SUMMARY—Revises provisions relating to prior authorization for medical or dental care under health insurance plans. (BDR 57-861)

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

AN ACT relating to insurance; imposing requirements governing prior authorization for medical or dental care; prohibiting an insurer from requiring prior authorization for covered emergency services or denying coverage for covered, medically necessary emergency services; requiring an insurer to publish certain information relating to requests for prior authorization on the Internet; requiring an insurer and the Commissioner of Insurance to compile certain reports; and providing other matters properly relating thereto.

**Legislative Counsel's Digest:**

Existing law authorizes certain health insurers to require prior authorization before an insured may receive coverage for health and dental care in certain circumstances. If an insurer requires prior authorization, existing law requires the insurer to: (1) file its procedure for obtaining prior authorization with the Commissioner of Insurance for approval; and (2) respond to a request for prior authorization within 20 days after receiving the request. (NRS 687B.225) This bill establishes additional requirements relating to the use of prior authorization for health and dental care by

health insurers, including Medicaid, the Children's Health Insurance Program and insurance for public employees.

Specifically, **sections 19 and 34** of this bill require that a procedure for obtaining prior authorization includes: (1) a list of the specific goods and services for which the insurer requires prior authorization; and (2) the clinical review criteria used by the insurer to evaluate requests for prior authorization. **Sections 19 and 34** also require an insurer to publish its procedure for obtaining prior authorization on its Internet website and update that website as necessary to account for any changes in the procedure. **Sections 19 and 34** prohibit an insurer from denying a claim for payment for medical or dental care because of the failure to obtain prior authorization if the insurer's procedures for obtaining prior authorization in effect on the date that the care was provided did not require prior authorization for that care.

**Sections 19 and 35** of this bill revise the period for insurers to take action on a request for prior authorization by requiring an insurer to approve or make an adverse determination on such a request, or request additional, medically relevant information within: (1) five days after receiving the request, for medical or dental care that is not urgent; or (2) twenty-four hours after receiving the request, for care that is urgent. **Sections 13 and 36** of this bill require any adverse determination on a request for prior authorization to be made by a licensed physician or, for a request relating to dental care, a dentist, who has certain qualifications. **Sections 13 and 36** require an insurer, in certain circumstances, to allow the provider of health care who requested the prior authorization to discuss the issues involved in the request with the physician or dentist who is responsible for making a determination on the request. **Sections 13 and 36** require an insurer, upon making an

adverse determination on a request for prior authorization, to transmit certain information to the insured to whom the request pertains, including information relating to the right of the insured to appeal the adverse determination. **Sections 13 and 36** further require: (1) an insurer to establish a process for appeals that provides for the timely resolution of appeals submitted by insureds; and (2) a decision upholding an adverse determination on an appeal submitted by an insured to be made by a physician or dentist who has qualifications beyond those required of a physician or dentist who evaluates initial requests for prior authorization.

**Sections 14 and 37** of this bill: (1) provide that a request for prior authorization that has been approved by the insurer remains valid for 12 months; and (2) require an insurer, for the first 90 days of the coverage period for a new insured, to honor a request for prior authorization that has been approved by the previous insurer of the new insured, under certain circumstances. **Sections 14 and 37** prohibit an insurer from denying or imposing additional limits on a request for prior authorization that the insurer has previously approved if the care at issue in the request is provided within 90 business days after the date on which the insurer receives the request and certain other requirements are met.

**Sections 15 and 38** of this bill prohibit an insurer from requiring prior authorization for covered emergency services. **Sections 15 and 38** also prohibit an insurer from requiring that an insured or provider of health care notify the insurer earlier than the end of the business day following the date of admission or the date on which the emergency services are provided. Finally, **sections 15 and 38**: (1) prohibit an insurer from denying coverage for covered medically necessary emergency services; and (2) establish a presumption of medical necessity under certain conditions.

**Sections 3-12 and 27-33** of this bill define certain terms relating to the process of obtaining and processing requests for prior authorization, and **sections 2 and 26** of this bill establish the applicability of those definitions. **Sections 16 and 39** of this bill provide that if an insurer violates any provision of **section 13-15, 19 or 34-38** with respect to a particular request for prior authorization, that the request is deemed approved. **Sections 16 and 39** also clarify that nothing in any provision of **section 13-15, 19 or 34-38** require an insurer to provide coverage: (1) for care that the insurer does not cover, regardless of the medical necessity of the care; or (2) to persons to whom the insured is not obligated to provide coverage.

**Sections 17 and 40** of this bill require an insurer to annually publish on its Internet website certain information relating to requests for prior authorization that have been processed by the insurer during the immediately preceding year. **Sections 18 and 41** of this bill additionally require an insurer to publish an annual report of certain information relating to requests for prior authorization processed by the insurer during the immediately preceding year.

**Section 20** of this bill requires a nonprofit hospital and medical or dental service corporation to comply with **sections 2-18**. **Section 21** of this bill requires the Director of the Department of Health and Human Services to administer the provisions of **sections 25-41** of this bill in the same manner as other provisions governing Medicaid. **Sections 22, 23 and 44** of this bill require plans of self-insurance for employees of local governments, the Public Employees' Benefits Program and plans of self-insurance for private employers, respectively, to comply with the requirements of **sections 2-19** of this bill to the extent applicable. **Section 25** provides that a managed care organization that provides services to recipients of Medicaid or the Children's Health Insurance Program is not

subject to **sections 26-41**, but must comply with **sections 2-19**. **Section 42** of this bill requires the policies and procedures for coverage for prescription drugs under Medicaid to comply with **sections 26-41**.

