ASSEMBLY BILL NO. 372–ASSEMBLYWOMAN SPIEGEL

MARCH 20, 2019

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions governing insurance coverage of emergency medical services. (BDR 57-940)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Yes.

CONTAINS UNFUNDED MANDATE (§ 13)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

~

EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets **[**~~omitted material~~**]** is material to be omitted.

AN ACT relating to insurance; requiring a health carrier to cover medically necessary emergency services; requiring health carriers, under certain circumstances, to treat the deductible, copayment or coinsurance paid by the covered person for medically necessary emergency services as if the expenses were paid to a participating health care provider for the purposes of determining certain annual maximum payments; prohibiting health carriers from retroactively denying a claim for emergency medical services under certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing federal law requires a group or individual health plan to cover emergency medical services necessary to stabilize a patient: (1) without a need for prior authorization; and (2) regardless of whether the provider who furnishes the services participates in the network of providers under contract to provide services under the plan. (42 U.S.C. § 300gg-19a) This bill enacts similar provisions in Nevada law. Specifically, **sections 2, 4, 5, 7-10, 12 and 13** of this bill prohibit an insurer, including a governmental entity providing insurance for employees and a managed care organization providing coverage to recipients of Medicaid, from: (1) requiring preauthorization for stabilizing emergency medical services; or (2) refusing to cover stabilizing emergency medical services if a prudent layperson would have believed at the time that the services were provided that the services were medically necessary. **Sections 2, 4, 5, 7-10, 12 and 13** also require an insurer to pay claims for stabilizing emergency medical services based on the symptoms of the insured if a prudent layperson would have believed at the time that the services

were provided that the services were medically necessary. **Sections 2, 4, 5, 7-10, 12 and 13** additionally prohibit an insurer from imposing a higher copayment or coinsurance for stabilizing emergency medical services provided by an out-of-network facility or provider than for the same services provided by a participating facility or provider if a prudent layperson would have believed that the delay caused by obtaining the services from a participating facility or provider would worsen the emergency. **Sections 2, 4, 5, 7-10, 12 and 13** require an insurer to treat any deductible, copayment or coinsurance paid for stabilizing emergency medical services provided out-of-network in the same manner as if the services were provided in-network for the purposes of determining the annual maximum deductible, copayment or coinsurance. **Sections 2, 4, 5, 7-10, 12 and 13** additionally prohibit an insurer from retracting prior authorization for emergency medical services after the services have been provided. **Sections 1, 3, 6 and 11** of this bill make conforming changes.

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

Section 1. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0413, 689A.044, 689A.0445, 689B.031, 689B.0313, 689B.0317, 689B.0374, 695B.1912, 695B.1914, 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1745, 695C.1751, 695G.170, 695G.171 and 695G.177 ~~[,]~~ ***and sections 2, 4 to 9, inclusive, and 12 of this act,*** any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:

(a) File its procedure for obtaining approval of care pursuant to this section for approval by the Commissioner; and

(b) Respond to any request for approval by the insured or member pursuant to this section within 20 days after it receives the request.

2. The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

Sec. 2. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer that issues a policy of health insurance:

(a) Shall not require preauthorization for stabilizing emergency services provided at a participating or out-of-network facility or provider; and

(b) If a prudent layperson would have believed at the time that stabilizing emergency services were provided that the services were medically necessary:

(1) Shall not refuse to cover the stabilizing emergency services; and

(2) Shall pay claims for the stabilizing emergency services based on the symptoms of the insured rather than the condition for which the insured was diagnosed.

2. An insurer that issues a network plan:

(a) Shall not impose a higher copayment or coinsurance for stabilizing emergency services provided by an out-of-network facility or provider than for the same services provided by a participating facility or provider if a prudent layperson would have believed that the delay caused by obtaining the services from a participating facility or provider would worsen the emergency.

(b) Shall treat any deductible, copayment or coinsurance paid by an insured to an out-of-network facility or provider of health care for stabilizing emergency services as if the deductible, copayment or coinsurance were paid to a participating provider of health care for the purposes of determining the annual maximum deductible, copayment or coinsurance that the insured must pay pursuant to the network plan.

