

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 hospitals and 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; 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; requiring the submission of a schedule of payments to a provider of health care under certain circumstances; 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:

- 1 **Section 1.** Chapter 679A of NRS is hereby amended by
2 adding thereto a new section to read as follows:
3 ***1. If an organization establishes a panel of providers of***
4 ***health care and makes the panel available for use by an insurer***
5 ***when offering health care services pursuant to chapter 689A,***
6 ***689B, 689C, 695A, 695B or 695C of NRS, the organization shall***
7 ***not charge the insurer or a provider of health care:***
8 ***(a) A fee to include the name of the provider on the panel of***
9 ***providers of health care; or***
10 ***(b) Any other fee related to establishing a provider of health***
11 ***care as a provider for the organization.***
12 ***2. If an organization violates the provisions of subsection 1,***
13 ***the organization shall pay to the insurer or provider of health***
14 ***care, as appropriate, an amount that is equal to twice the fee***
15 ***charged to the insurer or provider of health care.***
16 ***3. A court shall award costs and reasonable attorney's fees to***
17 ***the prevailing party in an action brought pursuant to this section.***
18 ***4. In addition to any relief granted pursuant to this section, if***
19 ***an organization violates the provisions of subsection 1, and if an***
20 ***insurer offering health care services pursuant to chapter 689A,***
21 ***689B, 689C, 695A, 695B or 695C of NRS has a contract with or***
22 ***otherwise uses the services of the organization, the Division shall***
23 ***require the insurer to suspend its performance under the contract***



1 *or discontinue using those services until the organization, as*
2 *determined by the Division:*

- 3 (a) *Complies with the provisions of subsection 1; and*
4 (b) *Refunds to all providers of health care any fees obtained by*
5 *the organization in violation of subsection 1.*

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

8 *If an administrator, managing general agent or producer of*
9 *insurance, or a health maintenance organization when acting as*
10 *an administrator pursuant to NRS 683A.0851 or a nonprofit*
11 *corporation for hospital or medical services when acting as an*
12 *administrator pursuant to NRS 683A.0852, contracts with a*
13 *provider of health care to provide health care to an insured*
14 *pursuant to this chapter, the administrator, managing general*
15 *agent, producer of insurance, health maintenance organization or*
16 *nonprofit corporation for hospital or medical services shall:*

17 1. *If requested by the provider of health care at the time the*
18 *contract is made, submit to the provider of health care a copy of*
19 *the schedule of payments applicable to the provider of health care;*
20 *or*

21 2. *If requested by the provider of health care at any other*
22 *time, submit to the provider of health care the schedule of*
23 *payments specified in subsection 1 within 7 days after receiving*
24 *the request.*

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

26 683A.0879 1. Except as otherwise provided in subsection 2,
27 an administrator shall approve or deny a claim relating to health
28 insurance coverage within 30 days after the administrator receives
29 the claim. If the claim is approved, the administrator shall pay the
30 claim within 30 days after it is approved. Except as otherwise
31 provided in this section, if the approved claim is not paid within that
32 period, the administrator shall pay interest on the claim at a rate of
33 interest equal to the prime rate at the largest bank in Nevada, as
34 ascertained by the Commissioner of Financial Institutions, on
35 January 1 or July 1, as the case may be, immediately preceding the
36 date on which the payment was due, plus 6 percent. The interest
37 must be calculated from 30 days after the date on which the claim is
38 approved until the date on which the claim is paid.

39 2. If the administrator requires additional information to
40 determine whether to approve or deny the claim, he shall notify the
41 claimant of his request for the additional information within 20 days
42 after he receives the claim. The administrator shall notify the
43 provider of health care of all the specific reasons for the delay in
44 approving or denying the claim. The administrator shall approve or
45 deny the claim within 30 days after receiving the additional



1 information. If the claim is approved, the administrator shall pay the
2 claim within 30 days after he receives the additional information. If
3 the approved claim is not paid within that period, the administrator
4 shall pay interest on the claim in the manner prescribed in
5 subsection 1.

6 3. An administrator shall not request a claimant to resubmit
7 information that the claimant has already provided to the
8 administrator, unless the administrator provides a legitimate reason
9 for the request and the purpose of the request is not to delay the
10 payment of the claim, harass the claimant or discourage the filing of
11 claims.

12 4. An administrator shall not pay only part of a claim that has
13 been approved and is fully payable.

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

16 6. The payment of interest provided for in this section for the
17 late payment of an approved claim may be waived only if the
18 payment was delayed because of an act of God or another cause
19 beyond the control of the administrator.

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

21 (a) The Commissioner may require an administrator to provide
22 evidence which demonstrates that the administrator has substantially
23 complied with the requirements set forth in this section . ~~including, without limitation, payment within 30 days of at least 95~~
24 ~~percent of approved claims or at least 90 percent of the total dollar~~
25 ~~amount for approved claims.]~~

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

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

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

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

38 9. *If the Commissioner determines, after notice and a*
39 *hearing, that an administrator is not in complete compliance with*
40 *the requirements set forth in subsection 8, the Commissioner shall*
41 *revoke the certificate of registration of the administrator.*
42 *Notwithstanding any other provision of law, if revocation is*
43 *required pursuant to this subsection, a lesser form of penalty,*
44



1 *including, without limitation, a suspension or a fine, must not be*
2 *substituted in lieu of the revocation.*

3 **Sec. 4.** NRS 686A.310 is hereby amended to read as follows:
4 686A.310 1. Engaging in any of the following activities is
5 considered to be an unfair practice:

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

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

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

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

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

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

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

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

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

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

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

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



1 (m) Failing to comply with the provisions of NRS 687B.310 to
2 687B.390, inclusive, or 687B.410.

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

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

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

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

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

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

18 *If a filing made with the Commissioner pursuant to subsection*
19 *1 of NRS 686B.070 pertains to insurance covering the liability of a*
20 *practitioner licensed pursuant to chapter 630, 631, 632 or 633 of*
21 *NRS for a breach of his professional duty toward a patient, any*
22 *interested person or entity may intervene as a matter of right in*
23 *any hearing or other proceeding conducted to determine whether*
24 *the applicable rate or proposed increase thereto:*

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

26 *2. Should be approved or disapproved.*

27 **Sec. 6.** NRS 686B.020 is hereby amended to read as follows:
28 686B.020 As used in NRS 686B.010 to 686B.1799, inclusive,
29 *and section 5 of this act*, unless the context otherwise requires:

30 1. “Advisory organization,” except as limited by NRS
31 686B.1752, means any person or organization which is controlled
32 by or composed of two or more insurers and which engages in
33 activities related to rate making. For the purposes of this subsection,
34 two or more insurers with common ownership or operating in this
35 state under common ownership constitute a single insurer. An
36 advisory organization does not include:

37 (a) A joint underwriting association;

38 (b) An actuarial or legal consultant; or

39 (c) An employee or manager of an insurer.

