ASSEMBLY BILL NO. 346–ASSEMBLYMAN ORENTLICHER

MARCH 22, 2021

Referred to Committee on Health and Human Services

SUMMARY—Establishes procedures to fix rates for certain health care goods and services. (BDR 40-786)

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

CONTAINS UNFUNDED MANDATE (§ 20)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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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 health care; establishing procedures for fixing the rates charged by hospitals, independent centers for emergency medical care, surgical centers for ambulatory patients and physicians for certain goods and services; authorizing the imposition of a civil penalty and initiation of disciplinary action against such a facility or a physician who fails to comply with provisions concerning rate fixing; creating certain causes of action to enforce those provisions; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Sections 3-12 of this bill establish procedures for the Division of Health Care Financing and Policy of the Department of Health and Human Services to fix the rates charged by hospitals, independent centers for emergency medical care, surgical centers for ambulatory patients and physicians for services that are reimbursable through Medicare when provided to a patient who is not indigent and is not covered by Medicare or Medicaid. **Sections 4-6** of this bill define necessary terms. **Section 7** of this bill generally prohibits such a health care facility or a physician from charging rates different from those established under **sections 3-12**. **Section 8** of this bill requires the Division to fix rates to ensure that each health care facility and physician is able to cover reasonable costs and earn a fair and reasonable profit. **Section 8** requires the Division to generally: (1) presume that the rates paid by Medicare allow a health care facility or physician to cover reasonable costs and earn a fair and reasonable profit; and (2) fix rates at that amount. However, **section 8** authorizes a health care facility, physician or group of physicians to request a different rate if the health care facility, physician or group of

physicians determines the rates paid by Medicare do not allow the health care facility, physician or physicians in the group to cover reasonable costs and earn a fair and reasonable profit. **Section 9** of this bill: (1) requires the Administrator of the Division to appoint a panel of employees who are experienced or trained in rate fixing to evaluate such requests; and (2) prescribes the procedure for evaluating such a request and the criteria that the panel is required to consider during the evaluation. **Section 10** of this bill prescribes requirements concerning an order relating to such a request. **Section 10** provides that such an order is valid for 1 year and authorizes a health care facility, physician or group of physicians to request to renew a rate.

Section 11 of this bill requires the Division to adopt certain regulations governing rate fixing, including regulations establishing civil penalties to be imposed against a health care facility or physician that violates provisions governing rate fixing. **Sections 12, 15, 23 and 24** of this bill provide for the imposition of disciplinary action against a health care facility or physician for such a violation. **Section 12** also authorizes: (1) the Division or Attorney General to maintain a suit for an injunction against such a violation; and (2) any person or entity injured by such a violation to maintain a suit for damages. **Sections 1, 13, 14, 16-22, 25-35 and 38** of this bill make conforming changes to clarify the application of or remove existing provisions concerning the rates that a health care facility or physician may charge for certain services.

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

Section 1. NRS 439A.190 is hereby amended to read as follows:

439A.190 1. A primary care practice shall not represent itself as a patient-centered medical home unless the primary care practice is certified, accredited or otherwise officially recognized as a patient-centered medical home by a nationally recognized organization for the accrediting of patient-centered medical homes.

2. The Department shall post on an Internet website maintained by the Department links to nationally recognized organizations for the accrediting of patient-centered medical homes and any other information specified by the Department to allow patients to find a patient-centered medical home that meets the requirements of this section and any regulations adopted pursuant thereto.

3. Any coordination between an insurer and a patient-centered medical home or acceptance of an incentive from an insurer by a patient-centered medical home that is authorized by federal law ***and is not prohibited by sections 3 to 12, inclusive, of this act*** shall not be deemed to be an unfair method of competition or an unfair or deceptive trade practice or other act or practice prohibited by the provisions of chapter 598 or 686A of NRS.

4. As used in this section:

(a) "Patient-centered medical home" means a primary care practice that:

(1) Offers patient-centered, continuous, culturally competent, evidence-based, comprehensive health care that is led by a provider of primary care and a team of health care providers, coordinates the health care needs of the patient and uses enhanced communication strategies and health information technology; and

(2) Emphasizes enhanced access to practitioners and preventive care to improve the outcomes for and experiences of patients and lower the costs of health services.

(b) "Primary care practice" means a federally qualified health center, as defined in 42 U.S.C. § 1396d(l)(2)(B), or a business where health services are provided by one or more advanced practice registered nurses or one or more physicians who are licensed pursuant to chapter 630 or 633 of NRS and who practice in the area of family practice, internal medicine or pediatrics.

Sec. 2. Chapter 439B of NRS is hereby amended by adding thereto the provisions set forth as sections 3 to 12, inclusive, of this act.

Sec. 3. ***As used in sections 3 to 12, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 4, 5 and 6 of this act have the meanings ascribed to them in those sections.***

Sec. 4. ***"Division" means the Division of Health Care Financing and Policy of the Department.***

Sec. 5. ***"Health care facility" means:***

1. A hospital, as defined in NRS 449.012, other than a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e).

2. An independent center for emergency medical care, as defined in NRS 449.013.

3. A surgical center for ambulatory patients, as defined in NRS 449.019.

Sec. 6. ***"Similarly situated" means that the factors prescribed by subsection 2 of section 9 of this act apply similarly to all physicians in the group.***

Sec. 7. ***1. A health care facility or physician shall charge rates determined in accordance with sections 3 to 12, inclusive, of this act for any goods or services described in subsection 2 that are provided to a patient who is not covered by Medicare, Medicaid or the Children's Health Insurance Program and is not entitled to relief under the provisions of chapter 428 of NRS.***

2. The provisions of sections 3 to 12, inclusive, of this act apply to goods and services that are reimbursable through Medicare as if provided to a patient who is covered by Medicare.

3. A health care facility or physician shall not provide any person with a discount, incentive or price reduction or enter into any arrangement where the effective amount paid to the health care facility or physician for goods or services is different from the rate established for those goods or services pursuant to sections 3 to 12, inclusive, of this act.

4. To the extent of their applicability, the provisions of sections 3 to 12, inclusive, of this act supersede any other provision of law relating to the rates charged by a health care facility or physician, including, without limitation, provisions requiring or authorizing reduced or discounted rates.

Sec. 8. *1. The Division shall fix rates pursuant to sections 3 to 12, inclusive, of this act to ensure that each health care facility and physician is able to cover reasonable costs and earn a fair and reasonable profit. If a health care facility or physician does not request a different rate pursuant to subsection 2, the Division shall:*

(a) Presume that the rates at which Medicare provides reimbursement for the goods and services provided by the health care facility or physician allow the health care facility or physician to cover reasonable costs and earn a fair and reasonable profit; and

(b) Fix the rates that the health care facility or physician may charge for goods or services at rates equal to the rates set forth in paragraph (a).

2. A health care facility or a physician who determines that the rates set forth in paragraph (a) of subsection 1 do not allow the health care facility or physician to cover reasonable costs and earn a fair and reasonable profit may, on or before March 1 of any year, submit to the Division a request for a rate different than the rate set forth in paragraph (a) of subsection 1. A group of similarly situated physicians may submit a request for different rates that apply to each physician in that group, and the Division may, after notice and the opportunity for a hearing for each affected physician, consolidate proceedings concerning requests submitted by similarly situated physicians. A request for different rates:

(a) May apply to particular goods or services provided by the health care facility, physician or physicians in the group, as applicable, or to all such goods and services.

