EXEMPT

(Reprinted with amendments adopted on May 23, 2003)

SECOND REPRINT **A.B. 320**

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; providing for certain defendants in malpractice actions to receive specified information from independent counsel under certain circumstances; prohibiting certain organizations from charging a fee for including the name of a provider of health care on a panel of providers of health care under certain circumstances; prescribing the manner in which a contract with a provider of health care may be modified; 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; authorizing suspension, limitation and revocation of the authority of certain insuring entities for failure to timely pay approved claims or for violating provisions of the Nevada Insurance Code under certain circumstances; 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; requiring certain policies of health insurance and health care plans to provide coverage for continued medical treatment by a provider of health care under certain circumstances; revising the circumstances under which the Commissioner of Insurance may suspend or revoke a certificate of authority issued to a health maintenance organization; requiring certain public organizations that provide health insurance to provide coverage for continued medical treatment by a provider of health care under certain circumstances; and providing other matters properly relating thereto.

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

Section 1. Chapter 679A of NRS is hereby amended by adding thereto a new section to read as follows:

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

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

(b) Any other fee related to establishing a provider of health care as a provider for the organization.

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

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

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

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

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

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

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

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

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

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

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

2. If the administrator requires additional information to determine whether to approve or deny the claim, he shall notify the claimant of his request for the additional information within 20 days after he receives the claim. The administrator shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The administrator shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the administrator shall pay the claim within 30 days after he receives the additional information. If the approved claim is not paid within that period, the administrator shall pay interest on the claim in the manner prescribed in subsection 1.

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

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

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

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

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

8. If the Commissioner determines that an administrator is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the administrator to pay an administrative fine in an amount to be determined by the Commissioner. ***Upon a second or subsequent determination that an administrator is not in substantial compliance with the requirements set forth in this section, the Commissioner may suspend or revoke the certificate of registration of the administrator.***

Sec. 4. (Deleted by amendment.)

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

If a filing made with the Commissioner pursuant to paragraph (a) of subsection 1 of NRS 686B.070 pertains to insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of his professional duty toward a patient, any interested person, and any association of persons or organization whose members may be affected, may intervene as a matter of right in any hearing or other proceeding conducted to determine whether the applicable rate or proposed increase thereto:

1. Complies with the standards set forth in NRS 686B.050 and subsection 2 of NRS 686B.070.

2. Should be approved or disapproved.

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

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

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

(a) A joint underwriting association;

(b) An actuarial or legal consultant; or

(c) An employee or manager of an insurer.

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

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

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

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

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

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

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

686B.040 ~~[The]~~

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

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

Sec. 8. NRS 686B.070 is hereby amended to read as follows:

686B.070 ***1.*** Every authorized insurer and every rate service organization licensed under NRS ~~[686B.130]~~ ***686B.140*** which has been designated by any insurer for the filing of rates under subsection 2 of NRS 686B.090 shall file with the Commissioner all:

~~[1.]~~ ***(a)*** Rates and proposed increases thereto;

~~[2.]~~ ***(b)*** Forms of policies to which the rates apply;

~~[3.]~~ ***(c)*** Supplementary rate information; and

~~[4.]~~ ***(d)*** Changes and amendments thereof,

made by it for use in this state.

2. If an insurer makes a filing for a proposed increase in a rate for insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of his professional duty toward a patient, the insurer shall not include in the filing any component that is directly or indirectly related to the following:

(a) Capital losses, diminished cash flow from any dividends, interest or other investment returns, or any other financial loss that is materially outside of the claims experience of the professional liability insurance industry, as determined by the Commissioner.

(b) Losses that are the result of any criminal or fraudulent activities of a director, officer or employee of the insurer.

If the Commissioner determines that a filing includes any such component, the Commissioner shall, pursuant to NRS 686B.110, disapprove the proposed increase, in whole or in part, to the extent that the proposed increase relies upon such a component.