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

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



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

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

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

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

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

13 686B.040 ~~[The]~~

14 *1. Except as otherwise provided in subsection 2, the*
15 Commissioner may by rule exempt any person or class of persons or
16 any market segment from any or all of the provisions of NRS
17 686B.010 to 686B.1799, inclusive, *and section 5 of this act*, if and
18 to the extent that he finds their application unnecessary to achieve
19 the purposes of those sections.

20 *2. The Commissioner may not, by rule or otherwise, exempt*
21 *an insurer from the provisions of NRS 686B.010 to 686B.1799,*
22 *inclusive, and section 5 of this act, with regard to insurance*
23 *covering the liability of a practitioner licensed pursuant to chapter*
24 *630, 631, 632 or 633 of NRS for a breach of his professional duty*
25 *toward a patient.*

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

27 686B.110 1. The Commissioner shall consider each proposed
28 increase or decrease in the rate of any kind or line of insurance or
29 subdivision thereof *that is* filed with ~~[him]~~ *the Commissioner*
30 pursuant to NRS 686B.070. ~~[H]~~

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

35 *3. In addition to the grounds for disapproval set forth in*
36 *subsection 2, if the proposal will increase the rate of insurance*
37 *covering the liability of a practitioner licensed pursuant to chapter*
38 *630, 631, 632 or 633 of NRS for a breach of his professional duty*
39 *toward a patient, the Commissioner shall disapprove the proposal,*
40 *or any constituent part thereof, if the Commissioner finds that the*
41 *proposal, or the constituent part thereof, has been proposed or is*
42 *necessitated because:*

43 *(a) The insurer has experienced or is reasonably likely to*
44 *experience capital losses, or diminished dividends, returns or*



1 *income or any other financial loss as a result of the imprudent*
2 *investment of money;*

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

- 5 (1) *Any fraudulent accounting practice;*
- 6 (2) *Any form of corporate fraud or securities fraud; or*
- 7 (3) *Any willful misconduct or wrongdoing that violates the*
8 *laws or regulations of the United States, this state or any other*
9 *state;*

10 (c) *The insurer has experienced or is reasonably likely to*
11 *experience losses or expenses as a result of the insurer or any*
12 *director, partner, officer, employee, agent or contractor of the*
13 *insurer having engaged in litigation unreasonably or vexatiously*
14 *after one or more opposing parties have made a reasonable offer*
15 *of settlement; or*

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

- 20 (1) *Ten judgments or settlements with regard to claims for*
21 *breach of the practitioner's professional duty toward a patient;*
22 *and*
- 23 (2) *A total of \$5,000,000 with regard to the judgments and*
24 *settlements identified in subparagraph (1).*

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

30 ~~2~~ 5. Whenever an insurer has no legally effective rates as a
31 result of the Commissioner's disapproval of rates or other act, the
32 Commissioner shall , on request , specify interim rates for the
33 insurer that are high enough to protect the interests of all parties and
34 may order that a specified portion of the premiums be placed in an
35 escrow account approved by him. When new rates become legally
36 effective, the Commissioner shall order the escrowed funds or any
37 overcharge in the interim rates to be distributed appropriately,
38 except that refunds to policyholders that are de minimis must not be
39 required.

40 ~~3~~ 6. If the Commissioner disapproves a proposed rate and an
41 insurer requests a hearing to determine the validity of his action, the
42 insurer has the burden of showing compliance with the applicable
43 standards for rates established in NRS 686B.010 to 686B.1799,
44 inclusive ~~4~~ , and section 5 of this act. Any such hearing must be
45 held:



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

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

5 If the hearing is not held within the period specified in paragraph (a)
6 or (b), or if the Commissioner fails to issue an order concerning the
7 proposed rate for which the hearing is held within 45 days after the
8 hearing, the proposed rate shall be deemed approved.

9 ~~[4.]~~ 7. The Commissioner shall ~~[by regulation]~~ specify the
10 documents or any other information which must be included in a
11 proposal to increase or decrease a rate submitted to him pursuant to
12 ~~[subsection 1.]~~ *this section*. Each such proposal shall be deemed
13 complete upon its filing with the Commissioner, unless the
14 Commissioner, within 15 business days after the proposal is filed
15 with him, determines that the proposal is incomplete because the
16 proposal does not comply with the regulations adopted by him
17 pursuant to this ~~[subsection.]~~ *section*.

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

22 **Sec. 9.** Chapter 689A of NRS is hereby amended by adding
23 thereto a new section to read as follows:

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

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

33 *(a) The insured may continue to obtain medical treatment for*
34 *the medical condition from the provider of health care pursuant to*
35 *this section; and*

36 *(b) The provider of health care is entitled to receive*
37 *reimbursement from the insurer for the medical treatment he*
38 *provides to the insured pursuant to this section at the same rate*
39 *and under the same conditions as before the contract was*
40 *terminated.*

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

43 *(a) The 180th day after the date the contract is terminated; or*

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

45 *(1) The date of delivery; or*



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

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

5 (a) *The provider of health care was under contract with the*
6 *insurer and the insurer terminated that contract because of the*
7 *incompetence or misconduct of the provider of health care; and*

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

11 5. *A policy subject to the provisions of this chapter that is*
12 *delivered, issued for delivery or renewed on or after October 1,*
13 *2003, has the legal effect of including the coverage required by*
14 *this section, and any provision of the policy or renewal thereof*
15 *that is in conflict with this section is void.*

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

18 **Sec. 10.** NRS 689A.035 is hereby amended to read as follows:

19 689A.035 1. *An insurer shall not charge a provider of health*
20 *care a fee to include the name of the provider on a list of providers*
21 *of health care given by the insurer to its insureds.*

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

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

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

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

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

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

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

41 (a) *Fully disclosed to the provider of health care not later than*
42 *15 business days before the date the contract is executed; or*

43 (b) *Necessary to comply with accreditation requirements of*
44 *state or federal law or a private accreditation organization. If an*