(b) Must include, without limitation:

(1) The goods and services for which the health care facility, physician or group of physicians is requesting a different rate;

(2) An explanation of why the health care facility, the physician or the physicians in the group are unable to cover reasonable costs and earn a fair and reasonable profit charging the rates set forth in paragraph (a) of subsection 1;

(3) The rates that the health care facility, physician or group of physicians has determined are necessary to cover reasonable costs and earn a fair and reasonable profit; and

(4) Any other information required by the Division pursuant to section 11 of this act.

Sec. 9. *1. The Administrator of the Division shall appoint a panel of employees to evaluate requests made pursuant to subsection 2 of section 8 of this act. The employees on the panel must be persons who are experienced or trained in setting rates of reimbursement for Medicaid.*

2. When evaluating requests made pursuant to subsection 2 of section 8 of this act, the panel shall ensure that each health care facility or physician is able to cover reasonable costs and earn a fair and reasonable profit. The health care facility, physician or group of physicians that submitted the request has the burden of demonstrating that the health care facility, the physician or the physicians in the group, as applicable, will not cover reasonable costs and earn a fair and reasonable profit charging the rates set forth in paragraph (a) of subsection 1 of section 8 of this act. When determining whether a health care facility, physician or group of physicians has met that burden and, if so, the appropriate rate, the panel shall consider, without limitation:

(a) The relative populations of persons and entities who pay for goods and services provided by the health care facility, physician or physicians in the group and the relative amounts of reimbursement paid by those persons and entities;

(b) Where applicable, the disparities in income between providers of primary care and specialty services or between providers of different types of specialty services;

(c) The effectiveness and efficiency of the services provided by the health care facility, physician or physicians in the group;

(d) Any financial hardship that rapidly reducing the rates that a health care facility or physician is authorized to charge would impose upon the health care facility or physician;

(e) The extent to which the facility, physician or physicians in the group provides care to patients who are more vulnerable or who suffer from comorbidities that make treatment more difficult;

(f) The emphasis placed by the facility, physician or physicians in the group on promoting population health; and

(g) Any other criteria prescribed by the Division pursuant to section 11 of this act.

3. When considering a request pursuant to subsection 2 of section 8 of this act, the panel:

(a) May request from the health care facility, physician or group of physicians any information that the panel determines to be necessary to render its decision; and

(b) Shall solicit input on the request from affected persons and entities, including, without limitation, insurers and patients.

Sec. 10. *1. After considering a request pursuant to subsection 2 of section 8 of this act, the panel shall issue an order:*

(a) Denying the request, fixing rates for the health care facility, physician or group of physicians in the amount set forth in paragraph (a) of subsection 1 of section 8 of this act and stating the reasons therefor;

(b) Adopting the rates requested by the health care facility, physician or group of physicians pursuant to subsection 2 of section 8 of this act; or

(c) Fixing rates for the health care facility, physician or group of physicians that are different from the rates requested by the health care facility, physician or group, as applicable, pursuant to subsection 2 of section 8 of this act.

2. An order issued pursuant to subsection 1 concerning a request pursuant to subsection 2 of section 8 of this act must be issued on or before May 1 of the year in which the request was filed. All rates fixed by the panel are in force, and are prima facie lawful, from the date of the order until 1 year after that date.

3. A health care facility, physician or group of physicians may request to renew a fixed rate on or before March 1 of the year in which the rate is set to expire. The health care facility, physician or group of physicians has the burden of demonstrating that the health care facility, physician or physicians in the group will not cover reasonable costs and earn a fair and reasonable profit charging the rates set forth in paragraph (a) of subsection 1 of section 8 of this act.

4. A physician that is not part of a group of physicians for which a rate was fixed pursuant to this section may request to the Division to join that group for the purposes of inclusion in an application to renew that rate pursuant to subsection 3. The Division must grant the request if it determines that the physician is similarly situated to members of the group.

Sec. 11. *The Division shall adopt any regulations necessary to carry out the provisions of sections 3 to 12, inclusive, of this act. Those regulations must include, without limitation, regulations prescribing:*

1. Any information that must be included in a request made pursuant to subsection 2 of section 8 of this act;

2. The procedure and specific criteria, in addition to those prescribed by section 9 of this act, that the panel established pursuant to that section must use when considering such a request;

3. A streamlined process for making and considering a request pursuant to subsection 3 of section 10 of this act to renew a rate established by the panel; and

4. Civil penalties that may be imposed against a health care facility or physician who charges rates different from those established for the health care facility or physician pursuant to sections 3 to 12, inclusive, of this act.

Sec. 12. ***1. The Division may report any failure by a health care facility or physician to comply with the provisions of sections 3 to 12, inclusive, of this act to the Division of Public and Behavioral Health of the Department, the Board of Medical Examiners or the State Board of Osteopathic Medicine, as applicable, for the initiation of disciplinary proceedings.***

2. The Division or the Attorney General may maintain in any court of competent jurisdiction a suit to enjoin any person from charging rates different from those established for the health care facility or physician under the provisions of sections 3 to 12, inclusive, of this act. Such an injunction:

(a) May be issued without proof of actual damage sustained by any person as a preventive or punitive measure.

(b) Does not relieve any person or business entity from any other legal action.

3. Any person or entity injured by the failure of a health care facility or physician to charge rates in accordance with the provisions of sections 3 to 12, inclusive, of this act may maintain in any court of competent jurisdiction a suit to recover:

(a) Damages resulting from such failure; and

(b) Attorney's fees and costs.

Sec. 13. NRS 439B.260 is hereby amended to read as follows:

439B.260 ~~[1. A major hospital shall reduce or discount the total billed charge by at least 30 percent for hospital services provided to an inpatient who:~~

~~(a) Has no policy of health insurance or other contractual agreement with a third party that provides health coverage for the charge;~~

~~(b) Is not eligible for coverage by a state or federal program of public assistance that would provide for the payment of the charge; and~~

~~(c) Makes reasonable arrangements within 30 days after the date that notice was sent pursuant to subsection 2 to pay the hospital bill.~~

~~2. A major hospital shall include on or with the first statement of the hospital bill provided to the patient after his or her discharge a notice of the reduction or discount available pursuant to this section, including, without limitation, notice of the criteria a patient must satisfy to qualify for a reduction or discount.~~

~~3. A major hospital or patient who disputes the reasonableness of arrangements made pursuant to paragraph (c) of subsection 1 may submit the dispute to the Bureau for Hospital Patients for resolution as provided in NRS 232.462.~~

~~4.~~] A major hospital shall reduce or discount the total billed charge of its outpatient pharmacy by at least 30 percent to a patient who is eligible for Medicare.