Sec. 8.3. NRS 686B.090 is hereby amended to read as follows:

686B.090 1. An insurer shall establish rates and supplementary rate information for any market segment based on the factors in NRS 686B.060. If an insurer has insufficient creditable loss experience, it may use rates and supplementary rate information prepared by a rate service organization, with modification for its own expense and loss experience.

2. An insurer may discharge its obligation under ***subsection 1 of*** NRS 686B.070 by giving notice to the Commissioner that it uses rates and supplementary rate information prepared by a designated rate service organization, with such information about modifications thereof as are necessary fully to inform the Commissioner. The insurer's rates and supplementary rate information shall be deemed those filed from time to time by the rate service organization, including any amendments thereto as filed, subject ~~[, however,]~~ to the modifications filed by the insurer.

Sec. 8.7. NRS 686B.110 is hereby amended to read as follows:

686B.110 1. The Commissioner shall consider each proposed increase or decrease in the rate of any kind or line of insurance or subdivision thereof filed with him pursuant to ***subsection 1 of*** NRS 686B.070. If the Commissioner finds that a proposed increase will result in a rate which is not in compliance with NRS 686B.050 ~~[,]~~ ***or subsection 2 of NRS 686B.070,*** he shall disapprove the proposal. The Commissioner shall approve or disapprove each proposal no later than 60 days after it is determined by him to be complete pursuant to subsection 4. If the Commissioner fails to approve or disapprove the proposal within that period, the proposal shall be deemed approved.

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

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

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

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

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

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

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

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

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

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

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

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

(b) The provider of health care is entitled to receive reimbursement from the insurer for the medical treatment he provides to the insured pursuant to this section, if the provider of health care agrees:

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

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

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

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

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

(1) The date of delivery; or

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

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

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

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

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

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

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

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

2. An insurer shall not contract with a provider of health care to provide health care to an insured unless the insurer uses the form prescribed by the Commissioner pursuant to section 40.3 of this act to obtain any information related to the credentials of the provider of health care.

3. A contract between an insurer and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the insurer upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

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

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

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

5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 11. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~[.]~~ ***, and section 9 of this act.***

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

689A.410 1. Except as otherwise provided in subsection 2, an insurer shall approve or deny a claim relating to a policy of health insurance within 30 days after the insurer receives the claim. If the claim is approved, the insurer shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the insurer shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

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

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

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

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

6. The payment of interest provided for in this section for the late payment of an approved claim may be waived only if the

payment was delayed because of an act of God or another cause beyond the control of the insurer.

7. The Commissioner may require an insurer to provide evidence which demonstrates that the insurer has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

8. If the Commissioner determines that an insurer is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the insurer to pay an administrative fine in an amount to be determined by the Commissioner. ***Upon a second or subsequent determination that an insurer is not in substantial compliance with the requirements set forth in this section, the Commissioner may suspend or revoke the certificate of authority of the insurer.***

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

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

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

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

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

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

(b) The provider of health care is entitled to receive reimbursement from the insurer for the medical treatment he provides to the insured pursuant to this section, if the provider of health care agrees:

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

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

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

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

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

(1) The date of delivery; or

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

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

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

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

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

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

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

689B.015 ***1.*** An insurer that issues a policy of group health insurance shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the insurer to its insureds.

2. An insurer specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the insurer uses the form prescribed by the Commissioner pursuant to section 40.3 of this act to obtain any information related to the credentials of the provider of health care.

3. A contract between an insurer specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the insurer upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes

effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If an insurer specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the insurer shall:

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

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

5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

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

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

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

3. An insurer shall not request a claimant to resubmit information that the claimant has already provided to the insurer, unless the insurer provides a legitimate reason for the request and

the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

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

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

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

7. The Commissioner may require an insurer to provide evidence which demonstrates that the insurer has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

8. If the Commissioner determines that an insurer is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the insurer to pay an administrative fine in an amount to be determined by the Commissioner. ***Upon a second or subsequent determination that an insurer is not in substantial compliance with the requirements set forth in this section, the Commissioner may suspend or revoke the certificate of authority of the insurer.***

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

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

2. A carrier specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the carrier uses the form prescribed by the Commissioner pursuant to section 40.3 of this act to obtain any information related to the credentials of the provider of health care.