1 *amendment is necessary pursuant to this paragraph, the provider*
2 *of health care may terminate the contract.*
3 *5. The contract must not contain any provision that requires*
4 *or permits access to information relating to an insured in violation*
5 *of state or federal law concerning the confidentiality of such*
6 *information.*
7 *6. The contract must not contain any provision that waives or*
8 *conflicts with any provision of this section.*
9 *7. A contract that contains any provision in violation of this*
10 *section is void.*
11 *8. The Commissioner shall develop the form required by*
12 *subsection 2.*
13 *9. If an insurer contracts with a provider of health care to*
14 *provide health care to an insured, the insurer shall:*
15 *(a) If requested by the provider of health care at the time the*
16 *contract is made, submit to the provider of health care the*
17 *schedule of payments applicable to the provider of health care; or*
18 *(b) If requested by the provider of health care at any other*
19 *time, submit to the provider of health care the schedule of*
20 *payments specified in paragraph (a) within 7 days after receiving*
21 *the request.*
22 **Sec. 11.** NRS 689A.330 is hereby amended to read as follows:
23 689A.330 If any policy is issued by a domestic insurer for
24 delivery to a person residing in another state, and if the insurance
25 commissioner or corresponding public officer of that other state has
26 informed the Commissioner that the policy is not subject to approval
27 or disapproval by that officer, the Commissioner may by ruling
28 require that the policy meet the standards set forth in NRS 689A.030
29 to 689A.320, inclusive ~~H~~, *and section 9 of this act.*
30 **Sec. 12.** NRS 689A.410 is hereby amended to read as follows:
31 689A.410 1. Except as otherwise provided in subsection 2,
32 an insurer shall approve or deny a claim relating to a policy of
33 health insurance within 30 days after the insurer receives the claim.
34 If the claim is approved, the insurer shall pay the claim within 30
35 days after it is approved. Except as otherwise provided in this
36 section, if the approved claim is not paid within that period, the
37 insurer shall pay interest on the claim at a rate of interest equal to
38 the prime rate at the largest bank in Nevada, as ascertained by the
39 Commissioner of Financial Institutions, on January 1 or July 1, as
40 the case may be, immediately preceding the date on which the
41 payment was due, plus 6 percent. The interest must be calculated
42 from 30 days after the date on which the claim is approved until the
43 date on which the claim is paid.
44 2. If the insurer requires additional information to determine
45 whether to approve or deny the claim, it shall notify the claimant of



1 its request for the additional information within 20 days after it
2 receives the claim. The insurer shall notify the provider of health
3 care of all the specific reasons for the delay in approving or denying
4 the claim. The insurer shall approve or deny the claim within 30
5 days after receiving the additional information. If the claim is
6 approved, the insurer shall pay the claim within 30 days after it
7 receives the additional information. If the approved claim is not paid
8 within that period, the insurer shall pay interest on the claim in the
9 manner prescribed in subsection 1.

10 3. An insurer shall not request a claimant to resubmit
11 information that the claimant has already provided to the insurer,
12 unless the insurer provides a legitimate reason for the request and
13 the purpose of the request is not to delay the payment of the claim,
14 harass the claimant or discourage the filing of claims.

15 4. An insurer shall not pay only part of a claim that has been
16 approved and is fully payable.

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

19 6. The payment of interest provided for in this section for the
20 late payment of an approved claim may be waived only if the
21 payment was delayed because of an act of God or another cause
22 beyond the control of the insurer.

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

24 (a) The Commissioner may require an insurer to provide
25 evidence which demonstrates that the insurer has substantially
26 complied with the requirements set forth in this section . ~~It~~
27 ~~including, without limitation, payment within 30 days of at least 95~~
28 ~~percent of approved claims or at least 90 percent of the total dollar~~
29 ~~amount for approved claims.]~~

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

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

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

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

41 9. *If the Commissioner determines, after notice and a*
42 *hearing, that an insurer is not in complete compliance with the*
43 *requirements set forth in subsection 8, the Commissioner shall*
44 *revoke the certificate of authority of the insurer. Notwithstanding*
45 *any other provision of law, if revocation is required pursuant to*



1 *this subsection, a lesser form of penalty, including, without*
2 *limitation, a suspension or a fine, must not be substituted in lieu of*
3 *the revocation.*

4 **Sec. 13.** Chapter 689B of NRS is hereby amended by adding
5 thereto a new section to read as follows:

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

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

15 *(a) The insured may continue to obtain medical treatment for*
16 *the medical condition from the provider of health care pursuant to*
17 *this section; and*

18 *(b) The provider of health care is entitled to receive*
19 *reimbursement from the insurer for the medical treatment he*
20 *provides to the insured pursuant to this section at the same rate*
21 *and under the same conditions as before the contract was*
22 *terminated.*

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

25 *(a) The 180th day after the date the contract is terminated; or*

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

27 *(1) The date of delivery; or*

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

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

32 *(a) The provider of health care was under contract with the*
33 *insurer and the insurer terminated that contract because of the*
34 *incompetence or misconduct of the provider of health care; and*

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

38 *5. A policy subject to the provisions of this chapter that is*
39 *delivered, issued for delivery or renewed on or after October 1,*
40 *2003, has the legal effect of including the coverage required by*
41 *this section, and any provision of the policy or renewal thereof*
42 *that is in conflict with this section is void.*

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



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1 **Sec. 14.** NRS 689B.015 is hereby amended to read as follows:
2 689B.015 **1.** An insurer that issues a policy of group health
3 insurance shall not charge a provider of health care a fee to include
4 the name of the provider on a list of providers of health care given
5 by the insurer to its insureds.

6 **2.** *An insurer specified in subsection 1 shall not contract with
7 a provider of health care to provide health care to an insured
8 unless:*

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

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

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

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

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

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

26 **(a)** *Fully disclosed to the provider of health care not later than
27 15 business days before the date the contract is executed; or*

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

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

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

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

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

42 **9.** *If an insurer specified in subsection 1 contracts with a
43 provider of health care to provide health care to an insured, the
44 insurer shall:*



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

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

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

9 689B.255 1. Except as otherwise provided in subsection 2, an
10 insurer shall approve or deny a claim relating to a policy of group
11 health insurance or blanket insurance within 30 days after the
12 insurer receives the claim. If the claim is approved, the insurer shall
13 pay the claim within 30 days after it is approved. Except as
14 otherwise provided in this section, if the approved claim is not paid
15 within that period, the insurer shall pay interest on the claim at a rate
16 of interest equal to the prime rate at the largest bank in Nevada, as
17 ascertained by the Commissioner of Financial Institutions, on
18 January 1 or July 1, as the case may be, immediately preceding the
19 date on which the payment was due, plus 6 percent. The interest
20 must be calculated from 30 days after the date on which the claim is
21 approved until the date on which the claim is paid.

22 2. If the insurer requires additional information to determine
23 whether to approve or deny the claim, it shall notify the claimant of
24 its request for the additional information within 20 days after it
25 receives the claim. The insurer shall notify the provider of health
26 care of all the specific reasons for the delay in approving or denying
27 the claim. The insurer shall approve or deny the claim within 30
28 days after receiving the additional information. If the claim is
29 approved, the insurer shall pay the claim within 30 days after it
30 receives the additional information. If the approved claim is not paid
31 within that period, the insurer shall pay interest on the claim in the
32 manner prescribed in subsection 1.

33 3. An insurer shall not request a claimant to resubmit
34 information that the claimant has already provided to the insurer,
35 unless the insurer provides a legitimate reason for the request and
36 the purpose of the request is not to delay the payment of the claim,
37 harass the claimant or discourage the filing of claims.

38 4. An insurer shall not pay only part of a claim that has been
39 approved and is fully payable.

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

42 6. The payment of interest provided for in this section for the
43 late payment of an approved claim may be waived only if the
44 payment was delayed because of an act of God or another cause
45 beyond the control of the insurer.