~~[5. As used in this section, "third party" means:~~

~~(a) An insurer, as that term is defined in NRS 679B.540;~~

~~(b) A health benefit plan, as that term is defined in NRS 687B.470, for employees which provides coverage for services and care at a hospital;~~

~~(c) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; or~~

~~(d) Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.~~

~~➥ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.~~]

Sec. 14. NRS 439B.400 is hereby amended to read as follows:

439B.400 Each hospital in this State shall maintain and use a uniform list of billed charges for that hospital for units of service or goods provided to all inpatients. A hospital may not use a billed charge for an inpatient that is different than the billed charge used for another inpatient for the same service or goods provided. This section does not restrict the ability of a hospital or other person to negotiate a discounted rate from the hospital's billed charges or to contract for a different rate or mechanism for payment of the hospital ~~[.]~~ ***for goods and services that are not subject to the provisions of sections 3 to 12, inclusive, of this act.***

Sec. 15. NRS 449.160 is hereby amended to read as follows:

449.160 1. The Division may deny an application for a license or may suspend or revoke any license issued under the provisions of NRS 449.029 to 449.2428, inclusive, upon any of the following grounds:

(a) Violation by the applicant or the licensee of any of the provisions of NRS 439B.410 or 449.029 to 449.245, inclusive, or of any other law of this State or of the standards, rules and regulations adopted thereunder.

(b) Aiding, abetting or permitting the commission of any illegal act.

(c) Conduct inimical to the public health, morals, welfare and safety of the people of the State of Nevada in the maintenance and operation of the premises for which a license is issued.

(d) Conduct or practice detrimental to the health or safety of the occupants or employees of the facility.

(e) Failure of the applicant to obtain written approval from the Director of the Department of Health and Human Services as required by NRS 439A.100 or as provided in any regulation adopted pursuant to NRS 449.001 to 449.430, inclusive, and 449.435 to 449.531, inclusive, and chapter 449A of NRS if such approval is required.

(f) Failure to comply with the provisions of NRS 449.2486.

(g) Violation of the provisions of NRS 458.112.

(h) Failure to comply with the provisions of sections 3 to 12, inclusive, of this act, any regulations adopted pursuant thereto or any order issued pursuant thereto.

2. In addition to the provisions of subsection 1, the Division may revoke a license to operate a facility for the dependent if, with respect to that facility, the licensee that operates the facility, or an agent or employee of the licensee:

(a) Is convicted of violating any of the provisions of NRS 202.470;

(b) Is ordered to but fails to abate a nuisance pursuant to NRS 244.360, 244.3603 or 268.4124; or

(c) Is ordered by the appropriate governmental agency to correct a violation of a building, safety or health code or regulation but fails to correct the violation.

3. The Division shall maintain a log of any complaints that it receives relating to activities for which the Division may revoke the license to operate a facility for the dependent pursuant to subsection 2. The Division shall provide to a facility for the care of adults during the day:

(a) A summary of a complaint against the facility if the investigation of the complaint by the Division either substantiates the complaint or is inconclusive;

(b) A report of any investigation conducted with respect to the complaint; and

(c) A report of any disciplinary action taken against the facility.

➥ The facility shall make the information available to the public pursuant to NRS 449.2486.

4. On or before February 1 of each odd-numbered year, the Division shall submit to the Director of the Legislative Counsel Bureau a written report setting forth, for the previous biennium:

(a) Any complaints included in the log maintained by the Division pursuant to subsection 3; and

(b) Any disciplinary actions taken by the Division pursuant to subsection 2.

Sec. 16. NRS 449.243 is hereby amended to read as follows:

449.243 Every hospital licensed pursuant to the provisions of NRS 449.029 to 449.2428, inclusive:

1. May, except as otherwise provided in subsection 2, utilize the Uniform Billing and Claims Forms established by the American Hospital Association.

2. Shall, except as otherwise provided in this section, on its billings to patients, itemize, on a daily basis, all charges for services, and charges for equipment used and the supplies and medicines provided incident to the provision of those services with specificity and in language that is understandable to an ordinary lay person. This itemized list must be timely provided after the patient is discharged at no additional cost.

3. ~~[Except as otherwise provided in this subsection, if a patient is charged a rate, pursuant to a contract or other agreement, that is different than the billed charges, shall provide to the patient either:~~

~~(a) A copy of the billing prepared pursuant to subsection 2;~~

~~(b) A statement specifying the agreed rate for the services; or~~

~~(c) If the patient is not obligated to pay any portion of the bill, a statement of the total charges.~~

~~➥ In any case, the hospital shall]~~ ***Shall*** include on the billing ~~[or statement]~~ ***prepared pursuant to subsection 2*** any copayment or deductible for which the patient is responsible. The hospital shall answer any questions regarding the bill.

4. If the hospital is paid by the insurer of a patient a rate that is based on the number of persons treated and not on the services actually rendered, shall, upon the discharge of the patient, advise the patient of the status of any copayment or deductible for which the patient is responsible.

5. Shall prepare a summary of charges for common services for patients admitted to the hospital and make it available to the public.

6. Shall provide to any patient upon request a copy of the billing prepared pursuant to subsection 2.

Sec. 17. NRS 449.490 is hereby amended to read as follows:

449.490 1. Every institution which is subject to the provisions of NRS 449.450 to 449.530, inclusive, shall file with the

Department the following financial statements or reports in a form and at intervals specified by the Director but at least annually:

(a) A balance sheet detailing the assets, liabilities and net worth of the institution for its fiscal year; and

(b) A statement of income and expenses for the fiscal year.

2. Each hospital with 100 or more beds shall file with the Department, in a form and at intervals specified by the Director but at least annually, a capital improvement report which includes, without limitation, any major service line that the hospital has added or is in the process of adding since the previous report was filed, any major expansion of the existing facilities of the hospital that has been completed or is in the process of being completed since the previous report was filed, and any major piece of equipment that the hospital has acquired or is in the process of acquiring since the previous report was filed.

3. In addition to the information required to be filed pursuant to subsections 1 and 2, each hospital with 100 or more beds shall file with the Department, in a form and at intervals specified by the Director but at least annually:

(a) The expenses that the hospital has incurred for providing community benefits and the in-kind services that the hospital has provided to the community in which it is located. These expenses must be reported as the total amount expended for community benefits and in-kind services and reported as a percentage of the total net revenues of the hospital. For the purposes of this paragraph, "community benefits" includes, without limitation, goods, services and resources provided by a hospital to a community to address the specific needs and concerns of that community, services provided by a hospital to the uninsured and underserved persons in that community, training programs for employees in a community and health care services provided in areas of a community that have a critical shortage of such services, for which the hospital does not receive full reimbursement.

(b) ~~[A statement of its policies and procedures for providing discounted services to, or reducing charges for services provided to, persons without health insurance that are in addition to any reduction or discount required to be provided pursuant to NRS 439B.260.~~

~~(c)]~~ A list of the services which the hospital purchased from its corporate home office.

~~[(d)]~~ ***(c)*** A report of the cost to the hospital of providing services to patients covered by Medicare.

~~[(e)]~~ ***(d)*** Financial information from the consolidated corporation, if the hospital is owned by such a corporation and if

that information is publicly available, including, without limitation, the annual report of the consolidated corporation.