3. An insurer shall not retract prior authorization for emergency medical services after the services have been provided unless the authorization was based on a material misrepresentation about the condition of the insured made by a provider of the emergency medical services or the insured.

4. As used in this section:

(a) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(b) "Medically necessary" means the absence of immediate medical attention may result in:

(1) Serious jeopardy to the health of an insured;

(2) Serious jeopardy to the health of an unborn child of an insured;

(3) Serious impairment of a bodily function; or

(4) Serious dysfunction of any bodily organ or part.

(c) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(d) "Out-of-network facility or provider" means a medical facility or provider of health care who is not a participating

medical facility or provider of health care in the applicable network plan.

(e) "Participating facility or provider" means a medical facility or provider of health care who participates in the applicable network plan.

(f) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(g) "Prudent layperson" means a person who:

(1) Is not a provider of health care;

(2) Possesses an average knowledge of health and medicine; and

(3) Is acting reasonably under the circumstances.

(h) "Stabilizing emergency services" means emergency medical services necessary to screen and stabilize an insured.

5. A policy of health insurance subject to the provisions of this section that is delivered, issued for delivery or renewed on or after July 1, 2019, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

Sec. 3. 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 2 of this act.***

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

1. An insurer that issues a policy of group health insurance:

(a) Shall not require preauthorization for stabilizing emergency services provided at a participating or out-of-network facility or provider; and

(b) If a prudent layperson would have believed at the time that stabilizing emergency services were provided that the services were medically necessary:

(1) Shall not refuse to cover the stabilizing emergency services; and

(2) Shall pay claims for the stabilizing emergency services based on the symptoms of the insured rather than the condition for which the insured was diagnosed.

2. An insurer that issues a network plan:

(a) Shall not impose a higher copayment or coinsurance for stabilizing emergency services provided by an out-of-network facility or provider than for the same services provided by a

participating facility or provider if a prudent layperson would have believed that the delay caused by obtaining the services from a participating facility or provider would worsen the emergency.

(b) Shall treat any deductible, copayment or coinsurance paid by an insured to an out-of-network facility or provider of health care for stabilizing emergency services as if the deductible, copayment or coinsurance were paid to a participating provider of health care for the purposes of determining the annual maximum deductible, copayment or coinsurance that the insured must pay pursuant to the network plan.

3. An insurer shall not retract prior authorization for emergency medical services after the services have been provided unless the authorization was based on a material misrepresentation about the condition of the insured made by a provider of the emergency medical services or the insured.

4. As used in this section:

(a) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(b) "Medically necessary" means the absence of immediate medical attention may result in:

(1) Serious jeopardy to the health of an insured;

(2) Serious jeopardy to the health of an unborn child of an insured;

(3) Serious impairment of a bodily function; or

(4) Serious dysfunction of any bodily organ or part.

(c) "Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(d) "Out-of-network facility or provider" means a medical facility or provider of health care who is not a participating medical facility or provider of health care in the applicable network plan.

(e) "Participating facility or provider" means a medical facility or provider of health care who participates in the applicable network plan.

(f) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(g) "Prudent layperson" means a person who:

(1) Is not a provider of health care;

(2) Possesses an average knowledge of health and medicine; and

(3) Is acting reasonably under the circumstances.

(h) "Stabilizing emergency services" means emergency medical services necessary to screen and stabilize an insured.

5. A policy of group health insurance subject to the provisions of this section that is delivered, issued for delivery or renewed on or after July 1, 2019, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

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

1. A carrier that issues a health benefit plan:

(a) Shall not require preauthorization for stabilizing emergency services provided at a participating or out-of-network facility or provider; and

(b) If a prudent layperson would have believed at the time that stabilizing emergency services were provided that the services were medically necessary:

(1) Shall not refuse to cover the stabilizing emergency services; and

(2) Shall pay claims for the stabilizing emergency services based on the symptoms of the insured rather than the condition for which the insured was diagnosed.

2. An carrier that issues a network plan:

(a) Shall not impose a higher copayment or coinsurance for stabilizing emergency services provided by an out-of-network facility or provider than for the same services provided by a participating facility or provider if a prudent layperson would have believed that the delay caused by obtaining the services from a participating facility or provider would worsen the emergency.