3. A contract between a carrier specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the carrier upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification

must not become effective unless agreed to by both parties as described in paragraph (a).

4. If a carrier specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the carrier shall:

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

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

5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

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

689C.485 1. Except as otherwise provided in subsection 2, a carrier serving small employers and a carrier that offers a contract to a voluntary purchasing group shall approve or deny a claim relating to a policy of health insurance within 30 days after the carrier receives the claim. If the claim is approved, the carrier shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the carrier shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

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

3. A carrier shall not request a claimant to resubmit information that the claimant has already provided to the carrier, unless the carrier provides a legitimate reason for the request and the

purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

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

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

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

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

8. If the Commissioner determines that a carrier is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the carrier to pay an administrative fine in an amount to be determined by the Commissioner. ***Upon a second or subsequent determination that a carrier is not in substantial compliance with the requirements set forth in this section, the Commissioner may suspend or revoke the certificate of authority of the carrier.***

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

Sec. 19. ***If a settlement or judgment exceeds the limits of the coverage provided by a policy of insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of his professional duty toward a patient, the Commissioner shall review the settlement or judgment. If the Commissioner finds, after notice and a hearing, or upon waiver of hearing by the insurer, that the insurer who issued the policy violated any provision of this code with regard to the settlement or judgment, any combination of such settlements or judgments, or any proceedings related thereto, the Commissioner may suspend, limit or revoke the insurer's certificate of authority.***

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

Sec. 21. *If an insurer, for a policy of insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of his professional duty toward a patient, sets the premium for the policy for the practitioner at a rate that is higher than the standard rate of the insurer for the applicable type of policy and specialty of the practitioner, the insurer shall, upon the request of the practitioner, disclose the reasons the insurer set the premium for the policy at the higher rate.*

Sec. 22. *1. Except as otherwise provided in this section, if an insurer intends to cancel, terminate or otherwise not renew all policies of professional liability insurance that it has issued to any class, type or specialty of practitioner licensed pursuant to chapter 630, 631 or 633 of NRS, the insurer must provide 120 days' notice of its intended action to the Commissioner and the practitioners before its intended action becomes effective.*

2. If an insurer intends to cancel, terminate or otherwise not renew a specific policy of professional liability insurance that it has issued to a practitioner who is practicing in one or more of the essential medical specialties designated by the Commissioner:

(a) The insurer must provide 120 days' notice to the practitioner before its intended action becomes effective; and

(b) The Commissioner may require the insurer to delay its intended action for a period of not more than 60 days if the Commissioner determines that a replacement policy is not readily available to the practitioner.

3. If an insurer intends to cancel, terminate or otherwise not renew all policies of professional liability insurance that it has issued to practitioners who are practicing in one or more of the essential medical specialties designated by the Commissioner:

(a) The insurer must provide 120 days' notice of its intended action to the Commissioner and the practitioners before its intended action becomes effective; and

(b) The Commissioner may require the insurer to delay its intended action for a period of not more than 60 days if the Commissioner determines that replacement policies are not readily available to the practitioners.

4. On or before April 1 of each year, the Commissioner shall:

(a) Determine whether there are any medical specialties in this state which are essential as a matter of public policy and which must be protected pursuant to this section from certain adverse actions relating to professional liability insurance that may impair the availability of those essential medical specialties to the residents of this state; and

(b) Make a list containing the essential medical specialties designated by the Commissioner and provide the list to each insurer that issues policies of professional liability insurance to practitioners who are practicing in one or more of the essential medical specialties.

5. The Commissioner may adopt any regulations that are necessary to carry out the provisions of this section.

6. Until the Commissioner determines which, if any, medical specialties are to be designated as essential medical specialties, the following medical specialties shall be deemed to be essential medical specialties for the purposes of this section:

(a) Emergency medicine.

(b) Neurosurgery.

(c) Obstetrics and gynecology.

(d) Orthopedic surgery.

(e) Pediatrics.

(f) Trauma surgery.