~~[(f)]~~ ***(e)*** A statement of its policies regarding patients' account receivables, including, without limitation, the manner in which a hospital collects or makes payment arrangements for patients' account receivables, the factors that initiate collections and the method by which unpaid account receivables are collected.

4. A complete current charge master must be available at each hospital during normal business hours for review by the Director, any payor that has a contract with the hospital to pay for services provided by the hospital, any payor that has received a bill from the hospital and any state agency that is authorized to review such information. The complete and current charge master must be made available to the Department, at the request of the Director, in an electronic format specified by the Department. The Department may use the electronic copy of the charge master to review and analyze the data contained in the charge master and, except as otherwise provided in NRS 439A.200 to 439A.290, inclusive, shall not release or publish the information contained in the charge master.

5. The Director shall require the certification of specified financial reports by an independent certified public accountant and may require attestations from responsible officers of the institution that the reports are, to the best of their knowledge and belief, accurate and complete to the extent that the certifications and attestations are not required by federal law.

6. The Director shall require:

(a) The filing of all reports by specified dates, and may adopt regulations which assess penalties for failure to file as required; and

(b) The submission of a final annual report not later than 6 months after the close of the fiscal year,

➥ and may grant extensions to institutions which can show that the required information is not available on the required reporting date.

7. All reports, except privileged medical information, filed under any provisions of NRS 449.450 to 449.530, inclusive:

(a) Are open to public inspection;

(b) Must be in a form which is readily understandable by a member of the general public;

(c) Must, as soon as practicable after those reports become available, be posted on the Internet website maintained pursuant to NRS 439A.270; and

(d) Must be available for examination at the office of the Department during regular business hours.

Sec. 18. NRS 449.520 is hereby amended to read as follows:

449.520 1. On or before October 1 of each year, the Director shall prepare and transmit to the Governor, the Legislative

Committee on Health Care and the Interim Finance Committee a report of the Department's operations and activities for the preceding fiscal year.

2. The report prepared pursuant to subsection 1 must include:

(a) Copies of all reports, summaries, compilations and supplementary reports required by NRS 449.450 to 449.530, inclusive, together with such facts, suggestions and policy recommendations as the Director deems necessary;

(b) A summary of the trends of the audits of hospitals in this State that the Department required or performed during the previous year;

(c) An analysis of the trends in the costs, expenses and profits of hospitals in this State;

(d) An analysis of the methodologies used to determine the corporate home office allocation of hospitals in this State;

(e) An examination and analysis of the manner in which hospitals are reporting the information that is required to be filed pursuant to NRS 449.490, including, without limitation, an examination and analysis of whether that information is being reported in a standard and consistent manner, which fairly reflect the operations of each hospital;

(f) ~~[A review and comparison of the policies and procedures used by hospitals in this State to provide discounted services to, and to reduce charges for services provided to, persons without health insurance;~~

~~(g)]~~ A review and comparison of the policies and procedures used by hospitals in this State to collect unpaid charges for services provided by the hospitals; and

~~[(h)]~~ ***(g)*** A summary of the status of the programs established pursuant to NRS 439A.220 and 439A.240 to increase public awareness of health care information concerning the hospitals and surgical centers for ambulatory patients in this State, including, without limitation, the information that was posted in the preceding fiscal year on the Internet website maintained for those programs pursuant to NRS 439A.270.

3. The Legislative Committee on Health Care shall develop a comprehensive plan concerning the provision of health care in this State which includes, without limitation:

(a) A review of the health care needs in this State as identified by state agencies, local governments, providers of health care and the general public; and

(b) A review of the capital improvement reports submitted by hospitals pursuant to subsection 2 of NRS 449.490.

Sec. 19. NRS 449A.118 is hereby amended to read as follows:

449A.118 1. Every medical facility and facility for the dependent shall inform each patient or the patient's legal representative, upon the admission of the patient to the facility, of the patient's rights as listed in NRS 449A.100 and 449A.106 to 449A.115, inclusive.

2. In addition to the requirements of subsection 1, if a person with a disability is a patient at a facility, as that term is defined in NRS 449A.218, the facility shall inform the patient of his or her rights pursuant to NRS 449A.200 to 449A.263, inclusive.

3. In addition to the requirements of subsections 1 and 2, every hospital shall, upon the admission of a patient to the hospital, provide to the patient or the patient's legal representative:

(a) Notice of the right of the patient to:

(1) Designate a caregiver pursuant to NRS 449A.300 to 449A.330, inclusive; and

(2) Express complaints and grievances as described in paragraphs (b) to (f), inclusive;

(b) The name and contact information for persons to whom such complaints and grievances may be expressed, including, without limitation, a patient representative or hospital social worker;

(c) Instructions for filing a complaint with the Division;

(d) The name and contact information of any entity responsible for accrediting the hospital;

(e) A written disclosure approved by the Director of the Department of Health and Human Services, which written disclosure must set forth:

(1) Notice of the existence of the Bureau for Hospital Patients created pursuant to NRS 232.462;

(2) The address and telephone number of the Bureau; and

(3) An explanation of the services provided by the Bureau, including, without limitation, the services for dispute resolution described in subsection 3 of NRS 232.462; and

(f) Contact information for any other state or local entity that investigates complaints concerning the abuse or neglect of patients.

~~[4. In addition to the requirements of subsections 1, 2 and 3, every hospital shall, upon the discharge of a patient from the hospital, provide to the patient or the patient's legal representative a written disclosure approved by the Director, which written disclosure must set forth:~~

~~(a) If the hospital is a major hospital:~~

~~(1) Notice of the reduction or discount available pursuant to NRS 439B.260, including, without limitation, notice of the criteria a patient must satisfy to qualify for a reduction or discount under that section; and~~

~~(2) Notice of any policies and procedures the hospital may have adopted to reduce charges for services provided to persons or to provide discounted services to persons, which policies and procedures are in addition to any reduction or discount required to be provided pursuant to NRS 439B.260. The notice required by this subparagraph must describe the criteria a patient must satisfy to qualify for the additional reduction or discount, including, without limitation, any relevant limitations on income and any relevant requirements as to the period within which the patient must arrange to make payment.~~

~~(b) If the hospital is not a major hospital, notice of any policies and procedures the hospital may have adopted to reduce charges for services provided to persons or to provide discounted services to persons. The notice required by this paragraph must describe the criteria a patient must satisfy to qualify for the reduction or discount, including, without limitation, any relevant limitations on income and any relevant requirements as to the period within which the patient must arrange to make payment.~~

~~➥ As used in this subsection, "major hospital" has the meaning ascribed to it in NRS 439B.115.~~

~~5. In addition to the requirements of subsections 1 to 4, inclusive, every hospital shall post in a conspicuous place in each public waiting room in the hospital a legible sign or notice in 14-point type or larger, which sign or notice must:~~

~~(a) Provide a brief description of any policies and procedures the hospital may have adopted to reduce charges for services provided to persons or to provide discounted services to persons, including, without limitation:~~

~~(1) Instructions for receiving additional information regarding such policies and procedures; and~~

~~(2) Instructions for arranging to make payment;~~

~~(b) Be written in language that is easy to understand; and~~

~~(c) Be written in English and Spanish.]~~

Sec. 20. NRS 450.420 is hereby amended to read as follows:

450.420 1. The board of county commissioners of the county in which a public hospital is located may determine whether patients presented to the public hospital for treatment are subjects of charity. Except as otherwise provided in NRS 439B.330, the board of county commissioners shall establish by ordinance criteria and procedures to be used in the determination of eligibility for medical care as medical indigents or subjects of charity.