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THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN

SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

**Section 1.** Chapter 687B of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 18, inclusive, of this act.

**Sec. 2.** ***As used in NRS 687B.225 and sections 2 to 18, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 12, inclusive, of this act have the meanings ascribed to them in those sections.***

**Sec. 3.** ***"Adverse determination" means a determination by a health carrier that an admission, availability of care, continued stay or other medical care or dental care that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested care or service or payment for the care or service is therefore denied, reduced or terminated.***

**Sec. 4.** ***"Emergency services" means health care services that are provided by a provider of health care to screen and to stabilize an insured after the sudden onset of a medical condition***

*that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:*

*1. Serious jeopardy to the health of the insured;*

*2. Serious jeopardy to the health of an unborn child of the insured;*

*3. Serious impairment of a bodily function of the insured; or*

*4. Serious dysfunction of any bodily organ or part of the insured.*

**Sec. 5.** *"Health carrier" has the meaning ascribed to it in NRS 695G.024, and includes, without limitation, an organization for dental care.*

**Sec. 6.** *"Individually identifiable health information" means information relating to the provision of health care to an insured:*

*1. That specifically identifies the insured; or*

*2. For which there is a reasonable basis to believe that the information can be used to identify the insured.*

**Sec. 7.** *"Insured" means a policyholder, subscriber, enrollee or other person covered by a health carrier.*

**Sec. 8.** *"Medically necessary" has the meaning ascribed to it in NRS 695G.055.*

**Sec. 9.** *"Network" means a defined set of providers of health care who are under contract with a health carrier to provide health care services pursuant to a network plan offered or issued by the health carrier.*

**Sec. 10.** *"Network plan" means a contract or policy of insurance offered by a health carrier under which the financing and delivery of medical or dental care is provided, in whole or in part, through a defined set of providers under contract with the health carrier.*

**Sec. 11.** *"Provider of health care" has the meaning ascribed to it in NRS 695G.070.*

**Sec. 12.** *"Urgent health care":*

*1. Means health care that, in the opinion of a provider of health care with knowledge of an insured's medical condition, if not rendered to the insured within 48 hours could:*

*(a) Seriously jeopardize the life or health of the insured or the ability of the insured to regain maximum function; or*

*(b) Subject the insured to severe pain that cannot be adequately managed without receiving such care.*

*2. Does not include emergency services.*

**Sec. 13.** *1. A health carrier shall not make an adverse determination on a request for prior authorization unless:*

*(a) The adverse determination is made by a physician or, for dental care, a dentist, who:*

*(1) Holds an unrestricted license to practice medicine or dentistry, as applicable, in any state or territory of the United States;*

*(2) Is of the same or similar specialty as a physician or dentist, as applicable, who typically manages or treats the medical or dental condition or provides the health or dental care involved in the request; and*

*(3) Has experience treating or managing the medical or dental condition involved in the request; and*

*(b) The adverse determination is reviewed and affirmed by:*

*(1) The medical director of the health carrier or a similar employee who is in charge of the medical operations of the health carrier; or*

*(2) A physician or, for dental care, a dentist, who:*

*(I) Has been designated by the medical director or similar employee to review the adverse determination; and*

*(II) Is employed by or contracted with the health carrier specifically to perform reviews or appeals of adverse determinations.*

*2. If a physician or dentist described in paragraph (a) of subsection 1 is considering making an adverse determination on a request for prior authorization on the basis that the medical or dental care involved in the request is not medically necessary, the health carrier that received the request shall:*

*(a) Immediately notify the provider of health care who submitted the request that the medical necessity of the requested care is being questioned by the health carrier; and*

*(b) Offer the provider of health care an opportunity to speak with the physician or dentist, as applicable, over the telephone or by videoconference to discuss the clinical issues involved in the request before the physician or dentist renders an initial determination on the request.*

*3. Upon rendering an adverse determination on a request for prior authorization, a health carrier shall immediately transmit to the insured to whom the request pertains a written notice that contains:*

*(a) A specific description of all reasons that the health carrier made the adverse determination;*

*(b) A description of any documentation that the health carrier requested from the insured or a provider of health care of the insured and did not receive or deemed insufficient, if the failure to receive sufficient documentation contributed to the adverse determination;*

*(c) A statement that the insured has the right to appeal the adverse determination;*

*(d) Instructions, written in clear language that is understandable to an ordinary layperson, describing how the insured can appeal the adverse determination through the process established pursuant to subsection 4; and*

*(e) A description of any documentation that may be necessary or pertinent to a potential appeal.*

*4. A health carrier shall establish a process that allows an insured to appeal an adverse determination on a request for prior authorization. The process must allow for the clear resolution of each appeal within a reasonable time.*

*5. A health carrier shall not uphold on appeal an adverse determination pertaining to a request for prior authorization unless the decision on the appeal is made by a physician or, for dental care, a dentist, who:*

*(a) Holds an unrestricted license to practice medicine or dentistry, as applicable, in any state or territory of the United States;*

*(b) Evaluates and treats patients in his or her capacity as an actively practicing physician or dentist, as applicable;*

*(c) Is of the same or similar specialty as a physician or dentist, as applicable, who typically manages or treats the medical or dental condition or provides the medical or dental care involved in the request;*

*(d) Has experience treating or managing the medical or dental condition involved in the request;*

*(e) Was not involved in making the adverse determination that is the subject of the appeal;*

*(f) Considers all known clinical aspects of the medical or dental care involved in the request; and*

*(g) Is employed by or contracted with the health carrier to:*

*(1) Participate in the network of the health carrier in his or her capacity as a practicing physician or dentist, as applicable; or*

*(2) Solely make determinations on reviews or appeals of adverse determinations.*

**Sec. 14.** *1. If a health carrier approves a request for prior authorization, the approval remains valid until 12 months after the date on which the request is approved.*

