of the health maintenance organization. Notwithstanding any other provision of law, if revocation is required pursuant to this subsection, a lesser form of penalty, including, without limitation, a suspension or a fine, must not be substituted in lieu of the revocation.

Sec. 32. 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 27 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. 33. 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. 34. NRS 695G.270 is hereby amended to read as follows:

695G.270 ***1.*** A managed care organization that establishes a panel of providers of health care for the purpose of offering health care services pursuant to chapter 689A, 689B, 689C, 695A, 695B or 695C of NRS shall not charge a provider of health care a fee to include the name of the provider on the panel of providers of health care.

2. A managed care organization shall not contract with a provider of health care to provide health care to an insured unless:

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

(b) The managed care organization includes in the contract a schedule setting forth the payments required to be made to the provider of health care pursuant to the contract; and

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

3. The contract must not contain any provision that authorizes a managed care organization 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.

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

Sec. 35. Chapter 41A of NRS is hereby amended by adding thereto the provisions set forth as sections 36 and 37 of this act.

Sec. 36. ***1. In an action for damages for medical malpractice or dental malpractice in which the defendant is insured pursuant to a policy of insurance covering the liability of the defendant for a breach of his professional duty toward a patient:***

(a) If a settlement conference is required, the defendant and the insurer shall attend.

(b) If the defendant, at a settlement conference or otherwise, receives a settlement demand that is equal to the limits of the insurance policy of the defendant, the insurer shall, upon receipt of a copy of the demand, inform the defendant of any applicable rights and obligations possessed by the defendant, whether or not derived from statute or the common law, including, without limitation, the right of the defendant to obtain independent counsel at the expense of the insurer and the method, described in this section, by which the defendant may obtain independent counsel.

(c) If the defendant notifies the judge not later than 15 days after receiving a settlement demand described in paragraph (b) that the defendant wishes to have independent counsel, the judge shall, not later than 15 days after receiving such notice, appoint independent counsel to represent the defendant. The fees for any

independent counsel appointed pursuant to this section must be paid by the insurer.

2. The Commissioner of Insurance shall prescribe a form that may be used by an insurer to fulfill the requirements of paragraph (b) of subsection 1.

Sec. 37. ***1. In an action for damages for medical malpractice or dental malpractice in which the defendant is insured pursuant to a policy of insurance covering the liability of the defendant for a breach of his professional duty toward a patient, the insurer that issued the policy is liable for the entire amount of the damages to the same extent that the defendant is liable to the plaintiff if:***

(a) The plaintiff made a settlement offer within the limits of coverage under the policy;

(b) The liability of the defendant was reasonably clear when the plaintiff made the settlement offer;

(c) The insurer, in contravention of the express instructions of the defendant, unreasonably rejected the settlement offer in light of all the surrounding facts and circumstances; and

(d) 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.

2. The court may determine the liability of an insurer pursuant to this section in the underlying action for medical malpractice or dental malpractice or in a separate proceeding.

3. If, pursuant to this section, an insurer is found to be liable for the entire amount of the damages to the same extent that the defendant is liable to the plaintiff, the insurer shall be deemed to have acted in bad faith regarding its obligations to provide insurance coverage.

Sec. 38. 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 689B.575 ***and section 13 of this act*** 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. 39. 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, 695G.150, 695G.160, 695G.170 and 695G.200 to 695G.230, inclusive, ***and section 33 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. 40. Chapter 616B of NRS is hereby amended by adding thereto a new section to read as follows:

1. If an insurer establishes a panel of providers of health care for the purpose of offering health care services pursuant to chapters 616A to 617, inclusive, of NRS, the insurer shall not charge a provider of health care a fee to include the name of the provider on the panel of providers of health care.

2. If an insurer violates the provisions of subsection 1, the insurer shall pay to the provider of health care an amount that is equal to twice the fee charged to the provider of health care.

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

Sec. 41. The amendatory provisions of this act apply to a:

1. Policy of insurance issued or renewed on or after October 1, 2003.

2. Offer to issue a policy of insurance communicated to the applicant for the policy on or after October 1, 2003.

3. Decision with regard to the issuance of a policy of insurance communicated to the applicant for the policy on or after October 1, 2003.

4. Cause of action that accrues on or after October 1, 2003.