2. The board of hospital trustees shall fix the charges for ~~[treatment of]~~ ***the provision of goods and services that are not subject to the provisions of sections 3 to 12, inclusive, of this act to*** those persons able to pay for the charges, as the board deems just

and proper. The board of hospital trustees may impose an interest charge of not more than 12 percent per annum on unpaid accounts. The receipts must be paid to the county treasurer and credited to the hospital fund. In fixing charges pursuant to this subsection the board of hospital trustees shall not include, or seek to recover from paying patients, any portion of the expense of the hospital which is properly attributable to the care of indigent patients.

3. Except as provided in subsection 4 of this section and subsection 3 of NRS 439B.320, the county is chargeable with the entire cost of services rendered by the hospital and any salaried staff physician or employee to any person admitted for emergency treatment, including all reasonably necessary recovery, convalescent and follow-up inpatient care required for any such person as determined by the board of trustees of the hospital, but the hospital shall use reasonable diligence to collect the charges from the emergency patient or any other person responsible for the support of the patient. Any amount collected must be reimbursed or credited to the county.

4. The county is not chargeable with the cost of services rendered by the hospital or any attending staff physician or surgeon to the extent the hospital is reimbursed for those services pursuant to NRS 428.115 to 428.255, inclusive.

Sec. 21. NRS 232.462 is hereby amended to read as follows:

232.462 1. The Bureau for Hospital Patients is hereby created within the Office for Consumer Health Assistance.

2. The Advocate:

(a) Is responsible for the operation of the Bureau, which must be easily accessible to the clientele of the Bureau.

(b) Shall appoint and supervise such additional employees as are necessary to carry out the duties of the Bureau. The employees of the Bureau are in the unclassified service of the State.

3. The Advocate or the Advocate's designee may, upon request made by either party, hear, mediate, arbitrate or resolve by alternative means of dispute resolution disputes between patients and hospitals. The Advocate or the Advocate's designee may decline to hear a case that in the Advocate's opinion is trivial, without merit or beyond the scope of his or her jurisdiction. The Advocate or the Advocate's designee may hear, mediate, arbitrate or resolve through alternative means of dispute resolution disputes regarding:

(a) The accuracy or amount of charges billed to a patient;

(b) The reasonableness of arrangements made for a patient to pay any bill for medical services **;** ~~**[**, including, without limitation, arrangements to pay hospital bills made pursuant to paragraph (c) of subsection 1 of NRS 439B.260;**]**~~ and

(c) Such other matters related to the charges for care provided to a patient as the Advocate or the Advocate's designee determines appropriate for arbitration, mediation or other alternative means of dispute resolution.

➥ The Advocate's designee must be an employee of the State and, except for the purposes of this subsection, must not be employed by, or otherwise associated with, the Bureau or the Office for Consumer Health Assistance.

4. The decision of the Advocate or the Advocate's designee is a final decision for the purpose of judicial review.

5. Each hospital, other than federal and state hospitals, with 49 or more licensed or approved hospital beds shall pay an annual assessment for the support of the Bureau. On or before July 15 of each year, the Advocate shall notify each hospital of its assessment for the fiscal year. Payment of the assessment is due on or before September 15. Late payments bear interest at the rate of 1 percent per month or fraction thereof.

6. The total amount assessed pursuant to subsection 5 for a fiscal year must not be more than $100,000 adjusted by the percentage change between January 1, 1991, and January 1 of the year in which the fees are assessed, in the Consumer Price Index (All Items) published by the United States Department of Labor.

7. The total amount assessed must be divided by the total number of patient days of care provided in the previous calendar year by the hospitals subject to the assessment. For each hospital, the assessment must be the result of this calculation multiplied by its number of patient days of care for the preceding calendar year.

Sec. 22. NRS 239.010 is hereby amended to read as follows:

239.010 1. Except as otherwise provided in this section and NRS 1.4683, 1.4687, 1A.110, 3.2203, 41.071, 49.095, 49.293, 62D.420, 62D.440, 62E.516, 62E.620, 62H.025, 62H.030, 62H.170, 62H.220, 62H.320, 75A.100, 75A.150, 76.160, 78.152, 80.113, 81.850, 82.183, 86.246, 86.54615, 87.515, 87.5413, 87A.200, 87A.580, 87A.640, 88.3355, 88.5927, 88.6067, 88A.345, 88A.7345, 89.045, 89.251, 90.730, 91.160, 116.757, 116A.270, 116B.880, 118B.026, 119.260, 119.265, 119.267, 119.280, 119A.280, 119A.653, 119A.677, 119B.370, 119B.382, 120A.690, 125.130, 125B.140, 126.141, 126.161, 126.163, 126.730, 127.007, 127.057, 127.130, 127.140, 127.2817, 128.090, 130.312, 130.712, 136.050, 159.044, 159A.044, 172.075, 172.245, 176.01249, 176.015, 176.0625, 176.09129, 176.156, 176A.630, 178.39801, 178.4715, 178.5691, 179.495, 179A.070, 179A.165, 179D.160, 200.3771, 200.3772, 200.5095, 200.604, 202.3662, 205.4651, 209.392, 209.3923, 209.3925, 209.419, 209.429, 209.521, 211A.140, 213.010, 213.040, 213.095, 213.131, 217.105, 217.110, 217.464,