(b) Shall treat any deductible, copayment or coinsurance paid by an insured to an out-of-network facility or provider of health care for stabilizing emergency services as if the deductible, copayment or coinsurance were paid to a participating provider of health care for the purposes of determining the annual maximum deductible, copayment or coinsurance that the insured must pay pursuant to the network plan.

3. A carrier shall not retract prior authorization for emergency medical services after the services have been provided unless the authorization was based on a material misrepresentation about the condition of the insured made by a provider of the emergency medical services or the insured.

4. As used in this section:

(a) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(b) "Medically necessary" means the absence of immediate medical attention may result in:

(1) Serious jeopardy to the health of an insured;

(2) Serious jeopardy to the health of an unborn child of an insured;

(3) Serious impairment of a bodily function; or

(4) Serious dysfunction of any bodily organ or part.

(c) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(d) "Out-of-network facility or provider" means a medical facility or provider of health care who is not a participating medical facility or provider of health care in the applicable network plan.

(e) "Participating facility or provider" means a medical facility or provider of health care who participates in the applicable network plan.

(f) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(g) "Prudent layperson" means a person who:

(1) Is not a provider of health care;

(2) Possesses an average knowledge of health and medicine; and

(3) Is acting reasonably under the circumstances.

(h) "Stabilizing emergency services" means emergency medical services necessary to screen and stabilize an insured.

5. A health benefit plan subject to the provisions of this section that is delivered, issued for delivery or renewed on or after July 1, 2019, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

Sec. 6. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, ***and section 5 of this act*** to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 7. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An society that issues a benefit contract:

(a) Shall not require preauthorization for stabilizing emergency services provided at a participating or out-of-network facility or provider; and

(b) If a prudent layperson would have believed at the time that stabilizing emergency services were provided that the services were medically necessary:

(1) Shall not refuse to cover the stabilizing emergency services; and

(2) Shall pay claims for the stabilizing emergency services based on the symptoms of the insured rather than the condition for which the insured was diagnosed.

2. A society that issues a network plan:

(a) Shall not impose a higher copayment or coinsurance for stabilizing emergency services provided by an out-of-network facility or provider than for the same services provided by a participating facility or provider if a prudent layperson would have believed that the delay caused by obtaining the services from a participating facility or provider would worsen the emergency.

(b) Shall treat any deductible, copayment or coinsurance paid by an insured to an out-of-network facility or provider of health care for stabilizing emergency services as if the deductible, copayment or coinsurance were paid to a participating provider of health care for the purposes of determining the annual maximum deductible, copayment or coinsurance that the insured must pay pursuant to the network plan.

3. A society shall not retract prior authorization for emergency medical services after the services have been provided unless the authorization was based on a material misrepresentation about the condition of the insured made by a provider of the emergency medical services or the insured.

4. As used in this section:

(a) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(b) "Medically necessary" means the absence of immediate medical attention may result in:

(1) Serious jeopardy to the health of an insured;

(2) Serious jeopardy to the health of an unborn child of an insured;

(3) Serious impairment of a bodily function; or

(4) Serious dysfunction of any bodily organ or part.

(c) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the society. The term does not include an arrangement for the financing of premiums.

(d) "Out-of-network facility or provider" means a medical facility or provider of health care who is not a participating

medical facility or provider of health care in the applicable network plan.

(e) "Participating facility or provider" means a medical facility or provider of health care who participates in the applicable network plan.

(f) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(g) "Prudent layperson" means a person who:

(1) Is not a provider of health care;

(2) Possesses an average knowledge of health and medicine; and

(3) Is acting reasonably under the circumstances.

(h) "Stabilizing emergency services" means emergency medical services necessary to screen and stabilize an insured.

5. A benefit contract subject to the provisions of this section that is delivered, issued for delivery or renewed on or after July 1, 2019, has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.