*2. A health carrier shall not revoke or impose an additional limit, condition or restriction on a request for prior authorization that the health carrier has previously approved unless:*

***(a) The care at issue in the request was not provided to the insured within 90 business days after the health carrier received the request;***

***(b) The health carrier determines that an insured or a provider of health care procured the approval by fraud or material misrepresentation; or***

***(c) The health carrier determines that the care at issue in the request was not covered by the health carrier at the time the care was provided.***

***3. A health carrier that has approved a request for prior authorization shall not deny or refuse to promptly pay a claim for the approved medical or dental care unless the health carrier determines that the insured or provider of health care procured the prior authorization by fraud or material misrepresentation. The claim must be paid at the same rate that the health carrier is contractually obligated to or would ordinarily pay a provider of health care for providing the specific type of care that was approved and provided to the insured.***

***4. Within the first 90 days of the coverage period for an insured, a health carrier shall honor a request for prior authorization that has been approved by a health carrier or other entity that previously provided the insured with coverage for medical or dental care if:***

***(a) The approval was issued within the 12 months immediately preceding the first day of the coverage period under the current contract or policy of insurance; and***

***(b) The specific medical or dental care included within the request is not affirmatively excluded under the terms and conditions of the contract or policy of insurance issued by the health carrier.***

*5. As used in this section, "coverage period" means the current term of a contract or policy of insurance issued by a health carrier.*

**Sec. 15.** *1. A health carrier shall not require prior authorization for emergency services covered by the health carrier, including, where applicable, transportation by ambulance to a hospital or other medical facility.*

*2. If a health carrier requires an insured or his or her provider of health care to notify the health carrier that the insured has been admitted to a hospital to receive emergency services or has received emergency services, the health carrier shall not require an insured or a provider of health care to transmit such a notice earlier than the end of the business day immediately following the day after the date on which the insured was admitted or the emergency services were provided, as applicable.*

*3. A health carrier shall not deny coverage for emergency services covered by the health carrier that are medically necessary. Emergency services are presumed to be medically necessary if, within 72 hours after an insured is admitted to receive emergency services, the insured's provider of health care transmits to the health carrier a certification, in writing, that the condition of the insured required emergency services. The health carrier may rebut that presumption by establishing, by clear and convincing evidence, that the emergency services were not medically necessary.*

*4. A health carrier shall make all determinations for whether emergency services are medically necessary without regard to whether a provider of health care that provided or billed for those services participates in the network of the health carrier.*

**Sec. 16.** *1. If a health carrier violates NRS 687B.225 or section 13, 14 or 15 of this act with respect to a particular request for prior authorization, the request shall be deemed approved.*

*2. Nothing in NRS 687B.225 or section 13, 14 or 15 of this act shall be construed to require a health carrier to provide coverage:*

*(a) For medical or dental care that, regardless of whether such care is medically necessary, would not be a covered benefit under the terms and conditions of the contract or policy of insurance;*

*(b) To a person who is not insured by the health carrier on the date on which medical or dental care is provided to the person; or*

*(c) To an insured who, as a result of his or her failure to pay the applicable premiums required under the terms and conditions of a contract or policy of insurance, has no coverage under the contract or policy on the date on which medical or dental care is provided to the insured.*

**Sec. 17.** *1. On or before March 1 of each calendar year, a health carrier shall publish on an Internet website maintained by the health carrier in an easily accessible format the following information for the immediately preceding calendar year, in aggregated form for all requests for prior authorization received by the insurer during the immediately preceding year and disaggregated in accordance with subsection 2:*

*(a) The percentage of requests for prior authorization for medical or dental care in this State that were approved upon initial review;*

*(b) The percentage of requests for prior authorization for medical or dental care in this State that resulted in an adverse determination upon initial review;*

*(c) The percentage of the adverse determinations described in paragraph (b) that were appealed;*

*(d) The percentage of appeals of adverse determinations described in paragraph (c) that resulted in a reversal of the adverse determination;*

*(e) The five most common reasons for the adverse determinations described in paragraph (b); and*

*(f) The average time between a request for prior authorization for medical or dental care in this State and the resolution of the request.*

*2. The information described in subsection 1 must be disaggregated for the following categories:*

*(a) The specialty of the provider of health care who submitted a request for prior authorization; and*

*(b) The types of health or dental care at issue in the request for prior authorization, including the specific types of prescription drugs, procedures or diagnostic tests involved in the requests.*

*3. A health carrier shall not include individually identifiable health information in the information published pursuant to subsection 1.*

**Sec. 18.** *1. On or before March 1 of each calendar year, a health carrier shall compile and transmit to the Commissioner, in a form prescribed by the Commissioner, and publish on*

***an Internet website maintained by the health carrier a report containing the following information:***

***(a) The specific goods and services for which the health carrier requires prior authorization and, for each good or service:***

***(1) The date on which prior authorization for that good or service became required for contracts or policies issued or delivered in this State and the date on which that requirement was listed on the Internet website of the health carrier pursuant to subsection 6 of NRS 687B.225;***

***(2) The number of requests for prior authorization received by the health carrier during the immediately preceding calendar year for the provision of the good or service to insureds in this State;***

***(3) The number and percentage of the requests listed pursuant to subparagraph (2) that were approved;***

***(4) The number and percentage of the requests listed pursuant to subparagraph (2) that resulted in adverse determinations; and***

***(5) The number of appeals from adverse determinations during the immediately preceding calendar year and the percentage of those appeals that were reversed on appeal by the health carrier.***

***(b) For all requests for prior authorization for non-urgent health or dental care received by the health carrier during the immediately preceding calendar year, the average and median time between:***