1 7. *Except as otherwise provided in subsections 8 and 9:*
2 (a) The Commissioner may require an insurer to provide
3 evidence which demonstrates that the insurer has substantially
4 complied with the requirements set forth in this section . ~~;~~
5 ~~including, without limitation, payment within 30 days of at least 95~~
6 ~~percent of approved claims or at least 90 percent of the total dollar~~
7 ~~amount for approved claims.]~~

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

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

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

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

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

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

28 689C.435 1. A carrier serving small employers and a carrier
29 that offers a contract to a voluntary purchasing group shall not
30 charge a provider of health care a fee to include the name of the
31 provider on a list of providers of health care given by the carrier to
32 its insureds.

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

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

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

40 3. *The contract must not contain any provision that*
41 *authorizes a carrier to amend the material terms of the contract or*
42 *any manual, policy or procedure document which is incorporated*
43 *in or referenced by the contract unless:*

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



1 ***(b) The amendment is necessary to comply with state or federal***
2 ***law or the accreditation requirements of a private accreditation***
3 ***organization. If an amendment is necessary pursuant to this***
4 ***paragraph, the provider of health care may terminate the contract.***
5 ***4. The contract must not contain any provision that requires***
6 ***the provider of health care to comply with quality improvement or***
7 ***utilization management programs or procedures unless the***
8 ***requirement is:***
9 ***(a) Fully disclosed to the provider of health care not later than***
10 ***15 business days before the date the contract is executed; or***
11 ***(b) Necessary to comply with accreditation requirements of***
12 ***state or federal law or a private accreditation organization. If an***
13 ***amendment is necessary pursuant to this paragraph, the provider***
14 ***of health care may terminate the contract.***
15 ***5. The contract must not contain any provision that requires***
16 ***or permits access to information relating to an insured in violation***
17 ***of state or federal law concerning the confidentiality of such***
18 ***information.***
19 ***6. The contract must not contain any provision that waives or***
20 ***conflicts with any provision of this section.***
21 ***7. A contract that contains any provision in violation of this***
22 ***section is void.***
23 ***8. The Commissioner shall develop the form required by***
24 ***subsection 2.***
25 ***9. If a carrier specified in subsection 1 contracts with a***
26 ***provider of health care to provide health care to an insured, the***
27 ***carrier shall:***
28 ***(a) If requested by the provider of health care at the time the***
29 ***contract is made, submit to the provider of health care the***
30 ***schedule of payments applicable to the provider of health care; or***
31 ***(b) If requested by the provider of health care at any other***
32 ***time, submit to the provider of health care the schedule of***
33 ***payments specified in paragraph (a) within 7 days after receiving***
34 ***the request.***
35 **Sec. 17.** NRS 689C.485 is hereby amended to read as follows:
36 689C.485 1. Except as otherwise provided in subsection 2, a
37 carrier serving small employers and a carrier that offers a contract to
38 a voluntary purchasing group shall approve or deny a claim relating
39 to a policy of health insurance within 30 days after the carrier
40 receives the claim. If the claim is approved, the carrier shall pay the
41 claim within 30 days after it is approved. Except as otherwise
42 provided in this section, if the approved claim is not paid within that
43 period, the carrier shall pay interest on the claim at a rate of interest
44 equal to the prime rate at the largest bank in Nevada, as ascertained
45 by the Commissioner of Financial Institutions, on January 1 or



1 July 1, as the case may be, immediately preceding the date on which
2 the payment was due, plus 6 percent. The interest must be calculated
3 from 30 days after the date on which the claim is approved until the
4 date on which the claim is paid.

5 2. If the carrier requires additional information to determine
6 whether to approve or deny the claim, it shall notify the claimant of
7 its request for the additional information within 20 days after it
8 receives the claim. The carrier shall notify the provider of health
9 care of all the specific reasons for the delay in approving or denying
10 the claim. The carrier shall approve or deny the claim within 30
11 days after receiving the additional information. If the claim is
12 approved, the carrier shall pay the claim within 30 days after it
13 receives the additional information. If the approved claim is not paid
14 within that period, the carrier shall pay interest on the claim in the
15 manner prescribed in subsection 1.

16 3. A carrier shall not request a claimant to resubmit
17 information that the claimant has already provided to the carrier,
18 unless the carrier provides a legitimate reason for the request and the
19 purpose of the request is not to delay the payment of the claim,
20 harass the claimant or discourage the filing of claims.

21 4. A carrier shall not pay only part of a claim that has been
22 approved and is fully payable.

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

25 6. The payment of interest provided for in this section for the
26 late payment of an approved claim may be waived only if the
27 payment was delayed because of an act of God or another cause
28 beyond the control of the carrier.

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

30 (a) The Commissioner may require a carrier to provide evidence
31 which demonstrates that the carrier has substantially complied with
32 the requirements set forth in this section . ~~[, including, without~~
33 ~~limitation, payment within 30 days of at least 95 percent of~~
34 ~~approved claims or at least 90 percent of the total dollar amount for~~
35 ~~approved claims.]~~

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

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

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



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

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

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

14 **Sec. 19.** *An insurer shall not cancel, refuse to renew or*
15 *increase the premium for renewal of a policy of insurance*
16 *covering the liability of a practitioner licensed pursuant to chapter*
17 *630, 631, 632 or 633 of NRS for a breach of his professional duty*
18 *toward a patient as a result of a claim against the practitioner*
19 *pursuant to the policy if the insurer:*

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

22 **2. Had the opportunity to settle the claim for an amount**
23 **equal to or less than the limit of the coverage under the policy;**
24 **and**

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

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

33 **Sec. 21.** **1. If an insurer, for a policy of insurance covering**
34 **the liability of a practitioner licensed pursuant to chapter 630, 631,**
35 **632 or 633 of NRS for a breach of his professional duty toward a**
36 **patient, sets the premium for the policy for the practitioner at a**
37 **rate that is higher than the applicable average rate determined**
38 **pursuant to subsection 2, the insurer shall, upon the request of the**
39 **practitioner, disclose to the practitioner the reasons the insurer set**
40 **the premium for the policy at a rate that is higher than the**
41 **applicable average rate determined pursuant to subsection 2.**

42 **2. For the purposes of this section, the Commissioner shall**
43 **determine an average rate for the premium for a policy of**
44 **insurance covering the liability of a practitioner licensed pursuant**
45 **to chapter 630, 631, 632 or 633 of NRS for a breach of his**



