
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:

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



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

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

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

3 687B.225 1. Except as otherwise provided in NRS
4 689A.0405, 689A.0413, 689A.044, 689A.0445, 689B.031,
5 689B.0313, 689B.0317, 689B.0374, 695B.1912, 695B.1914,
6 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1745,
7 695C.1751, 695G.170, 695G.171 and 695G.177 **and sections 2,**
8 **4 to 9, inclusive, and 12 of this act,** any contract for group, blanket
9 or individual health insurance or any contract by a nonprofit
10 hospital, medical or dental service corporation or organization for
11 dental care which provides for payment of a certain part of medical
12 or dental care may require the insured or member to obtain prior
13 authorization for that care from the insurer or organization. The
14 insurer or organization shall:

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

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

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

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

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

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



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

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

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

9 2. *An insurer that issues a network plan:*

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

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

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

28 4. *As used in this section:*

29 (a) *“Medical facility” has the meaning ascribed to it in*
30 *NRS 449.0151.*

31 (b) *“Medically necessary” means the absence of immediate*
32 *medical attention may result in:*

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

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

36 (3) *Serious impairment of a bodily function; or*

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

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

44 (d) *“Out-of-network facility or provider” means a medical*
45 *facility or provider of health care who is not a participating*



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

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

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

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

9 *(1) Is not a provider of health care;*

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

12 *(3) Is acting reasonably under the circumstances.*

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

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

20 **Sec. 3.** NRS 689A.330 is hereby amended to read as follows:

21 689A.330 If any policy is issued by a domestic insurer for
22 delivery to a person residing in another state, and if the insurance
23 commissioner or corresponding public officer of that other state has
24 informed the Commissioner that the policy is not subject to approval
25 or disapproval by that officer, the Commissioner may by ruling
26 require that the policy meet the standards set forth in NRS 689A.030
27 to 689A.320, inclusive ~~1~~, and section 2 of this act.

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

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

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

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

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

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

42 *2. An insurer that issues a network plan:*

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



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

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

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

16 *4. As used in this section:*

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

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

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

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

24 *(3) Serious impairment of a bodily function; or*

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

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

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

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

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

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

42 *(1) Is not a provider of health care;*

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

45 *(3) Is acting reasonably under the circumstances.*



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

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

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

10 1. A carrier that issues a health benefit plan:

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

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

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

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

22 2. An carrier that issues a network plan:

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

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

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

41 4. As used in this section:

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

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



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

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

4 (3) *Serious impairment of a bodily function; or*

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

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

12 (d) *“Out-of-network facility or provider” means a medical*
13 *facility or provider of health care who is not a participating*
14 *medical facility or provider of health care in the applicable*
15 *network plan.*

16 (e) *“Participating facility or provider” means a medical facility*
17 *or provider of health care who participates in the applicable*
18 *network plan.*

19 (f) *“Provider of health care” has the meaning ascribed to it in*
20 *NRS 629.031.*

21 (g) *“Prudent layperson” means a person who:*

22 (1) *Is not a provider of health care;*

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

25 (3) *Is acting reasonably under the circumstances.*

26 (h) *“Stabilizing emergency services” means emergency*
27 *medical services necessary to screen and stabilize an insured.*

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

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

34 689C.425 A voluntary purchasing group and any contract
35 issued to such a group pursuant to NRS 689C.360 to 689C.600,
36 inclusive, are subject to the provisions of NRS 689C.015 to
37 689C.355, inclusive, *and section 5 of this act* to the extent
38 applicable and not in conflict with the express provisions of NRS
39 687B.408 and 689C.360 to 689C.600, inclusive.