***(1) The health carrier receiving a request for prior authorization and the health carrier approving or making an adverse determination on the request; and***

***(2) The submission of an appeal of an adverse determination on a request for prior authorization and the resolution of the appeal.***

***(c) For all requests for prior authorization for urgent health care received by the health carrier during the immediately preceding calendar year, the average and median time between:***

***(1) The health carrier receiving a request for prior authorization and the health carrier approving or making an adverse determination on the request; and***

***(2) The submission of an appeal of an adverse determination on a request for prior authorization and the resolution of the appeal.***

***2. On or before May 1 of each even-numbered year, the Commissioner shall:***

***(a) Compile a report summarizing the information submitted to the Commissioner pursuant to subsection 1 during the immediately preceding biennium and providing recommendations for legislation to improve the process for obtaining prior authorization; and***

***(b) Submit the report and all information provided to the Commissioner pursuant to subsection 1 to the Director of the Legislative Counsel Bureau for transmittal to the Joint Interim Standing Committee on Health and Human Services and the Joint Interim Standing Committee on Commerce and Labor.***

***3. A health carrier shall not include individually identifiable health information in a report published pursuant to subsection 1.***

**Sec. 19.** NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0412, 689A.0413, 689A.0418, 689A.0437, 689A.044, 689A.0445, 689A.0459, 689B.031, 689B.0312, 689B.0313, 689B.0315, 689B.0317, 689B.0319, 689B.0374, 689B.0378, 689C.1665, 689C.1671, 689C.1675, 689C.1676, 695A.1843, 695A.1856, 695A.1865, 695A.1874, 695B.1912, 695B.1913, 695B.1914, 695B.1919, 695B.19197, 695B.1924, 695B.1925, 695B.1942, 695C.1696, 695C.1699, 695C.1713, 695C.1735, 695C.1737, 695C.1743, 695C.1745, 695C.1751, 695G.170, 695G.1705, 695G.171, 695G.1714, 695G.1715, 695G.1719 and 695G.177, ***and section 15 of this act,*** any contract ~~[for group, blanket or individual health]~~ ***or policy of*** insurance ~~[or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care]~~ ***issued by a health carrier*** which provides for payment of a certain part of medical or dental care may require the insured ~~[or member]~~ to obtain prior authorization for that care from the ~~[insurer or organization. The insurer or organization]~~ ***health carrier in a manner consistent with this section and sections 2 to 18, inclusive, of this act.***

***2. A health carrier that requires an insured to obtain prior authorization*** shall:

(a) File its procedure for obtaining ~~[approval of care]~~ ***prior authorization*** pursuant to this section ***, including, without limitation, a list of the specific goods and services for which the health carrier requires prior authorization and the clinical review criteria used by the health carrier to evaluate requests for prior authorization,*** for approval by the Commissioner ***.*** ~~[; and]~~

(b) Unless a shorter time period is prescribed by a specific statute, including, without limitation, NRS 689A.0446, 689B.0361, 689C.1688, 695A.1859, 695B.19087, 695C.16932 and 695G.1703, ~~[respond to]~~ ***and except as otherwise provided by paragraph (c), approve or make***

***an adverse determination on*** any request for ~~[approval by the insured or member]~~ ***prior authorization submitted by or on behalf of the insured*** pursuant to this section ~~[within 20 days after it receives the request.]~~ ***and notify the insured and his or her provider of health care of the approval or adverse determination:***

***(1) For non-urgent medical or dental care, within 5 days after receiving the request.***

***(2) For urgent health care, within 24 hours after receiving the request.***

***(c) If the health carrier requires additional, medically relevant information or documentation in order to adequately evaluate a request for prior authorization:***

***(1) Notify the insured and the provider of health care who submitted the request within the applicable amount of time described in paragraph (b) that additional information is required to evaluate the request;***

***(2) Include within the notification sent pursuant to subparagraph (1) a description, with reasonable specificity, of the information that the health carrier requires to make a determination on the request for prior authorization; and***

***(3) Approve or make an adverse determination on the request:***

***(I) For non-urgent medical or dental care, within 5 days after receiving the information.***

***(II) For urgent health care, within 24 hours after receiving the information.***

~~[2.]~~ ***3.*** The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

***4. If a health carrier seeks to amend its procedure for obtaining prior authorization, including, without limitation, changing the goods and services for which the health carrier requires prior authorization or changing the clinical review criteria used by the health carrier, the health carrier:***

***(a) Must file a request to amend the procedure for approval by the Commissioner.***

***(b) May not allow the amended procedure to take effect until:***

***(1) The Commissioner notifies the health carrier that the request is approved; and***

***(2) The health carrier satisfies the requirements of subsection 5 after the health carrier receives a notice of approval from the Commissioner.***

***5. A change to a health carrier's procedure for obtaining prior authorization may not take effect until:***

***(a) The health carrier transmits a notice that contains a summary of the changes to the procedure to each of its insureds and providers of health care who participate in the network of the health carrier;***

***(b) The health carrier updates the information published on its Internet website pursuant to subsection 6 to reflect the amended procedure for obtaining prior authorization and the date on which the amended procedure takes effect; and***

***(c) At least 60 days have passed after the later of:***

***(1) The date on which the health carrier transmitted the notice to its insureds and providers of health care who participate in the network of the health carrier pursuant to paragraph (a); or***

***(2) The date on which the health carrier updated the information published on its Internet website pursuant to paragraph (b).***

***6. A health carrier shall publish its procedures for obtaining prior authorization, including, without limitation, the clinical review criteria, on its Internet website:***