217.475, 218A.350, 218E.625, 218F.150, 218G.130, 218G.240, 218G.350, 226.300, 228.270, 228.450, 228.495, 228.570, 231.069, 231.1473, 233.190, 237.300, 239.0105, 239.0113, 239.014, 239B.030, 239B.040, 239B.050, 239C.140, 239C.210, 239C.230, 239C.250, 239C.270, 239C.420, 240.007, 241.020, 241.030, 241.039, 242.105, 244.264, 244.335, 247.540, 247.550, 247.560, 250.087, 250.130, 250.140, 250.150, 268.095, 268.0978, 268.490, 268.910, 269.174, 271A.105, 281.195, 281.805, 281A.350, 281A.680, 281A.685, 281A.750, 281A.755, 281A.780, 284.4068, 286.110, 286.118, 287.0438, 289.025, 289.080, 289.387, 289.830, 293.4855, 293.5002, 293.503, 293.504, 293.558, 293.5757, 293.870, 293.906, 293.908, 293.910, 293B.135, 293D.510, 331.110, 332.061, 332.351, 333.333, 333.335, 338.070, 338.1379, 338.1593, 338.1725, 338.1727, 348.420, 349.597, 349.775, 353.205, 353A.049, 353A.085, 353A.100, 353C.240, 360.240, 360.247, 360.255, 360.755, 361.044, 361.2242, 361.610, 365.138, 366.160, 368A.180, 370.257, 370.327, 372A.080, 378.290, 378.300, 379.0075, 379.008, 379.1495, 385A.830, 385B.100, 387.626, 387.631, 388.1455, 388.259, 388.501, 388.503, 388.513, 388.750, 388A.247, 388A.249, 391.033, 391.035, 391.0365, 391.120, 391.925, 392.029, 392.147, 392.264, 392.271, 392.315, 392.317, 392.325, 392.327, 392.335, 392.850, 393.045, 394.167, 394.16975, 394.1698, 394.447, 394.460, 394.465, 396.3295, 396.405, 396.525, 396.535, 396.9685, 398A.115, 408.3885, 408.3886, 408.3888, 408.5484, 412.153, 414.280, 416.070, 422.2749, 422.305, 422A.342, 422A.350, 425.400, 427A.1236, 427A.872, 432.028, 432.205, 432B.175, 432B.280, 432B.290, 432B.407, 432B.430, 432B.560, 432B.5902, 432C.140, 432C.150, 433.534, 433A.360, 437.145, 437.207, 439.4941, 439.840, 439.914, 439B.420, ~~[439B.754, 439B.760,]~~ 440.170, 441A.195, 441A.220, 441A.230, 442.330, 442.395, 442.735, 442.774, 445A.665, 445B.570, 445B.7773, 447.345, 449.209, 449.245, 449.4315, 449A.112, 450.140, 450B.188, 453.164, 453.720, 453A.610, 453A.700, 458.055, 458.280, 459.050, 459.3866, 459.555, 459.7056, 459.846, 463.120, 463.15993, 463.240, 463.3403, 463.3407, 463.790, 467.1005, 480.535, 480.545, 480.935, 480.940, 481.063, 481.091, 481.093, 482.170, 482.5536, 483.340, 483.363, 483.575, 483.659, 483.800, 484A.469, 484E.070, 485.316, 501.344, 503.452, 522.040, 534A.031, 561.285, 571.160, 584.655, 587.877, 598.0964, 598.098, 598A.110, 599B.090, 603.070, 603A.210, 604A.303, 604A.710, 612.265, 616B.012, 616B.015, 616B.315, 616B.350, 618.341, 618.425, 622.238, 622.310, 623.131, 623A.137, 624.110, 624.265, 624.327, 625.425, 625A.185, 628.418, 628B.230, 628B.760, 629.047, 629.069, 630.133, 630.2673, 630.30665, 630.336, 630A.555, 631.368, 632.121, 632.125, 632.3415, 632.405, 633.283, 633.301, 633.4715,

633.524, 634.055, 634.214, 634A.185, 635.158, 636.107, 637.085, 637B.288, 638.087, 638.089, 639.2485, 639.570, 640.075, 640A.220, 640B.730, 640C.580, 640C.600, 640C.620, 640C.745, 640C.760, 640D.190, 640E.340, 641.090, 641.221, 641.325, 641A.191, 641A.262, 641A.289, 641B.170, 641B.282, 641B.460, 641C.760, 641C.800, 642.524, 643.189, 644A.870, 645.180, 645.625, 645A.050, 645A.082, 645B.060, 645B.092, 645C.220, 645C.225, 645D.130, 645D.135, 645G.510, 645H.320, 645H.330, 647.0945, 647.0947, 648.033, 648.197, 649.065, 649.067, 652.228, 653.900, 654.110, 656.105, 657A.510, 661.115, 665.130, 665.133, 669.275, 669.285, 669A.310, 671.170, 673.450, 673.480, 675.380, 676A.340, 676A.370, 677.243, 678A.470, 678C.710, 678C.800, 679B.122, 679B.124, 679B.152, 679B.159, 679B.190, 679B.285, 679B.690, 680A.270, 681A.440, 681B.260, 681B.410, 681B.540, 683A.0873, 685A.077, 686A.289, 686B.170, 686C.306, 687A.110, 687A.115, 687C.010, 688C.230, 688C.480, 688C.490, 689A.696, 692A.117, 692C.190, 692C.3507, 692C.3536, 692C.3538, 692C.354, 692C.420, 693A.480, 693A.615, 696B.550, 696C.120, 703.196, 704B.325, 706.1725, 706A.230, 710.159, 711.600, sections 35, 38 and 41 of chapter 478, Statutes of Nevada 2011 and section 2 of chapter 391, Statutes of Nevada 2013 and unless otherwise declared by law to be confidential, all public books and public records of a governmental entity must be open at all times during office hours to inspection by any person, and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. Any such copies, abstracts or memoranda may be used to supply the general public with copies, abstracts or memoranda of the records or may be used in any other way to the advantage of the governmental entity or of the general public. This section does not supersede or in any manner affect the federal laws governing copyrights or enlarge, diminish or affect in any other manner the rights of a person in any written book or record which is copyrighted pursuant to federal law.

2. A governmental entity may not reject a book or record which is copyrighted solely because it is copyrighted.

3. A governmental entity that has legal custody or control of a public book or record shall not deny a request made pursuant to subsection 1 to inspect or copy or receive a copy of a public book or record on the basis that the requested public book or record contains information that is confidential if the governmental entity can redact, delete, conceal or separate, including, without limitation, electronically, the confidential information from the information included in the public book or record that is not otherwise confidential.

4. If requested, a governmental entity shall provide a copy of a public record in an electronic format by means of an electronic medium. Nothing in this subsection requires a governmental entity to provide a copy of a public record in an electronic format or by means of an electronic medium if:

(a) The public record:

(1) Was not created or prepared in an electronic format; and

(2) Is not available in an electronic format; or

(b) Providing the public record in an electronic format or by means of an electronic medium would:

(1) Give access to proprietary software; or

(2) Require the production of information that is confidential and that cannot be redacted, deleted, concealed or separated from information that is not otherwise confidential.

5. An officer, employee or agent of a governmental entity who has legal custody or control of a public record:

(a) Shall not refuse to provide a copy of that public record in the medium that is requested because the officer, employee or agent has already prepared or would prefer to provide the copy in a different medium.

(b) Except as otherwise provided in NRS 239.030, shall, upon request, prepare the copy of the public record and shall not require the person who has requested the copy to prepare the copy himself or herself.

Sec. 23. NRS 630.3062 is hereby amended to read as follows:

630.3062 1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

(a) Failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient.

(b) Altering medical records of a patient.

(c) Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law or knowingly or willfully obstructing or inducing another to obstruct such filing.

(d) Failure to make the medical records of a patient available for inspection and copying as provided in NRS 629.061, if the licensee is the custodian of health care records with respect to those records.

(e) Failure to comply with the requirements of NRS 630.3068.

(f) Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board within 30 days after the date the licensee knows or has reason to know of the violation.

(g) Failure to comply with the requirements of NRS 453.163, 453.164, 453.226, 639.23507, 639.23535 and 639.2391 to

639.23916, inclusive, and any regulations adopted by the State Board of Pharmacy pursuant thereto.

(h) Fraudulent, illegal, unauthorized or otherwise inappropriate prescribing, administering or dispensing of a controlled substance listed in schedule II, III or IV.