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

1. A hospital or medical service corporation that issues a policy of health insurance:

(a) Shall not require preauthorization for stabilizing emergency services provided at a participating or out-of-network facility or provider; and

(b) If a prudent layperson would have believed at the time that stabilizing emergency services were provided that the services were medically necessary:

(1) Shall not refuse to cover the stabilizing emergency services; and

(2) Shall pay claims for the stabilizing emergency services based on the symptoms of the insured rather than the condition for which the insured was diagnosed.

2. A hospital or medical service corporation that issues a network plan:

(a) Shall not impose a higher copayment or coinsurance for stabilizing emergency services provided by an out-of-network facility or provider than for the same services provided by a participating facility or provider if a prudent layperson would have believed that the delay caused by obtaining the services from a participating facility or provider would worsen the emergency.

(b) Shall treat any deductible, copayment or coinsurance paid by an insured to an out-of-network facility or provider of health care for stabilizing emergency services as if the deductible,

copayment or coinsurance were paid to a participating provider of health care for the purposes of determining the annual maximum deductible, copayment or coinsurance that the insured must pay pursuant to the network plan.

3. A hospital or medical service corporation shall not retract prior authorization for emergency medical services after the services have been provided unless the authorization was based on a material misrepresentation about the condition of the insured made by a provider of the emergency medical services or the insured.

4. As used in this section:

(a) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(b) "Medically necessary" means the absence of immediate medical attention may result in:

(1) Serious jeopardy to the health of an insured;

(2) Serious jeopardy to the health of an unborn child of an insured;

(3) Serious impairment of a bodily function; or

(4) Serious dysfunction of any bodily organ or part.

(c) "Network plan" means a policy of health insurance offered by a hospital or medical service corporation under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the hospital or medical service corporation. The term does not include an arrangement for the financing of premiums.

(d) "Out-of-network facility or provider" means a medical facility or provider of health care who is not a participating medical facility or provider of health care in the applicable network plan.

(e) "Participating facility or provider" means a medical facility or provider of health care who participates in the applicable network plan.

(f) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(g) "Prudent layperson" means a person who:

(1) Is not a provider of health care;

(2) Possesses an average knowledge of health and medicine; and

(3) Is acting reasonably under the circumstances.

(h) "Stabilizing emergency services" means emergency medical services necessary to screen and stabilize an insured.

5. A policy of health insurance subject to the provisions of this section that is delivered, issued for delivery or renewed on or

after July 1, 2019, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

Sec. 9. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health maintenance organization that offers or issues a health care plan:

(a) Shall not require preauthorization for stabilizing emergency services provided at a participating or out-of-network facility or provider; and

(b) If a prudent layperson would have believed at the time that stabilizing emergency services were provided that the services were medically necessary:

(1) Shall not refuse to cover the stabilizing emergency services; and

(2) Shall pay claims for the stabilizing emergency services based on the symptoms of the enrollee rather than the condition for which the enrollee was diagnosed.

2. A health maintenance organization that issues a network plan:

(a) Shall not impose a higher copayment or coinsurance for stabilizing emergency services provided by an out-of-network facility or provider than for the same services provided by a participating facility or provider if a prudent layperson would have believed that the delay caused by obtaining the services from a participating facility or provider would worsen the emergency.

(b) Shall treat any deductible, copayment or coinsurance paid by an enrollee to an out-of-network facility or provider of health care for stabilizing emergency services as if the deductible, copayment or coinsurance were paid to a participating provider of health care for the purposes of determining the annual maximum deductible, copayment or coinsurance that the enrollee must pay pursuant to the network plan.

3. A health maintenance organization shall not retract prior authorization for emergency medical services after the services have been provided unless the authorization was based on a material misrepresentation about the condition of the enrollee made by a provider of the emergency medical services or the enrollee.

4. As used in this section:

(a) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(b) "Medically necessary" means the absence of immediate medical attention may result in:

(1) Serious jeopardy to the health of an enrollee;

(2) Serious jeopardy to the health of an unborn child of an enrollee;

(3) Serious impairment of a bodily function; or

(4) Serious dysfunction of any bodily organ or part.

(c) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(d) "Out-of-network facility or provider" means a medical facility or provider of health care who is not a participating medical facility or provider of health care in the applicable network plan.

(e) "Participating facility or provider" means a medical facility or provider of health care who participates in the applicable network plan.