***(a) Using clear language that is understandable to an ordinary layperson, where practicable; and***

***(b) In a place that is readily accessible and conspicuous to insureds and the public.***

***7. A health carrier shall not deny a claim based on the failure of an insured to obtain prior authorization for medical or dental care if the procedure for obtaining prior authorization established by the health carrier did not require the insured to obtain prior authorization for that medical or dental care on the date that the medical or dental care was provided to the insured.***

***8. As used in this section, "clinical review criteria" means any written screening procedure, decision abstract, clinical protocol or practice guideline used by the health carrier to determine the necessity and appropriateness of medical or dental care.***

**Sec. 20.** NRS 695B.320 is hereby amended to read as follows:

695B.320 1. Nonprofit hospital and medical or dental service corporations are subject to the provisions of this chapter, and to the provisions of chapters 679A and 679B of NRS, subsections 2, 4, 17, 18 and 30 of NRS 680B.010, NRS 680B.025 to 680B.060, inclusive, chapter 681B of NRS, NRS 686A.010 to 686A.315, inclusive, 686B.010 to 686B.175, inclusive, 687B.010 to 687B.040, inclusive, 687B.070 to 687B.140, inclusive, 687B.150, 687B.160, 687B.180, 687B.200

to 687B.255, inclusive, ***and sections 2 to 18, inclusive, of this act,*** 687B.270, 687B.310 to 687B.380, inclusive, 687B.410, 687B.420, 687B.430, 687B.500 and chapters 692B, 692C, 693A and 696B of NRS, to the extent applicable and not in conflict with the express provisions of this chapter.

2. For the purposes of this section and the provisions set forth in subsection 1, a nonprofit hospital and medical or dental service corporation is included in the meaning of the term "insurer."

**Sec. 21.** NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, ***and sections 25 to 41, inclusive, of this act,*** 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities

of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department.

**Sec. 22.** NRS 287.010 is hereby amended to read as follows:

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

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

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

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 439.581 to 439.597, inclusive, 686A.135, ***paragraphs (b) and (c) of subsection 2 and subsections 1, 3, 5, 6 and 7 of NRS 687B.225,*** 687B.352, 687B.408, 687B.692, 687B.723, 687B.725, 687B.805, 689B.030 to 689B.0317, inclusive, paragraphs (b) and (c) of subsection 1 of NRS 689B.0319, subsections 2, 4, 6 and 7 of NRS 689B.0319, 689B.033 to 689B.0369, inclusive, 689B.0375 to 689B.050, inclusive, 689B.0675, 689B.265, 689B.287 and 689B.500 ***and sections 2 to 18, inclusive, of this act*** apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and 689B.500 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.

(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws

governing the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada.

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

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

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

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

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

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

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

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

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

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

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

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 439.581 to 439.597, inclusive, 686A.135, ***paragraphs (b) and (c) of subsection 2 and subsections 1, 3, 5, 6 and 7 of NRS 687B.225,*** 687B.352, 687B.409, 687B.692, 687B.723, 687B.725, 687B.805, 689B.0353, 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.1675, 695G.170 to 695G.1712, inclusive, 695G.1714 to 695G.174, inclusive, 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, 695G.405 and 695G.415, ***and sections 2 to 18, inclusive, of this act*** in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

**Sec. 24.** Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 25 to 41, inclusive, of this act.

**Sec. 25.** ***1. The provisions of sections 26 to 41, inclusive, of this act and any policies developed pursuant thereto do not apply to the delivery of services to recipients of Medicaid or the Children's Health Insurance Program through managed care in accordance with NRS 422.273.***

***2. A health maintenance organization or other managed care organization that enters into a contract with the Department or the Division pursuant to NRS 422.273 to provide health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program shall comply with NRS 687B.225 and sections 2 to 18, inclusive, of this act.***

**Sec. 26.** ***As used in sections 26 to 41, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 27 to 33, inclusive, of this act have the meanings ascribed to them in those sections.***

**Sec. 27.** ***"Adverse determination" means a determination by the Department that an admission, availability of care, continued stay or other medical care or dental care that is a covered benefit has been reviewed and, based upon the information provided, does not meet the Department's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested care or service or payment for the care or service is therefore denied, reduced or terminated.***

**Sec. 28.** ***"Emergency services" means health care services that are provided by a provider of health care to screen and to stabilize a recipient after the sudden onset of a medical condition***

*that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:*

*1. Serious jeopardy to the health of the recipient;*

*2. Serious jeopardy to the health of an unborn child of the recipient;*

*3. Serious impairment of a bodily function of the recipient; or*

*4. Serious dysfunction of any bodily organ or part of the recipient.*

**Sec. 29.** *"Individually identifiable health information" means information relating to the provision of health care to a recipient:*

*1. That specifically identifies the recipient; or*

*2. For which there is a reasonable basis to believe that the information can be used to identify the recipient.*

**Sec. 30.** *"Medically necessary" has the meaning ascribed to it in NRS 695G.055.*

**Sec. 31.** *"Provider of health care" has the meaning ascribed to it in NRS 695G.070.*

**Sec. 32.** *"Recipient" means a natural person who receives benefits through Medicaid or the Children's Health Insurance Program, as applicable.*

**Sec. 33.** *"Urgent health care":*

*1. Means health care that, in the opinion of a provider of health care with knowledge of a recipient's medical condition, if not rendered to the recipient within 48 hours could:*

*(a) Seriously jeopardize the life or health of the recipient or the ability of the recipient to regain maximum function; or*

*(b) Subject the recipient to severe pain that cannot be adequately managed without receiving such care.*

*2. Does not include emergency services.*

**Sec. 34.** *1. The Department, with respect to Medicaid and the Children's Health Insurance Program, shall establish written procedures for obtaining prior authorization for medical or dental care which must include, without limitation:*

*(a) A list of the specific goods and services for which the Department requires prior authorization; and*