7. As used in this section, "professional liability insurance" means insurance covering the liability of a practitioner for a breach of his professional duty toward a patient.

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

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

2. A society shall not contract with a provider of health care to provide health care to an insured unless the society uses the form prescribed by the Commissioner pursuant to section 40.3 of this act to obtain any information related to the credentials of the provider of health care.

3. A contract between a society and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the society upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

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

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

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

5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

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

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

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

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

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

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

(b) The provider of health care is entitled to receive reimbursement from the hospital or medical service corporation for the medical treatment he provides to the insured pursuant to this section, if the provider of health care agrees:

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

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

provider of health care still under contract with the hospital or medical service corporation.

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

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

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

(1) The date of delivery; or

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

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

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

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

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

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

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

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

2. A corporation specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the corporation uses the form prescribed by the Commissioner pursuant to section 40.3 of this act to obtain any information related to the credentials of the provider of health care.

3. A contract between a corporation specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the corporation upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes

effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If a corporation specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the corporation shall:

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

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

5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

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

695B.2505 1. Except as otherwise provided in subsection 2, a corporation subject to the provisions of this chapter shall approve or deny a claim relating to a contract for dental, hospital or medical services within 30 days after the corporation receives the claim. If the claim is approved, the corporation shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the corporation shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

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

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

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

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

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

7. The Commissioner may require a corporation to provide evidence which demonstrates that the corporation has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

8. If the Commissioner determines that a corporation is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the corporation to pay an administrative fine in an amount to be determined by the Commissioner. ***Upon a second or subsequent determination that a corporation is not in substantial compliance with the requirements set forth in this section, the Commissioner may suspend or revoke the certificate of authority of the corporation.***

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

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

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

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

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

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

(b) The provider of health care is entitled to receive reimbursement from the health maintenance organization for the medical treatment he provides to the insured pursuant to this section, if the provider of health care agrees:

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

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

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

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

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

(1) The date of delivery; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. A health maintenance organization shall not contract with a provider of health care to provide health care to an insured unless the health maintenance organization uses the form prescribed by the Commissioner pursuant to section 40.3 of this act to obtain any information related to the credentials of the provider of health care.

2. A contract between a health maintenance organization and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the health maintenance organization upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

3. If a health maintenance organization contracts with a provider of health care to provide health care to an enrollee, the health maintenance organization shall:

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

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

4. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

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

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

must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

2. If the health maintenance organization requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for the additional information within 20 days after it receives the claim. The health maintenance organization shall notify the provider of health care services of all the specific reasons for the delay in approving or denying the claim. The health maintenance organization shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the health maintenance organization shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the health maintenance organization shall pay interest on the claim in the manner prescribed in subsection 1.

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

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

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

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

7. The Commissioner may require a health maintenance organization to provide evidence which demonstrates that the health maintenance organization has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

8. If the Commissioner determines that a health maintenance organization is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the health maintenance organization to pay an administrative fine in an amount to be determined by the Commissioner. ***Upon a second or subsequent determination that a health maintenance organization is not in substantial compliance with the requirements set forth in this section, the Commissioner may suspend or revoke the certificate of authority of the health maintenance organization.***

Sec. 32. NRS 695C.330 is hereby amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The provider of health care is entitled to receive reimbursement from the managed care organization for the medical treatment he provides to the insured pursuant to this section, if the provider of health care agrees:

(1) To provide medical treatment under the terms of the contract between the provider of health care and the managed care organization with regard to the insured, including, without limitation, the rates of payment for providing medical service, as

those terms existed before the termination of the contract between the provider of health care and the managed care organization; and

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

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

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

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

(1) The date of delivery; or

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

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

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

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

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

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

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

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

2. In addition to the provisions of this chapter, each managed care organization shall comply with ~~[any]~~ ***:***

(a) The provisions of chapter 686A of NRS, including all obligations and remedies set forth therein; and

(b) Any other applicable provision of this title.

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

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

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

1. A managed care organization shall not contract with a provider of health care to provide health care to an insured unless the managed care organization uses the form prescribed by the Commissioner pursuant to section 40.3 of this act to obtain any information related to the credentials of the provider of health care.