1 *professional duty toward a patient. The Commissioner may*
2 *determine different average rates applicable to different:*
3 *(a) Types of policies, including, without limitation, policies of*
4 *claims-made insurance and policies of occurrence-based*
5 *insurance;*
6 *(b) Types and specialties of practitioners; and*
7 *(c) Geographic areas of this state within which a practitioner*
8 *may practice.*
9 *3. The Commissioner shall review and update the average*
10 *rates determined pursuant to subsection 2 not less than once every*
11 *2 years.*
12 **Sec. 22. 1. The Commissioner shall, on or before April 1 of**
13 **each year:**
14 *(a) Specify for the purposes of this section, by regulation,*
15 *categories of practitioners licensed pursuant to chapter 630, 631,*
16 *632 or 633 of NRS;*
17 *(b) Determine for each category of practitioner specified*
18 *pursuant to paragraph (a), using data applicable to the previous*
19 *calendar year, the relative market share in this state among*
20 *insurers with respect to policies of insurance issued to cover the*
21 *liability of the practitioners within the category for breach of*
22 *professional duty toward a patient; and*
23 *(c) Provide notice of the applicability of this section to each*
24 *insurer whom the Commissioner determines, pursuant to*
25 *paragraph (b), possesses more than 40 percent of the market in*
26 *this state within a category of practitioner.*
27 *2. A determination by the Commissioner pursuant to*
28 *subsection 1 that an insurer possesses more than 40 percent of the*
29 *market in this state within a category of practitioner is valid for*
30 *the period beginning on April 1 of the year in which the*
31 *determination is made and ending on March 31 of the following*
32 *year, without regard to any actual change in market share during*
33 *that period.*
34 *3. During any period specified in subsection 2 for which an*
35 *insurer is determined by the Commissioner pursuant to subsection*
36 *1 to possess more than 40 percent of the market in this state within*
37 *a category of practitioner, the insurer shall, before withdrawing*
38 *from that market, comply with the provisions of subsections 4*
39 *and 5.*
40 *4. An insurer described in subsection 3 shall, at least 120*
41 *days before withdrawing:*
42 *(a) Give written notice of its intent to withdraw to the*
43 *Commissioner and to each practitioner within the applicable*
44 *category whom the insurer insures against liability for a breach of*
45 *his professional duty toward a patient; and*



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

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

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

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

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

20 ***7. The Commissioner shall adopt regulations:***

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

23 ***(b) Providing a procedure for determining, pursuant to***
24 ***subsection 1, the relative market share in this state among***
25 ***insurers with respect to policies of insurance issued to cover the***
26 ***liability of a practitioner licensed pursuant to chapter 630, 631,***
27 ***632 or 633 of NRS for a breach of his professional duty toward a***
28 ***patient.***

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

30 695A.095 ***1.*** A society shall not charge a provider of health
31 care a fee to include the name of the provider on a list of providers
32 of health care given by the society to its insureds.

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

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

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

39 ***3. The contract must not contain any provision that***
40 ***authorizes a society to amend the material terms of the contract or***
41 ***any manual, policy or procedure document which is incorporated***
42 ***in or referenced by the contract unless:***

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

44 ***(b) The amendment is necessary to comply with state or federal***
45 ***law or the accreditation requirements of a private accreditation***



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1 organization. If an amendment is necessary pursuant to this
2 paragraph, the provider of health care may terminate the contract.

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

7 (a) Fully disclosed to the provider of health care not later than
8 15 business days before the date the contract is executed; or

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

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

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

19 7. A contract that contains any provision in violation of this
20 section is void.

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

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

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

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

32 **Sec. 24.** Chapter 695B of NRS is hereby amended by adding
33 thereto a new section to read as follows:

34 1. The provisions of this section apply to a policy of health
35 insurance offered or issued by a hospital or medical service
36 corporation if an insured covered by the policy receives health
37 care through a defined set of providers of health care who are
38 under contract with the hospital or medical service corporation.

39 2. Except as otherwise provided in this section, if an insured
40 who is covered by a policy described in subsection 1 is receiving
41 medical treatment for a medical condition from a provider of
42 health care whose contract with the hospital or medical service
43 corporation is terminated during the course of the medical
44 treatment, the policy must provide that:



1 (a) *The insured may continue to obtain medical treatment for*
2 *the medical condition from the provider of health care pursuant to*
3 *this section; and*

4 (b) *The provider of health care is entitled to receive*
5 *reimbursement from the hospital or medical service corporation*
6 *for the medical treatment he provides to the insured pursuant to*
7 *this section at the same rate and under the same conditions as*
8 *before the contract was terminated.*

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

11 (a) *The 180th day after the date the contract is terminated; or*

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

13 (1) *The date of delivery; or*

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

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

18 (a) *The provider of health care was under contract with the*
19 *hospital or medical service corporation and the hospital or*
20 *medical service corporation terminated that contract because of*
21 *the incompetence or misconduct of the provider of health care;*
22 *and*

23 (b) *The hospital or medical service corporation did not enter*
24 *into another contract with the provider of health care after the*
25 *contract was terminated pursuant to paragraph (a).*

26 5. *A policy subject to the provisions of this chapter that is*
27 *delivered, issued for delivery or renewed on or after October 1,*
28 *2003, has the legal effect of including the coverage required by*
29 *this section, and any provision of the policy or renewal thereof*
30 *that is in conflict with this section is void.*

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

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

34 695B.035 1. A corporation subject to the provisions of this
35 chapter shall not charge a provider of health care a fee to include the
36 name of the provider on a list of providers of health care given by
37 the corporation to its insureds.

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

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

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



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

- 5 (a) *The provider of health care agrees to the amendment; or*
- 6 (b) *The amendment is necessary to comply with state or federal*
7 *law or the accreditation requirements of a private accreditation*
8 *organization. If an amendment is necessary pursuant to this*
9 *paragraph, the provider of health care may terminate the contract.*

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

- 14 (a) *Fully disclosed to the provider of health care not later than*
15 *15 business days before the date the contract is executed; or*
- 16 (b) *Necessary to comply with accreditation requirements of*
17 *state or federal law or a private accreditation organization. If an*
18 *amendment is necessary pursuant to this paragraph, the provider*
19 *of health care may terminate the contract.*

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

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

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

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

30 9. *If a corporation specified in subsection 1 contracts with a*
31 *provider of health care to provide health care to an insured, the*
32 *corporation shall:*

- 33 (a) *If requested by the provider of health care at the time the*
34 *contract is made, submit to the provider of health care the*
35 *schedule of payments applicable to the provider of health care; or*
- 36 (b) *If requested by the provider of health care at any other*
37 *time, submit to the provider of health care the schedule of*
38 *payments specified in paragraph (a) within 7 days after receiving*
39 *the request.*

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

42 695B.2505 1. Except as otherwise provided in subsection 2, a
43 corporation subject to the provisions of this chapter shall approve or
44 deny a claim relating to a contract for dental, hospital or medical
45 services within 30 days after the corporation receives the claim. If



1 the claim is approved, the corporation shall pay the claim within 30
2 days after it is approved. Except as otherwise provided in this
3 section, if the approved claim is not paid within that period, the
4 corporation shall pay interest on the claim at a rate of interest equal
5 to the prime rate at the largest bank in Nevada, as ascertained by the
6 Commissioner of Financial Institutions, on January 1 or July 1, as
7 the case may be, immediately preceding the date on which the
8 payment was due, plus 6 percent. The interest must be calculated
9 from 30 days after the date on which the claim is approved until the
10 date on which the claim is paid.