*(b) A description of the clinical review criteria used by the Department.*

*2. The Department shall publish the written procedures for obtaining prior authorization established by the Department pursuant to subsection 1, including, without limitation, the clinical review criteria, on an Internet website maintained by the Department:*

*(a) Using clear language that is understandable to an ordinary layperson, where practicable; and*

*(b) In a place that is readily accessible and conspicuous to recipients and the public.*

*3. If the Department amends the procedure for obtaining prior authorization adopted pursuant to subsection 1, including, without limitation, changing the goods and services for which the Department requires prior authorization or changing the clinical review criteria used by the Department, the Department shall:*

*(a) Transmit a notice containing a summary of the changes made to the procedure to each recipient and each provider of goods or services under Medicaid or the Children's Health Insurance Program, as applicable; and*

*(b) Update the information published on its Internet website pursuant to subsection 2 to reflect the amended procedure for obtaining prior authorization and the date on which the amended procedure takes effect.*

*4. A change to the Department's procedure for obtaining prior authorization may not take effect until 60 days have passed after the later of:*

*(a) The date on which the Department transmitted the notice to recipients and providers of goods or services under Medicaid or the Children's Health Insurance Program, as applicable, pursuant to paragraph (a) of subsection 3; or*

*(b) The date on which the Department updated the information published on its Internet website pursuant to paragraph (b) of subsection 3.*

*5. The Department shall not deny a claim based on the failure of a recipient to obtain prior authorization for medical or dental care if the procedure for obtaining prior authorization established by the Department pursuant to this section did not require the recipient to obtain prior authorization for that medical or dental care on the date that the medical or dental care was provided to the recipient.*

*6. As used in this section, "clinical review criteria" means any written screening procedure, decision abstract, clinical protocol or practice guideline used by the Department to determine the necessity and appropriateness of medical or dental care.*

**Sec. 35.** *1. Unless a shorter time period is prescribed by a specific statute, and except as otherwise provided in subsection 2, the Department, with respect to Medicaid and the Children's Health Insurance Program, shall approve or make an adverse determination on a request for prior authorization submitted by or on behalf of a recipient and notify the recipient and his or her provider of health care of the approval or adverse determination:*

*(a) For non-urgent medical or dental care, within 5 days after receiving the request.*

*(b) For urgent health care, within 24 hours after receiving the request.*

*2. If the Department requires additional, medically relevant information or documentation in order to adequately evaluate a request for prior authorization, the Department shall:*

*(a) Notify the recipient and the provider of health care who submitted the request within the applicable amount of time described in subsection 1 that additional information is required to evaluate the request;*

*(b) Include within the notification sent pursuant to paragraph (a) a description, with reasonable specificity, of the information that the Department requires to make a determination on the request for prior authorization; and*

*(c) Approve or make an adverse determination on the request:*

*(1) For non-urgent medical or dental care, within 5 days after receiving the information.*

*(2) For urgent health care, within 24 hours after receiving the information.*

**Sec. 36.** *1. The Department, with respect to Medicaid and the Children's Health Insurance Program, shall not make an adverse determination on a request for prior*

***authorization unless the adverse determination is made by a physician or, for a request relating to dental care, a dentist, who:***

***(a) Holds an unrestricted license to practice medicine or dentistry, as applicable, in any state or territory of the United States;***

***(b) Is of the same or similar specialty as a physician or dentist, as applicable, who typically manages or treats the medical or dental condition or provides the medical or dental care involved in the request; and***

***(c) Has experience treating or managing the medical or dental condition involved in the request.***

***2. If a physician or dentist described in subsection 1 is considering making an adverse determination on a request for prior authorization on the basis that the medical or dental care involved in the request is not medically necessary, the Department shall:***

***(a) Immediately notify the provider of health care who submitted the request that the medical necessity of the requested care is being questioned by the Department; and***

***(b) Offer the provider of health care an opportunity to speak with the physician or dentist, as applicable, over the telephone or by videoconference to discuss the clinical issues involved in the request before the physician or dentist renders an initial determination on the request.***

***3. Upon rendering an adverse determination on a request for prior authorization, the Department shall immediately transmit to the recipient to whom the request pertains a written notice that contains:***

*(a) A specific description of all reasons that the Department made the adverse determination;*

*(b) A description of any documentation that the Department requested from the recipient or a provider of health care of the recipient and did not receive or deemed insufficient, if the failure to receive sufficient documentation contributed to the adverse determination;*

*(c) A statement that the recipient has the right to appeal the adverse determination;*

*(d) Instructions, written in clear language that is understandable to an ordinary layperson, describing how the recipient can appeal the adverse determination through the process established pursuant to subsection 4; and*

*(e) A description of any documentation that may be necessary or pertinent to a potential appeal.*

*4. The Department shall establish a process that allows a recipient to appeal an adverse determination on a request for prior authorization. The process must allow for the clear resolution of each appeal within a reasonable time.*

*5. The Department shall not uphold on appeal an adverse determination pertaining to a request for prior authorization unless the decision on the appeal is made by a physician, or, for an appeal relating to dental care, a dentist, who:*

*(a) Holds an unrestricted license to practice medicine or dentistry, as applicable, in any state or territory of the United States;*

*(b) Evaluates and treats patients in his or her capacity as an actively practicing physician or dentist, as applicable;*

*(c) Is of the same or similar specialty as a physician or dentist, as applicable, who typically manages or treats the medical or dental condition or provides the medical or dental care involved in the request;*

*(d) Has experience treating or managing the medical or dental condition involved in the request;*

*(e) Was not involved in making the adverse determination that is the subject of the appeal;*

*(f) Considers all known clinical aspects of the medical or dental care involved in the request; and*