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

42 1. *An society that issues a benefit contract:*

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



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

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

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

9 2. *A society that issues a network plan:*

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

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

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

28 4. *As used in this section:*

29 (a) *“Medical facility” has the meaning ascribed to it in*
30 *NRS 449.0151.*

31 (b) *“Medically necessary” means the absence of immediate*
32 *medical attention may result in:*

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

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

36 (3) *Serious impairment of a bodily function; or*

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

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

44 (d) *“Out-of-network facility or provider” means a medical*
45 *facility or provider of health care who is not a participating*



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

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

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

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

9 *(1) Is not a provider of health care;*

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

12 *(3) Is acting reasonably under the circumstances.*

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

15 *5. A benefit contract subject to the provisions of this section*
16 *that is delivered, issued for delivery or renewed on or after July 1,*
17 *2019, has the legal effect of including the coverage required by*
18 *this section, and any provision of the contract or the renewal*
19 *which is in conflict with this section is void.*

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

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

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

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

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

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

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

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

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



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

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

11 4. *As used in this section:*

12 (a) *“Medical facility” has the meaning ascribed to it in*
13 *NRS 449.0151.*

14 (b) *“Medically necessary” means the absence of immediate*
15 *medical attention may result in:*

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

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

19 (3) *Serious impairment of a bodily function; or*

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

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

28 (d) *“Out-of-network facility or provider” means a medical*
29 *facility or provider of health care who is not a participating*
30 *medical facility or provider of health care in the applicable*
31 *network plan.*

32 (e) *“Participating facility or provider” means a medical facility*
33 *or provider of health care who participates in the applicable*
34 *network plan.*

35 (f) *“Provider of health care” has the meaning ascribed to it in*
36 *NRS 629.031.*

37 (g) *“Prudent layperson” means a person who:*

38 (1) *Is not a provider of health care;*

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

41 (3) *Is acting reasonably under the circumstances.*

42 (h) *“Stabilizing emergency services” means emergency*
43 *medical services necessary to screen and stabilize an insured.*

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



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

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

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

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

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

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

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

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

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

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

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

40 *4. As used in this section:*

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

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

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



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

3 (3) *Serious impairment of a bodily function; or*

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

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

12 (d) *“Out-of-network facility or provider” means a medical*
13 *facility or provider of health care who is not a participating*
14 *medical facility or provider of health care in the applicable*
15 *network plan.*

16 (e) *“Participating facility or provider” means a medical facility*
17 *or provider of health care who participates in the applicable*
18 *network plan.*

19 (f) *“Provider of health care” has the meaning ascribed to it in*
20 *NRS 629.031.*

21 (g) *“Prudent layperson” means a person who:*

22 (1) *Is not a provider of health care;*

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

25 (3) *Is acting reasonably under the circumstances.*

26 (h) *“Stabilizing emergency services” means emergency*
27 *medical services necessary to screen and stabilize an enrollee.*

28 5. *A health care plan subject to the provisions of this section*
29 *that is delivered, issued for delivery or renewed on or after July 1,*
30 *2019, has the legal effect of including the coverage required by*
31 *this section, and any provision of the plan or the renewal which is*
32 *in conflict with this section is void.*

33 **Sec. 10.** NRS 695C.050 is hereby amended to read as follows:

34 695C.050 1. Except as otherwise provided in this chapter or
35 in specific provisions of this title, the provisions of this title are not
36 applicable to any health maintenance organization granted a
37 certificate of authority under this chapter. This provision does not
38 apply to an insurer licensed and regulated pursuant to this title
39 except with respect to its activities as a health maintenance
40 organization authorized and regulated pursuant to this chapter.

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



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

4 4. The provisions of NRS 695C.110, 695C.125, 695C.1691,
5 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to
6 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734,
7 695C.1751, 695C.1755, 695C.176 to 695C.200, inclusive, and
8 695C.265 do not apply to a health maintenance organization that
9 provides health care services through managed care to recipients of
10 Medicaid under the State Plan for Medicaid or insurance pursuant to
11 the Children's Health Insurance Program pursuant to a contract with
12 the Division of Health Care Financing and Policy of the Department
13 of Health and Human Services. This subsection does not exempt a
14 health maintenance organization from any provision of this chapter
15 for services provided pursuant to any other contract.