11 2. If the corporation requires additional information to
12 determine whether to approve or deny the claim, it shall notify the
13 claimant of its request for the additional information within 20 days
14 after it receives the claim. The corporation shall notify the provider
15 of dental, hospital or medical services of all the specific reasons for
16 the delay in approving or denying the claim. The corporation shall
17 approve or deny the claim within 30 days after receiving the
18 additional information. If the claim is approved, the corporation
19 shall pay the claim within 30 days after it receives the additional
20 information. If the approved claim is not paid within that period, the
21 corporation shall pay interest on the claim in the manner prescribed
22 in subsection 1.

23 3. A corporation shall not request a claimant to resubmit
24 information that the claimant has already provided to the
25 corporation, unless the corporation provides a legitimate reason for
26 the request and the purpose of the request is not to delay the
27 payment of the claim, harass the claimant or discourage the filing of
28 claims.

29 4. A corporation shall not pay only part of a claim that has
30 been approved and is fully payable.

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

33 6. The payment of interest provided for in this section for the
34 late payment of an approved claim may be waived only if the
35 payment was delayed because of an act of God or another cause
36 beyond the control of the corporation.

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

38 (a) The Commissioner may require a corporation to provide
39 evidence which demonstrates that the corporation has substantially
40 complied with the requirements set forth in this section . ~~;~~
41 ~~including, without limitation, payment within 30 days of at least 95~~
42 ~~percent of approved claims or at least 90 percent of the total dollar~~
43 ~~amount for approved claims.]~~

44 (b) If the Commissioner determines that a corporation is not in
45 substantial compliance with the requirements set forth in this



1 section, the Commissioner may require the corporation to pay an
2 administrative fine in an amount to be determined by the
3 Commissioner.

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

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

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

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

18 **Sec. 27.** Chapter 695C of NRS is hereby amended by adding
19 thereto a new section to read as follows:

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

25 *2. Except as otherwise provided in this section, if an insured
26 who is covered by a health care plan described in subsection 1 is
27 receiving medical treatment for a medical condition from a
28 provider of health care whose contract with the health
29 maintenance organization is terminated during the course of the
30 medical treatment, the health care plan must provide that:*

31 *(a) The insured may continue to obtain medical treatment for
32 the medical condition from the provider of health care pursuant to
33 this section; and*

34 *(b) The provider of health care is entitled to receive
35 reimbursement from the health maintenance organization for the
36 medical treatment he provides to the insured pursuant to this
37 section at the same rate and under the same conditions as before
38 the contract was terminated.*

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

41 *(a) The 180th day after the date the contract is terminated; or*

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

43 *(1) The date of delivery; or*

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



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

3 (a) **The provider of health care was under contract with the**
4 **health maintenance organization and the health maintenance**
5 **organization terminated that contract because of the incompetence**
6 **or misconduct of the provider of health care; and**

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

10 **5. An evidence of coverage for a health care plan subject to**
11 **the provisions of this chapter that is delivered, issued for delivery**
12 **or renewed on or after October 1, 2003, has the legal effect of**
13 **including the coverage required by this section, and any provision**
14 **of the evidence of coverage or renewal thereof that is in conflict**
15 **with this section is void.**

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

18 **Sec. 28.** NRS 695C.050 is hereby amended to read as follows:

19 695C.050 1. Except as otherwise provided in this chapter or
20 in specific provisions of this title, the provisions of this title are not
21 applicable to any health maintenance organization granted a
22 certificate of authority under this chapter. This provision does not
23 apply to an insurer licensed and regulated pursuant to this title
24 except with respect to its activities as a health maintenance
25 organization authorized and regulated pursuant to this chapter.

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

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

33 4. The provisions of **chapter 686A**, NRS 695C.110, **695C.125**,
34 **695C.170** to **695C.200**, inclusive, **695C.250** and **695C.265** **and**
35 **section 27 of this act** do not apply to a health maintenance
36 organization that provides health care services through managed
37 care to recipients of Medicaid under the State Plan for Medicaid or
38 insurance pursuant to the Children’s Health Insurance Program
39 pursuant to a contract with the Division of Health Care Financing
40 and Policy of the Department of Human Resources. This subsection
41 does not exempt a health maintenance organization from any
42 provision of this chapter for services provided pursuant to any other
43 contract.

44 5. The provisions of NRS 695C.1694 and 695C.1695 apply to
45 a health maintenance organization that provides health care services



1 through managed care to recipients of Medicaid under the State Plan
2 for Medicaid.

3 **Sec. 29.** NRS 695C.055 is hereby amended to read as follows:

4 695C.055 1. The provisions of NRS 449.465, 679B.700,
5 subsections 2, 4, 18, 19 and 32 of NRS 680B.010, NRS 680B.025 to
6 680B.060, inclusive, and ~~chapter~~ *chapters 686A and 695G* of
7 NRS *and section 1 of this act* apply to a health maintenance
8 organization.

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

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

14 695C.125 ~~[A health maintenance organization shall not charge a~~
15 ~~provider of health care a fee to include the name of the provider on a~~
16 ~~list of providers of health care given by the health maintenance~~
17 ~~organization to its enrollees.]~~

18 *1. A health maintenance organization shall not contract with*
19 *a provider of health care to provide health care to an insured*
20 *unless:*

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

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

25 *2. The contract must not contain any provision that*
26 *authorizes a health maintenance organization to amend the*
27 *material terms of the contract or any manual, policy or procedure*
28 *document which is incorporated in or referenced by the contract*
29 *unless:*

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

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

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

39 *(a) Fully disclosed to the provider of health care not later than*
40 *15 business days before the date the contract is executed; or*

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



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

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

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

9 7. *The Commissioner shall develop the form required by*
10 *subsection 2.*

11 8. *If a health maintenance organization contracts with a*
12 *provider of health care to provide health care to an enrollee, the*
13 *health maintenance organization shall:*

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

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

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

22 695C.185 1. Except as otherwise provided in subsection 2, a
23 health maintenance organization shall approve or deny a claim
24 relating to a health care plan within 30 days after the health
25 maintenance organization receives the claim. If the claim is
26 approved, the health maintenance organization shall pay the claim
27 within 30 days after it is approved. Except as otherwise provided in
28 this section, if the approved claim is not paid within that period, the
29 health maintenance organization shall pay interest on the claim at a
30 rate of interest equal to the prime rate at the largest bank in Nevada,
31 as ascertained by the Commissioner of Financial Institutions, on
32 January 1 or July 1, as the case may be, immediately preceding the
33 date on which the payment was due, plus 6 percent. The interest
34 must be calculated from 30 days after the date on which the claim is
35 approved until the date on which the claim is paid.

36 2. If the health maintenance organization requires additional
37 information to determine whether to approve or deny the claim, it
38 shall notify the claimant of its request for the additional information
39 within 20 days after it receives the claim. The health maintenance
40 organization shall notify the provider of health care services of all
41 the specific reasons for the delay in approving or denying the claim.
42 The health maintenance organization shall approve or deny the
43 claim within 30 days after receiving the additional information. If
44 the claim is approved, the health maintenance organization shall pay
45 the claim within 30 days after it receives the additional information.