*(g) Is employed by or contracted with the Department solely to make determinations on appeals of adverse determinations.*

**Sec. 37.** *1. If the Department approves a request for prior authorization, the approval remains valid until 12 months after the date on which the request is approved.*

*2. The Department shall not revoke or impose an additional limit, condition or restriction on a request for prior authorization that the Department has previously approved unless:*

*(a) The care at issue in the request was not provided to the recipient within 90 business days after the Department received the request;*

*(b) The Department determines that a recipient or a provider of health care procured the approval by fraud or material misrepresentation; or*

*(c) The Department determines that the care at issue in the request was not covered by Medicaid or the Children's Health Insurance Program, as applicable, at the time the care was provided.*

*3. If the Department has approved a request for prior authorization, the Department shall not deny or refuse to promptly pay a claim for the approved medical or dental care unless the Department determines that the recipient or provider of health care procured the prior authorization by fraud or material misrepresentation. The claim must be paid at the same rate that the Department is contractually obligated to or would ordinarily pay a provider of health care for providing the specific type of care that was approved and provided to the recipient.*

*4. Within the first 90 days that a recipient is enrolled in Medicaid or the Children's Health Insurance Program, as applicable, the Department shall honor a request for prior authorization that has been approved by a health carrier or other entity that previously provided the recipient with coverage for medical or dental care if:*

*(a) The approval was issued within the 12 months immediately preceding the first day of the enrollment of the recipient; and*

*(b) The specific medical or dental care included within the request is not affirmatively excluded under the terms and conditions of Medicaid or the Children's Health Insurance Program, as applicable.*

*5. As used in this section, "health carrier" has the meaning ascribed to it in NRS 695G.024 and includes, without limitation, an organization for dental care.*

**Sec. 38.** *1. The Department, with respect to Medicaid and the Children's Health Insurance Program, shall not require prior authorization for covered emergency services, including, where applicable, transportation by ambulance to a hospital or other medical facility.*

*2. If the Department requires a recipient or his or her provider of health care to notify the Department that the recipient has been admitted to a hospital to receive emergency services or has received emergency services, the Department shall not require a recipient or a provider of health care to transmit such a notice earlier than the end of the business day immediately following the day after the date on which the recipient was admitted or the emergency services were provided, as applicable.*

*3. The Department shall not deny coverage for emergency services covered by Medicaid or the Children's Health Insurance Program that are medically necessary. Emergency services are presumed to be medically necessary if, within 72 hours after a recipient is admitted to receive emergency services, the recipient's provider of health care transmits to the Department a certification, in writing, that the condition of the recipient required emergency services. The Department may rebut that presumption by establishing, by clear and convincing evidence, that the emergency services were not medically necessary.*

**Sec. 39.** *1. If the Department violates sections 34 to 38, inclusive, of this act with respect to a particular request for prior authorization, the request shall be deemed approved.*

*2. Nothing in sections 34 to 38, inclusive, of this act shall be construed to require the Department to provide coverage:*

*(a) For medical or dental care that, regardless of whether such care is medically necessary, would not be a covered benefit under the terms and conditions of Medicaid or the Children's Health Insurance Program, as applicable; or*

*(b) To a person who is not a recipient or is not otherwise eligible to receive coverage under Medicaid or the Children's Health Insurance Program, as applicable, on the date on which medical or dental care is provided to the person.*

**Sec. 40.** *1. On or before March 1 of each calendar year, the Department shall publish on an Internet website maintained by the Department in an easily accessible format the following information for the immediately preceding calendar year, in aggregated form for all requests for prior authorization received by the insurer during the immediately preceding year and disaggregated in accordance with subsection 2:*

*(a) The percentage of requests for prior authorization for medical or dental care that were approved upon initial review;*

*(b) The percentage of requests for prior authorization for medical or dental care that resulted in an adverse determination upon initial review;*

*(c) The percentage of the adverse determinations described in paragraph (b) that were appealed;*

*(d) The percentage of appeals of adverse determinations described in paragraph (c) that resulted in a reversal of the adverse determination;*

*(e) The five most common reasons for the adverse determinations described in paragraph (b); and*

*(f) The average time between a request for prior authorization for medical or dental care in this State and the resolution of the request.*

*2. The information described in subsection 1 must be disaggregated for the following categories:*

*(a) The specialty of the provider of health care who submitted a request for prior authorization; and*

*(b) The types of health or dental care at issue in the request for prior authorization, including the specific types of prescription drugs, procedures or diagnostic tests involved in the requests.*

*3. The Department shall not include individually identifiable health information in the information published pursuant to subsection 1.*

**Sec. 41.** *1. On or before March 1 of each calendar year, the Department shall:*

*(a) Compile a report containing the following information for Medicaid and the Children's Health Insurance Program:*

*(1) The specific goods and services for which the Department requires prior authorization and, for each good or service:*

*(I) The date on which the Department began requiring prior authorization for that good or service and the date on which that requirement was listed on the Internet website of the Department pursuant to section 34 of this act;*

*(II) The number of requests for prior authorization received by the Department during the immediately preceding calendar year for the provision of the good or service;*

*(III) The number and percentage of the requests listed pursuant to sub-subparagraph (II) that were approved;*

*(IV) The number and percentage of the requests listed pursuant to sub-subparagraph (II) that resulted in adverse determinations; and*

*(V) The number of appeals from adverse determinations during the immediately preceding calendar year and the percentage of those appeals that were reversed on appeal by the Department;*

*(2) For all requests for prior authorization for non-urgent health or dental care received by the Department during the immediately preceding calendar year, the average and median time between:*

*(I) The Department receiving a request for prior authorization and the Department approving or making an adverse determination on the request; and*