16 5. The provisions of NRS 695C.1694 to 695C.1698, inclusive,
17 695C.1708, 695C.1731, 695C.17345, 695C.1735, 695C.1745 and
18 695C.1757 *and section 9 of this act* apply to a health maintenance
19 organization that provides health care services through managed
20 care to recipients of Medicaid under the State Plan for Medicaid.

21 **Sec. 11.** NRS 695C.330 is hereby amended to read as follows:

22 695C.330 1. The Commissioner may suspend or revoke any
23 certificate of authority issued to a health maintenance organization
24 pursuant to the provisions of this chapter if the Commissioner finds
25 that any of the following conditions exist:

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

33 (b) The health maintenance organization issues evidence of
34 coverage or uses a schedule of charges for health care services
35 which do not comply with the requirements of NRS 695C.1691 to
36 695C.200, inclusive, *and section 9 of this act* or 695C.207;

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

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

41 (1) Does not meet the requirements of subsection 1 of NRS
42 695C.080; or

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



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

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

8 (g) The health maintenance organization has failed to put into
9 effect the system required by NRS 695C.260 for:

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

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

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

18 (i) The continued operation of the health maintenance
19 organization would be hazardous to its enrollees or creditors or to
20 the general public;

21 (j) The health maintenance organization fails to provide the
22 coverage required by NRS 695C.1691; or

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

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

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

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

43 **Sec. 12.** NRS 695G.170 is hereby amended to read as follows:

44 695G.170 1. Each managed care organization *that offers or*
45 *issues a health care plan* shall ~~provide~~ :



1 (a) *Include in the health care plan* coverage ~~for medically~~ of
2 necessary emergency services provided at ~~any hospital~~
3 ~~—2. A managed care organization shall~~ a participating or out-
4 of-network facility or provider;

5 (b) *Shall* not require prior authorization for ~~medically~~
6 ~~necessary~~ stabilizing emergency services ~~[-~~
7 ~~—3.]~~ ; and

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

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

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

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

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

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

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

36 4. As used in this section ~~[-“medically”~~ :

37 (a) *“Medical facility” has the meaning ascribed to it in NRS*
38 *449.0151.*

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

45 ~~{(a)}~~ (1) *Serious jeopardy to the health of an insured;*



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

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

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

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

10 **Sec. 13.** NRS 287.010 is hereby amended to read as follows:

11 287.010 1. The governing body of any county, school
12 district, municipal corporation, political subdivision, public
13 corporation or other local governmental agency of the State of
14 Nevada may:

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

22 (b) Purchase group policies of life, accident or health insurance,
23 or any combination thereof, for the benefit of such officers and
24 employees, and the dependents of such officers and employees, as
25 have authorized the purchase, from insurance companies authorized
26 to transact the business of such insurance in the State of Nevada,
27 and, where necessary, deduct from the compensation of officers and
28 employees the premiums upon insurance and pay the deductions
29 upon the premiums.

30 (c) Provide group life, accident or health coverage through a
31 self-insurance reserve fund and, where necessary, deduct
32 contributions to the maintenance of the fund from the compensation
33 of officers and employees and pay the deductions into the fund. The
34 money accumulated for this purpose through deductions from the
35 compensation of officers and employees and contributions of the
36 governing body must be maintained as an internal service fund as
37 defined by NRS 354.543. The money must be deposited in a state or
38 national bank or credit union authorized to transact business in the
39 State of Nevada. Any independent administrator of a fund created
40 under this section is subject to the licensing requirements of chapter
41 683A of NRS, and must be a resident of this State. Any contract
42 with an independent administrator must be approved by the
43 Commissioner of Insurance as to the reasonableness of
44 administrative charges in relation to contributions collected and
45 benefits provided. The provisions of NRS 687B.408, 689B.030 to



1 689B.050, inclusive, and 689B.287 *and section 4 of this act* apply
2 to coverage provided pursuant to this paragraph, except that the
3 provisions of NRS 689B.0378 and 689B.03785 only apply to
4 coverage for active officers and employees of the governing body,
5 or the dependents of such officers and employees.

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

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

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

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

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

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

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

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

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



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

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

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

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

⑩