1 If the approved claim is not paid within that period, the health
2 maintenance organization shall pay interest on the claim in the
3 manner prescribed in subsection 1.

4 3. A health maintenance organization shall not request a
5 claimant to resubmit information that the claimant has already
6 provided to the health maintenance organization, unless the health
7 maintenance organization provides a legitimate reason for the
8 request and the purpose of the request is not to delay the payment of
9 the claim, harass the claimant or discourage the filing of claims.

10 4. A health maintenance organization shall not pay only part of
11 a claim that has been approved and is fully payable.

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

14 6. The payment of interest provided for in this section for the
15 late payment of an approved claim may be waived only if the
16 payment was delayed because of an act of God or another cause
17 beyond the control of the health maintenance organization.

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

19 (a) The Commissioner may require a health maintenance
20 organization to provide evidence which demonstrates that the health
21 maintenance organization has substantially complied with the
22 requirements set forth in this section . ~~[-, including, without~~
23 ~~limitation, payment within 30 days of at least 95 percent of~~
24 ~~approved claims or at least 90 percent of the total dollar amount for~~
25 ~~approved claims.]~~

26 (b) If the Commissioner determines that a health maintenance
27 organization is not in substantial compliance with the requirements
28 set forth in this section, the Commissioner may require the health
29 maintenance organization to pay an administrative fine in an amount
30 to be determined by the Commissioner.

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

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

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

38 9. *If the Commissioner determines, after notice and a*
39 *hearing, that a health maintenance organization is not in complete*
40 *compliance with the requirements set forth in subsection 8, the*
41 *Commissioner shall revoke the certificate of authority of the*
42 *health maintenance organization. Notwithstanding any other*
43 *provision of law, if revocation is required pursuant to this*
44 *subsection, a lesser form of penalty, including, without limitation,*



1 *a suspension or a fine, must not be substituted in lieu of the*
2 *revocation.*

3 **Sec. 32.** NRS 695C.330 is hereby amended to read as follows:
4 695C.330 1. The Commissioner may suspend or revoke any
5 certificate of authority issued to a health maintenance organization
6 pursuant to the provisions of this chapter if he finds that any of the
7 following conditions exist:

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

15 (b) The health maintenance organization issues evidence of
16 coverage or uses a schedule of charges for health care services
17 which do not comply with the requirements of NRS ~~695C.170~~
18 *695C.1694* to 695C.200, inclusive, ~~for 695C.1694, 695C.1695~~ or
19 695C.207;

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

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

24 (1) Does not meet the requirements of subsection 2 of NRS
25 695C.080; or

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

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

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

35 (g) The health maintenance organization has failed to put into
36 effect the system for *resolving* complaints required by NRS
37 695C.260 in a manner reasonably to dispose of valid complaints;

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

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

43 (j) *The health maintenance organization fails to provide the*
44 *coverage required by section 27 of this act; or*



- 1 (k) The health maintenance organization has otherwise failed to
- 2 comply substantially with the provisions of this chapter.
- 3 2. A certificate of authority must be suspended or revoked only
- 4 after compliance with the requirements of NRS 695C.340.
- 5 3. If the certificate of authority of a health maintenance
- 6 organization is suspended, the health maintenance organization shall
- 7 not, during the period of that suspension, enroll any additional
- 8 groups or new individual contracts, unless those groups or persons
- 9 were contracted for before the date of suspension.
- 10 4. If the certificate of authority of a health maintenance
- 11 organization is revoked, the organization shall proceed, immediately
- 12 following the effective date of the order of revocation, to wind up its
- 13 affairs and shall conduct no further business except as may be
- 14 essential to the orderly conclusion of the affairs of the organization.
- 15 It shall engage in no further advertising or solicitation of any kind.
- 16 The Commissioner may , by written order , permit such further
- 17 operation of the organization as he may find to be in the best interest
- 18 of enrollees to the end that enrollees are afforded the greatest
- 19 practical opportunity to obtain continuing coverage for health care.
- 20 **Sec. 33.** Chapter 695G of NRS is hereby amended by adding
- 21 thereto a new section to read as follows:
- 22 1. *The provisions of this section apply to a health care plan*
- 23 *offered or issued by a managed care organization if an insured*
- 24 *covered by the health care plan receives health care through a*
- 25 *defined set of providers of health care who are under contract with*
- 26 *the managed care organization.*
- 27 2. *Except as otherwise provided in this section, if an insured*
- 28 *who is covered by a health care plan described in subsection 1 is*
- 29 *receiving medical treatment for a medical condition from a*
- 30 *provider of health care whose contract with the managed care*
- 31 *organization is terminated during the course of the medical*
- 32 *treatment, the health care plan must provide that:*
- 33 (a) *The insured may continue to obtain medical treatment for*
- 34 *the medical condition from the provider of health care pursuant to*
- 35 *this section; and*
- 36 (b) *The provider of health care is entitled to receive*
- 37 *reimbursement from the managed care organization for the*
- 38 *medical treatment he provides to the insured pursuant to this*
- 39 *section at the same rate and under the same conditions as before*
- 40 *the contract was terminated.*
- 41 3. *The coverage required by subsection 2 must be provided*
- 42 *until the later of:*
- 43 (a) *The 180th day after the date the contract is terminated; or*
- 44 (b) *If the medical condition is pregnancy, the 45th day after:*
- 45 (1) *The date of delivery; or*



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

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

5 (a) *The provider of health care was under contract with the*
6 *managed care organization and the managed care organization*
7 *terminated that contract because of the incompetence or*
8 *misconduct of the provider of health care; and*

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

12 5. *An evidence of coverage for a health care plan subject to*
13 *the provisions of this chapter that is delivered, issued for delivery*
14 *or renewed on or after October 1, 2003, has the legal effect of*
15 *including the coverage required by this section, and any provision*
16 *of the evidence of coverage or renewal thereof that is in conflict*
17 *with this section is void.*

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

20 **Sec. 33.5.** NRS 695G.090 is hereby amended to read as
21 follows:

22 695G.090 1. ~~[The]~~ *Except as otherwise provided in*
23 *subsection 3, the provisions of this chapter apply to each*
24 *organization and insurer that operates as a managed care*
25 *organization and may include, without limitation, an insurer that*
26 *issues a policy of health insurance, an insurer that issues a policy of*
27 *individual or group health insurance, a carrier serving small*
28 *employers, a fraternal benefit society, a hospital or medical service*
29 *corporation and a health maintenance organization.*

30 2. In addition to the provisions of this chapter, each managed
31 care organization shall comply with any other applicable provision
32 of this title.