*(II) The submission of an appeal of an adverse determination on a request for prior authorization and the resolution of the appeal; and*

*(3) For all requests for prior authorization for urgent health care received by the Department during the immediately preceding calendar year, the average and median time between:*

*(I) The Department receiving a request for prior authorization and the Department approving or making an adverse determination on the request; and*

*(II) The submission of an appeal of an adverse determination on a request for prior authorization and the resolution of the appeal;*

*(b) Post the report on the Internet website maintained by the Department; and*

***(c) Submit the report to the Director of the Legislative Counsel Bureau for transmittal to the Joint Interim Standing Committee on Health and Human Services.***

***2. The Department shall not include individually identifiable health information in a report published pursuant to subsection 1.***

**Sec. 42.** NRS 422.403 is hereby amended to read as follows:

422.403 1. The Department shall, by regulation, establish and manage the use by the Medicaid program of step therapy and prior authorization for prescription drugs.

2. The Drug Use Review Board shall:

(a) Advise the Department concerning the use by the Medicaid program of step therapy and prior authorization for prescription drugs;

(b) Develop step therapy protocols and prior authorization policies and procedures ***that comply with the provisions of sections 26 to 41, inclusive, of this act*** for use by the Medicaid program for prescription drugs; and

(c) Review and approve, based on clinical evidence and best clinical practice guidelines and without consideration of the cost of the prescription drugs being considered, step therapy protocols used by the Medicaid program for prescription drugs.

3. The step therapy protocol established pursuant to this section must not apply to a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition of a recipient of Medicaid, if:

(a) The drug has been approved by the Food and Drug Administration with indications for the psychiatric condition of the insured or the use of the drug to treat that psychiatric condition is otherwise supported by medical or scientific evidence;

(b) The drug is prescribed by:

(1) A psychiatrist;

(2) A physician assistant under the supervision of a psychiatrist;

(3) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120; or

(4) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraph (1), (2) or (3), if the closest practitioner listed in subparagraph (1), (2) or (3) who participates in Medicaid is located 60 miles or more from the residence of the recipient; and

(c) The practitioner listed in paragraph (b) who prescribed the drug knows, based on the medical history of the recipient, or reasonably expects each alternative drug that is required to be used earlier in the step therapy protocol to be ineffective at treating the psychiatric condition.

4. The Department shall not require the Drug Use Review Board to develop, review or approve prior authorization policies or procedures necessary for the operation of the list of preferred prescription drugs developed pursuant to NRS 422.4025.

5. The Department shall accept recommendations from the Drug Use Review Board as the basis for developing or revising step therapy protocols and prior authorization policies and procedures used by the Medicaid program for prescription drugs.

6. As used in this section:

(a) "Medical or scientific evidence" has the meaning ascribed to it in NRS 695G.053.

(b) "Step therapy protocol" means a procedure that requires a recipient of Medicaid to use a prescription drug or sequence of prescription drugs other than a drug that a practitioner recommends for treatment of a psychiatric condition of the recipient before Medicaid provides coverage for the recommended drug.

**Sec. 43.** NRS 439B.736 is hereby amended to read as follows:

439B.736 1. "Third party" includes, without limitation:

(a) The issuer of a health benefit plan, as defined in NRS 695G.019 ***;*** ~~**[**, which provides coverage for medically necessary emergency services;**]**~~

(b) The Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043;

(c) The Public Option established pursuant to NRS 695K.200; and

(d) Any other entity or organization that elects pursuant to NRS 439B.757 for the provisions of NRS 439B.700 to 439B.760, inclusive, to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons.

2. The term does not include the State Plan for Medicaid, the Children's Health Insurance Program or a health maintenance organization, as defined in NRS 695C.030, or managed care organization, as defined in NRS 695G.050, when providing health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the

Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department.

**Sec. 44.** NRS 608.1555 is hereby amended to read as follows:

608.1555 Any employer who provides benefits for health care to his or her employees shall provide the same benefits and pay providers of health care in the same manner as a policy of insurance pursuant to chapters 689A and 689B of NRS, including, without limitation, as required by ***paragraphs (b) and (c) of subsection 2 and subsections 1, 3, 5, 6 and 7 of NRS 687B.225,*** NRS 687B.409, 687B.723 and 687B.725 ~~[.]~~ ***and sections 2 to 18, inclusive, of this act.***

**Sec. 45.** 1. The amendatory provisions of this act do not apply to a request for prior authorization submitted:

(a) Under a contract or policy of health insurance issued before January 1, 2026, but apply to any request for prior authorization submitted under any renewal of such a contract or policy.

(b) To the Department of Health and Human Services before January 1, 2026, for medical or dental care provided to a recipient of Medicaid.

2. A health carrier must, in order to continue requiring prior authorization in contracts or policies of health insurance issued or renewed after January 1, 2026:

(a) Develop a procedure for obtaining prior authorization that complies with NRS 687B.225, as amended by section 19 of this act, and sections 2 to 18, inclusive, of this act; and

(b) Obtain the approval of the Commissioner of Insurance pursuant to NRS 687B.225, as amended by section 19 of this act, for the procedure developed pursuant to paragraph (a).

3. As used in this section, "health carrier" has the meaning ascribed to it in section 5 of this act.

**Sec. 46.** The provisions 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. 47.** 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. 48.** 1. This section and section 45 of this act become effective upon passage and approval.

2. Sections 1 to 44, inclusive, 46 and 47 of this act become effective:

(a) Upon passage and approval for the purpose of adopting any regulations, performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act and approving procedures for obtaining prior authorization pursuant to NRS 687B.225, as amended by section 19 of this act, and section 45 of this act; and

(b) On January 1, 2026, for all other purposes.