(f) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(g) "Prudent layperson" means a person who:

(1) Is not a provider of health care;

(2) Possesses an average knowledge of health and medicine; and

(3) Is acting reasonably under the circumstances.

(h) "Stabilizing emergency services" means emergency medical services necessary to screen and stabilize an enrollee.

5. A health care plan subject to the provisions of this section that is delivered, issued for delivery or renewed on or after July 1, 2019, has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

Sec. 10. 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.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. 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 to 695C.1698, inclusive, 695C.1708, 695C.1731, 695C.17345, 695C.1735, 695C.1745 and 695C.1757 ***and section 9 of this act*** apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 11. 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 the Commissioner 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.1691 to 695C.200, inclusive, ***and section 9 of this act*** or 695C.207;

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

(d) The Commissioner certifies that the health maintenance organization:

(1) Does not meet the requirements of subsection 1 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 required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(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 creditors or to the general public;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; 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 the Commissioner 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. 12. NRS 695G.170 is hereby amended to read as follows:

695G.170 1. Each managed care organization ***that offers or issues a health care plan*** shall ~~[provide]~~ ***:***

(a) Include in the health care plan coverage ~~[for medically]~~ ***of*** necessary emergency services provided at ~~[any hospital.~~

~~2. A managed care organization shall]~~ ***a participating or out-of-network facility or provider;***

(b) Shall not require prior authorization for ~~[medically necessary]~~ ***stabilizing*** emergency services ~~[.~~

~~3.]~~ ***; and***

(c) If a prudent layperson would have believed at the time that stabilizing emergency services were provided that the services were medically necessary:

(1) Shall not refuse to cover the stabilizing emergency services; and

(2) Shall pay claims for the stabilizing emergency services based on the symptoms of the insured rather than the condition for which the insured was diagnosed.

2. An managed care organization that issues a network plan:

(a) Shall not impose a higher copayment or coinsurance for stabilizing emergency services provided by an out-of-network facility or provider than for the same services provided by a participating facility or provider if a prudent layperson would have believed that the delay caused by obtaining the services from a participating facility or provider would worsen the emergency.

(b) Shall treat any deductible, copayment or coinsurance paid by an insured to an out-of-network facility or provider of health care for stabilizing emergency services as if the deductible, copayment or coinsurance were paid to a participating provider of health care for the purposes of determining the annual maximum deductible, copayment or coinsurance that the insured must pay pursuant to the network plan.

3. A managed care organization shall not retract prior authorization for emergency medical services after the services have been provided unless the authorization was based on a material misrepresentation about the condition of the insured made by a provider of the emergency medical services or the insured.

4. As used in this section ~~[, "medically]~~ ***:***

(a) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(b) "Medically necessary ~~[emergency services"]~~ ***"*** means ~~[health care services that are provided to an insured by a provider of health care after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that]~~ the absence of immediate medical attention ~~[could]~~ ***may*** result in:

~~[(a)]~~ ***(1)*** Serious jeopardy to the health of an insured;

~~[~~(b)~~]~~ ***(2)*** Serious jeopardy to the health of an unborn child ~~[.]~~ ***of an insured;***

~~[~~(c)~~]~~ ***(3)*** Serious impairment of a bodily function; or

~~[~~(d)~~]~~ ***(4)*** Serious dysfunction of any bodily organ or part.

~~[~~4.~~]~~ ***5.*** A health care plan subject to the provisions of this section that is delivered, issued for delivery or renewed on or after ~~[~~October~~]~~ ***July*** 1, ~~[~~1999,~~]~~ ***2019,*** has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

Sec. 13. 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 local governmental 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 687B.408, 689B.030 to

689B.050, inclusive, and 689B.287 ***and section 4 of this act*** apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378 and 689B.03785 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.

(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 local governmental 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.

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.

4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.

5. A contract that is entered into pursuant to subsection 3:

(a) Must be submitted to the Commissioner of Insurance for approval not less than 30 days before the date on which the contract is to become effective.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

6. As used in this section, "legal services organization" means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.

Sec. 14. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 15. This act becomes effective on July 1, 2019.

㉚