33 3. *The provisions of subsections 2 to 9, inclusive, of NRS*
34 *695G.270 and section 33 of this act do not apply to a managed*
35 *care organization that provides health care services to recipients*
36 *of Medicaid under the State Plan for Medicaid or insurance*
37 *pursuant to the Children's Health Insurance Program pursuant to*
38 *a contract with the Division of Health Care Financing and Policy*
39 *of the Department of Human Resources. This subsection does not*
40 *exempt a managed care organization from any provision of this*
41 *chapter for services provided pursuant to any other contract.*

42 **Sec. 34.** NRS 695G.270 is hereby amended to read as follows:

43 695G.270 ~~[A managed care organization that establishes a panel~~
44 ~~of providers of health care for the purpose of offering health care~~
45 ~~services pursuant to chapters 689A, 689B, 689C, 695A, 695B, or~~



1 ~~695C of NRS shall not charge a provider of health care a fee to~~
2 ~~include the name of the provider on the panel of providers of health~~
3 ~~care.]~~

4 1. A managed care organization shall not contract with a
5 provider of health care to provide health care to an insured
6 unless:

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

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

11 2. The contract must not contain any provision that
12 authorizes a managed care organization to amend the material
13 terms of the contract or any manual, policy or procedure
14 document which is incorporated in or referenced by the contract
15 unless:

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

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

21 3. The contract must not contain any provision that requires
22 the provider of health care to comply with quality improvement or
23 utilization management programs or procedures unless the
24 requirement is:

25 (a) Fully disclosed to the provider of health care not later than
26 15 business days before the date the contract is executed; or

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

31 4. The contract must not contain any provision that requires
32 or permits access to information relating to an insured in violation
33 of state or federal law concerning the confidentiality of such
34 information.

35 5. The contract must not contain any provision that waives or
36 conflicts with any provision of this section.

37 6. A contract that contains any provision in violation of this
38 section is void.

39 7. The Commissioner shall develop the form required by
40 subsection 2.

41 8. If a managed care organization contracts with a provider
42 of health care to provide health care services pursuant to chapter
43 689A, 689B, 689C, 695A, 695B or 695C of NRS, the managed care
44 organization shall:



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

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

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

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

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

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

27 (c) *If the defendant notifies the judge not later than 15 days*
28 *after receiving a settlement demand described in paragraph (b)*
29 *that the defendant wishes to have independent counsel, the judge*
30 *shall, not later than 15 days after receiving such notice, appoint*
31 *independent counsel to represent the defendant. The fees for any*
32 *independent counsel appointed pursuant to this section must be*
33 *paid by the insurer.*

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

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

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



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

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

6 ***(d) The court enters a judgment in favor of the plaintiff that***
7 ***imposes liability on the defendant for damages in an amount that***
8 ***exceeds the limits of coverage under the policy.***

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

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

17 **Sec. 38.** NRS 287.010 is hereby amended to read as follows:

18 287.010 1. The governing body of any county, school
19 district, municipal corporation, political subdivision, public
20 corporation or other public agency of the State of Nevada may:

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

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

36 (c) Provide group life, accident or health coverage through a
37 self-insurance reserve fund and, where necessary, deduct
38 contributions to the maintenance of the fund from the compensation
39 of officers and employees and pay the deductions into the fund. The
40 money accumulated for this purpose through deductions from
41 the compensation of officers and employees and contributions of the
42 governing body must be maintained as an internal service fund as
43 defined by NRS 354.543. The money must be deposited in a state or
44 national bank or credit union authorized to transact business in the
45 State of Nevada. Any independent administrator of a fund created



1 under this section is subject to the licensing requirements of chapter
2 683A of NRS, and must be a resident of this state. Any contract
3 with an independent administrator must be approved by the
4 Commissioner of Insurance as to the reasonableness of
5 administrative charges in relation to contributions collected and
6 benefits provided. The provisions of NRS 689B.030 to 689B.050,
7 inclusive, and 689B.575 *and section 13 of this act* apply to
8 coverage provided pursuant to this paragraph, except that the
9 provisions of NRS 689B.0359 do not apply to such coverage.

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

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

22 **Sec. 39.** NRS 287.04335 is hereby amended to read as
23 follows:

24 287.04335 If the Board provides health insurance through a
25 plan of self-insurance, it shall comply with the provisions of NRS
26 689B.255, 695G.150, 695G.160, 695G.170 and 695G.200 to
27 695G.230, inclusive, *and section 33 of this act*, in the same manner
28 as an insurer that is licensed pursuant to title 57 of NRS is required
29 to comply with those provisions.

30 **Sec. 39.5.** Chapter 449 of NRS is hereby amended by adding
31 thereto a new section to read as follows:

32 *1. If a hospital in this state establishes a panel of providers of*
33 *health care and makes the panel available for use by an insurer*
34 *when offering health care services pursuant to chapter 616A to*
35 *617, inclusive, 689A, 689B, 689C, 695A, 695B or 695C of NRS,*
36 *the hospital shall not charge the insurer or a provider of health*
37 *care:*

38 *(a) A fee to include the name of the provider on the panel of*
39 *providers of health care; or*

40 *(b) Any other fee related to establishing a provider of health*
41 *care as a provider for the hospital.*

42 *2. If a hospital in this state violates the provisions of*
43 *subsection 1, the hospital shall pay to the insurer or provider of*
44 *health care, as appropriate, an amount that is equal to twice the*
45 *fee charged to the insurer or provider of health care.*



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

3 4. *In addition to any relief granted pursuant to this section, if*
4 *a hospital in this state violates the provisions of subsection 1, and*
5 *if an insurer offering health care services pursuant to chapter*
6 *616A to 617, inclusive, 689A, 689B, 689C, 695A, 695B or 695C of*
7 *NRS has a contract with or otherwise uses the services of the*
8 *hospital, the Division of Insurance of the Department of Business*
9 *and Industry shall require the insurer to suspend its performance*
10 *under the contract or discontinue using those services until the*
11 *hospital, as determined by the Division of Insurance of the*
12 *Department of Business and Industry:*

- 13 (a) *Complies with the provisions of subsection 1; and*
14 (b) *Refunds to all providers of health care any fees obtained by*
15 *the hospital in violation of subsection 1.*

16 **Sec. 40.** Chapter 616B of NRS is hereby amended by adding
17 thereto a new section to read as follows:

18 1. *If an insurer establishes a panel of providers of health care*
19 *for the purpose of offering health care services pursuant to*
20 *chapters 616A to 617, inclusive, of NRS, the insurer shall not*
21 *charge a provider of health care:*

- 22 (a) *A fee to include the name of the provider on the panel of*
23 *providers of health care; or*
24 (b) *Any other fee related to establishing a provider of health*
25 *care as a provider for the insurer.*

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

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

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

- 32 1. Policy of insurance issued or renewed on or after October 1,
33 2003.
34 2. Offer to issue a policy of insurance communicated to the
35 applicant for the policy on or after October 1, 2003.
36 3. Decision with regard to the issuance of a policy of insurance
37 communicated to the applicant for the policy on or after October 1,
38 2003.
39 4. Cause of action that accrues on or after October 1, 2003.