(i) Failure to comply with the provisions of sections 3 to 12, inclusive, of this act, any regulations adopted pursuant thereto or any order issued pursuant thereto.

2. As used in this section, "custodian of health care records" has the meaning ascribed to it in NRS 629.016.

Sec. 24. NRS 633.511 is hereby amended to read as follows:

633.511 1. The grounds for initiating disciplinary action pursuant to this chapter are:

(a) Unprofessional conduct.

(b) Conviction of:

(1) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;

(2) A felony relating to the practice of osteopathic medicine or practice as a physician assistant;

(3) A violation of any of the provisions of NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440, inclusive;

(4) Murder, voluntary manslaughter or mayhem;

(5) Any felony involving the use of a firearm or other deadly weapon;

(6) Assault with intent to kill or to commit sexual assault or mayhem;

(7) Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;

(8) Abuse or neglect of a child or contributory delinquency; or

(9) Any offense involving moral turpitude.

(c) The suspension of a license to practice osteopathic medicine or to practice as a physician assistant by any other jurisdiction.

(d) Malpractice or gross malpractice, which may be evidenced by a claim of malpractice settled against a licensee.

(e) Professional incompetence.

(f) Failure to comply with the requirements of NRS 633.527.

(g) Failure to comply with the requirements of subsection 3 of NRS 633.471.

(h) Failure to comply with the provisions of NRS 633.694.

(i) Operation of a medical facility, as defined in NRS 449.0151, at any time during which:

(1) The license of the facility is suspended or revoked; or

(2) An act or omission occurs which results in the suspension or revocation of the license pursuant to NRS 449.160.

➥ This paragraph applies to an owner or other principal responsible for the operation of the facility.

(j) Failure to comply with the provisions of subsection 2 of NRS 633.322.

(k) Signing a blank prescription form.

(l) Knowingly or willfully procuring or administering a controlled substance or a dangerous drug as defined in chapter 454 of NRS that is not approved by the United States Food and Drug Administration, unless the unapproved controlled substance or dangerous drug:

(1) Was procured through a retail pharmacy licensed pursuant to chapter 639 of NRS;

(2) Was procured through a Canadian pharmacy which is licensed pursuant to chapter 639 of NRS and which has been recommended by the State Board of Pharmacy pursuant to subsection 4 of NRS 639.2328;

(3) Is cannabis being used for medical purposes in accordance with chapter 678C of NRS; or

(4) Is an investigational drug or biological product prescribed to a patient pursuant to NRS 630.3735 or 633.6945.

(m) Attempting, directly or indirectly, by intimidation, coercion or deception, to obtain or retain a patient or to discourage the use of a second opinion.

(n) Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient.

(o) In addition to the provisions of subsection 3 of NRS 633.524, making or filing a report which the licensee knows to be false, failing to file a record or report that is required by law or knowingly or willfully obstructing or inducing another to obstruct the making or filing of such a record or report.

(p) Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board within 30 days after the date the licensee knows or has reason to know of the violation.

(q) Failure by a licensee or applicant to report in writing, within 30 days, any criminal action taken or conviction obtained against the licensee or applicant, other than a minor traffic violation, in this State or any other state or by the Federal Government, a branch of the Armed Forces of the United States or any local or federal jurisdiction of a foreign country.

(r) Engaging in any act that is unsafe in accordance with regulations adopted by the Board.

(s) Failure to comply with the provisions of NRS 629.515.

(t) Failure to supervise adequately a medical assistant pursuant to the regulations of the Board.

(u) Failure to obtain any training required by the Board pursuant to NRS 633.473.

(v) Failure to comply with the provisions of NRS 633.6955.

(w) Failure to comply with the provisions of NRS 453.163, 453.164, 453.226, 639.23507, 639.23535 and 639.2391 to 639.23916, inclusive, and any regulations adopted by the State Board of Pharmacy pursuant thereto.

(x) Fraudulent, illegal, unauthorized or otherwise inappropriate prescribing, administering or dispensing of a controlled substance listed in schedule II, III or IV.

(y) Failure to comply with the provisions of NRS 454.217 or 629.086.

(z) Failure to comply with the provisions of sections 3 to 12, inclusive, of this act, any regulations adopted pursuant thereto or any order issued pursuant thereto.

2. As used in this section, "investigational drug or biological product" has the meaning ascribed to it in NRS 454.351.

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

683A.0879 1. Except as otherwise provided in subsection 2 **,** ~~[and NRS 439B.754,]~~ 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, the administrator shall notify the claimant of the administrator's request for the additional information within 20 days after receiving 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 receiving 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. 26. NRS 689A.041 is hereby amended to read as follows:

689A.041 1. A policy of health insurance which provides coverage for the surgical procedure known as a mastectomy must also provide commensurate coverage for:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical structure; and

(c) Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

2. The provision of services must be determined by the attending physician and the patient.

3. The plan or issuer may require deductibles and coinsurance payments if they are consistent with those established for other benefits.

4. Written notice of the availability of the coverage must be given upon enrollment and annually thereafter. The notice must be sent to all participants:

(a) In the next mailing made by the plan or issuer to the participant or beneficiary; or

(b) As part of any annual information packet sent to the participant or beneficiary,

➥ whichever is earlier.

5. A plan or issuer may not:

(a) Deny eligibility, or continued eligibility, to enroll or renew coverage, in order to avoid the requirements of subsections 1 to 4, inclusive; or

(b) Penalize, or limit reimbursement to, a provider of care, or provide incentives to a provider of care, in order to induce the provider not to provide the care listed in subsections 1 to 4, inclusive.

6. ~~[A plan or issuer may negotiate rates of reimbursement with providers of care.~~

~~7.]~~ If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal the amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the terms, conditions and exclusions contained in the policy at the time of the reconstructive surgery.

~~[8.]~~ ***7.*** A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2001, 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.

~~[9.]~~ ***8.*** For the purposes of this section, "reconstructive surgery" means a surgical procedure performed following a mastectomy on one breast or both breasts to re-establish symmetry between the two breasts. The term includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

Sec. 27. NRS 689A.410 is hereby amended to read as follows:

689A.410 1. Except as otherwise provided in subsection 2 **,** ~~[and NRS 439B.754,]~~ 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. 28. NRS 689B.0375 is hereby amended to read as follows:

689B.0375 1. A policy of group health insurance which provides coverage for the surgical procedure known as a mastectomy must also provide commensurate coverage for:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical structure; and

(c) Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

2. The provision of services must be determined by the attending physician and the patient.

3. The plan or issuer may require deductibles and coinsurance payments if they are consistent with those established for other benefits.

4. Written notice of the availability of the coverage must be given upon enrollment and annually thereafter. The notice must be sent to all participants:

(a) In the next mailing made by the plan or issuer to the participant or beneficiary; or

(b) As part of any annual information packet sent to the participant or beneficiary,

➥ whichever is earlier.

5. A plan or issuer may not:

(a) Deny eligibility, or continued eligibility, to enroll or renew coverage, in order to avoid the requirements of subsections 1 to 4, inclusive; or

(b) Penalize, or limit reimbursement to, a provider of care, or provide incentives to a provider of care, in order to induce the provider not to provide the care listed in subsections 1 to 4, inclusive.