2. A contract between a managed care organization and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the managed care organization upon giving to the provider 30 days' written notice of the modification. If the provider fails to object in writing to the modification within the 30-day period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the 30-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

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

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

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

4. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 35. Chapter 41A of NRS is hereby amended by adding thereto a new section to read as follows:

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

(a) At any settlement conference, the judge may recommend that the action be settled for the limits of the policy of insurance.

(b) If the judge makes the recommendation described in paragraph (a), the defendant is entitled to obtain from independent counsel an opinion letter explaining the rights of, obligations of and potential consequences to the defendant with regard to the recommendation. The insurer shall pay the independent counsel to provide the opinion letter described in this paragraph, except that the insurer is not required to pay more than $1,500 to the independent counsel to provide the opinion letter.

2. The section does not:

(a) Prohibit the plaintiff from making any offer of settlement.

(b) Require an insurer to provide or pay for independent counsel for a defendant except as expressly provided in this section.

Secs. 36 and 37. (Deleted by amendment.)

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

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

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

(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized

to transact the business of such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this state. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 689B.030 to 689B.050, inclusive, and 689B.575 ***and section 13 of this act*** apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0359 do not apply to such coverage.

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

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

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

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

Sec. 39.5. (Deleted by amendment.)

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

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

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

(b) Any other fee related to establishing a provider of health care as a provider for the insurer.

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

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

Sec. 40.3. Chapter 629 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 2, the Commissioner of Insurance shall develop, prescribe for use and make available a single, standardized form for use by insurers, carriers, societies, corporations, health maintenance organizations and managed care organizations in obtaining any information related to the credentials of a provider of health care.

2. The provisions of subsection 1 do not prohibit the Commissioner of Insurance from developing, prescribing for use and making available:

(a) Appropriate variations of the form described in that subsection for use in different geographical regions of this state.

(b) Addenda or supplements to the form described in that subsection to address, until such time as a new form may be developed, prescribed for use and made available, any requirements newly imposed by the Federal Government, the State or one of its agencies, or a body that accredits hospitals, medical facilities or health care plans.

3. With respect to the form described in subsection 1, the Commissioner of Insurance shall:

(a) Hold public hearings to seek input regarding the development of the form;

(b) Develop the form in consideration of the input received pursuant to paragraph (a);

(c) Ensure that the form is developed in such a manner as to accommodate and reflect the different types of credentials applicable to different classes of providers of health care;

(d) Ensure that the form is developed in such a manner as to reflect standards of accreditation adopted by national

organizations which accredit hospitals, medical facilities and health care plans; and

(e) Ensure that the form is developed to be used efficiently and is developed to be neither unduly long nor unduly voluminous.

4. As used in this section:

(a) "Carrier" has the meaning ascribed to it in NRS 689C.025.

(b) "Corporation" means a corporation operating pursuant to the provisions of chapter 695B of NRS.

(c) "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

(d) "Insurer" means:

(1) An insurer that issues policies of individual health insurance in accordance with chapter 689A of NRS; and

(2) An insurer that issues policies of group health insurance in accordance with chapter 689B of NRS.

(e) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

(f) "Provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

(g) "Society" has the meaning ascribed to it in NRS 695A.044.

Sec. 40.7. 1. The Commissioner of Insurance shall develop, prescribe for use and make available the form described in section 40.3 of this act on or before July 1, 2004.

2. Notwithstanding the provisions of sections 10, 14, 16, 23, 25, 30 and 34 of this act, an insurer, carrier, society, corporation, health maintenance organization and managed care organization is not required to use the form described in section 40.3 of this act until the earlier of:

(a) The date by which the Commissioner of Insurance develops, prescribes for use and makes available that form; or

(b) July 1, 2004.

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

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

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

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

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

Sec. 42. 1. This section and sections 40.3 and 40.7 of this act become effective upon passage and approval.

2. Sections 1 to 40, inclusive, and 41 of this act become effective on October 1, 2003.

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