6. ~~[A plan or issuer may negotiate rates of reimbursement with providers of care.~~

~~7.]~~ If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal those amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the terms, conditions and exclusions contained in the policy at the time of the reconstructive surgery.

~~[8.]~~ ***7.*** A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2001, 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.

~~[9.]~~ ***8.*** For the purposes of this section, "reconstructive surgery" means a surgical procedure performed following a mastectomy on one breast or both breasts to re-establish symmetry between the two breasts. The term includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

Sec. 29. NRS 689B.255 is hereby amended to read as follows:

689B.255 1. Except as otherwise provided in subsection 2 **,** ~~[and NRS 439B.754,]~~ 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. 30. NRS 689C.485 is hereby amended to read as follows:

689C.485 1. Except as otherwise provided in subsection 2 , ~~[and NRS 439B.754,]~~ 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. 31. NRS 695A.188 is hereby amended to read as follows:

695A.188 1. Except as otherwise provided in subsection 2 **,** ~~[and NRS 439B.754,]~~ a society shall approve or deny a claim relating to a certificate of health insurance within 30 days after the society receives the claim. If the claim is approved, the society shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the society shall pay interest on the claim at the rate of interest established pursuant to NRS 99.040 unless a different rate of interest is established pursuant to an express written contract between the society and the provider of health care. The interest must be calculated from 30 days after the date on which the claim is approved until the claim is paid.

2. If the society 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 society shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The society shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the society shall pay the claim within 30 days after it

receives the additional information. If the approved claim is not paid within that period, the society shall pay interest on the claim in the manner prescribed in subsection 1.

3. A society shall not request a claimant to resubmit information that the claimant has already provided to the society, unless the society 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 society 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.

Sec. 32. NRS 695B.191 is hereby amended to read as follows:

695B.191 1. A policy of health insurance, issued by a medical service corporation, which provides coverage for the surgical procedure known as a mastectomy must also provide commensurate coverage for:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical structure; and

(c) Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

2. The provision of services must be determined by the attending physician and the patient.

3. The plan or issuer may require deductibles and coinsurance payments if they are consistent with those established for other benefits.

4. Written notice of the availability of the coverage must be given upon enrollment and annually thereafter. The notice must be sent to all participants:

(a) In the next mailing made by the plan or issuer to the participant or beneficiary; or

(b) As part of any annual information packet sent to the participant or beneficiary,

➥ whichever is earlier.

5. A plan or issuer may not:

(a) Deny eligibility, or continued eligibility, to enroll or renew coverage, in order to avoid the requirements of subsections 1 to 4, inclusive; or

(b) Penalize, or limit reimbursement to, a provider of care, or provide incentives to a provider of care, in order to induce the provider not to provide the care listed in subsections 1 to 4, inclusive.

6. ~~[A plan or issuer may negotiate rates of reimbursement with providers of care.~~

~~7.]~~ If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal those amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the terms, conditions and exclusions contained in the policy at the time of the reconstructive surgery.

~~[8.]~~ ***7.*** A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2001, 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.

~~[9.]~~ ***8.*** For the purposes of this section, "reconstructive surgery" means a surgical procedure performed following a mastectomy on one breast or both breasts to re-establish symmetry between the two breasts. The term includes augmentation mammoplasty, reduction mammoplasty and mastopexy.

Sec. 33. NRS 695B.2505 is hereby amended to read as follows:

695B.2505 1. Except as otherwise provided in subsection 2 **,** ~~[and NRS 439B.754,]~~ 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. 34. NRS 695C.171 is hereby amended to read as follows:

695C.171 1. A health maintenance plan which provides coverage for the surgical procedure known as a mastectomy must also provide commensurate coverage for:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical structure; and

(c) Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

2. The provision of services must be determined by the attending physician and the patient.

3. The plan or issuer may require deductibles and coinsurance payments if they are consistent with those established for other benefits.

4. Written notice of the availability of the coverage must be given upon enrollment and annually thereafter. The notice must be sent to all participants:

(a) In the next mailing made by the plan or issuer to the participant or beneficiary; or

(b) As part of any annual information packet sent to the participant or beneficiary,

➥ whichever is earlier.

5. A plan or issuer may not:

(a) Deny eligibility, or continued eligibility, to enroll or renew coverage, in order to avoid the requirements of subsections 1 to 4, inclusive; or

(b) Penalize, or limit reimbursement to, a provider of care, or provide incentives to a provider of care, in order to induce the provider not to provide the care listed in subsections 1 to 4, inclusive.

6. ~~[A plan or issuer may negotiate rates of reimbursement with providers of care.~~

~~7.]~~ If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal those amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the terms, conditions and exclusions contained in the policy at the time of the reconstructive surgery.

~~[8.]~~ ***7.*** A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 2001, 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.

~~[9.]~~ ***8.*** For the purposes of this section, "reconstructive surgery" means a surgical procedure performed following a mastectomy on one breast or both breasts to re-establish symmetry between the two breasts. The term includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Sec. 35. NRS 695C.185 is hereby amended to read as follows:

695C.185 1. Except as otherwise provided in subsection 2 **,** ~~[and NRS 439B.754,]~~ 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. 36. The provisions of subsection 1 of NRS 218D.380 do not apply to any provision of this act which adds or revises a requirement to submit a report to the Legislature.

Sec. 37. 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. 38. NRS 439B.700, 439B.703, 439B.706, 439B.709, 439B.712, 439B.715, 439B.718, 439B.721, 439B.724, 439B.727, 439B.730, 439B.733, 439B.736, 439B.739, 439B.742, 439B.745, 439B.748, 439B.751, 439B.754, 439B.757 and 439B.760 are hereby repealed.

Sec. 39. 1. This section becomes effectives upon passage and approval.

2. Sections 1 to 38, inclusive, of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On January 1, 2022, for all other purposes.

LEADLINES OF REPEALED SECTIONS

439B.700 Definitions.

439B.703 "Covered person" defined.

439B.706 "Independent center for emergency medical care" defined.

439B.709 "In-network emergency facility" defined.

439B.712 "In-network provider" defined.

439B.715 "Medically necessary emergency services" defined.

439B.718 "Out-of-network emergency facility" defined.

439B.721 "Out-of-network provider" defined.

439B.724 "Provider contract" defined.

439B.727 "Provider of health care" defined.

439B.730 "Prudent person" defined.

439B.733 "Screen" defined.

439B.736 "Third party" defined.

439B.739 "To stabilize" and "stabilized" defined.

439B.742 Inapplicability of provisions to certain hospitals, persons and health care services.

439B.745 Limitation on amount out-of-network provider may collect from covered person; duties of out-of-network emergency facility upon providing services.

439B.748 Payment to out-of-network emergency facility by third party.

439B.751 Payment to out-of-network provider, other than emergency facility, by third party.

439B.754 Determination of amount owed when no recent contract exists between out-of-network provider and third party; arbitration to resolve dispute; no interest pending resolution of dispute; confidentiality of arbitration.

439B.757 Election by certain entities and organizations not otherwise covered to submit to provisions; regulations.

439B.760 Reports; confidentiality of information.

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