ASSEMBLY BILL NO. 295–ASSEMBLYMEMBERS YUREK, EDGEWORTH; AND BROWN-MAY

FEBRUARY 25, 2025

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to health insurance. (BDR 57-238)

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

CONTAINS UNFUNDED MANDATE (§ 12)
(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 insurance; imposing requirements relating to prior authorization; prescribing certain requirements relating to the use of artificial intelligence by health insurers; requiring the compilation and publication of certain reports relating to prior authorization; providing for the investigation and adjudication of certain violations; providing for the imposition of civil and administrative penalties for such violations; 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 respond to a request for prior authorization within 20 days of the receiving the request. (NRS 687B.225) **Sections 9 and 17** of this bill require an insurer, including Medicaid and the Children's Health Insurance Program, to approve or make an adverse determination on a request for prior authorization, 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) forty-eight hours after receiving the request, for care that is urgent. **Sections 9 and 17** require an insurer to transmit certain information to an insured and his or her provider of health care after making an adverse determination on a request for prior authorization pertaining to the insured. **Sections 9 and 17** also provide that a request for prior authorization that has been approved by the insurer for a

continuous course of treatment relating to a chronic or long-term condition remains valid for 12 months, with certain exceptions.

Sections 6 and 18 of this bill require an insurer that employs or utilizes an artificial intelligence system or automated decision tool and, if such a system or tool is used under Medicaid or the Children's Health Insurance Program, the Department of Health and Human Services to process requests for prior authorization to transmit a notice to each of its insureds that: (1) discloses the insurer's use of the system or tool to process requests for prior authorization; and (2) describes certain aspects of the system or tool. **Section 6 and 18** prohibit an insurer from using an artificial intelligence system or automated decision tool to make an adverse determination on a request for prior authorization, or to terminate, reduce or modify a previously approved request for prior authorization, unless that action is independently reviewed by a physician or dentist, as applicable, who possesses certain qualifications.

Section 7 of this bill requires certain insurers to annually compile and submit a report to the Commissioner of Insurance and the Director of the Department of Health and Human Services that contains certain information relating to the requests for prior authorization for care provided to insureds in this State during the immediately preceding year. **Section 7** requires the Director and the Commissioner to publish the reports submitted by insurers to on their respective Internet websites. **Section 19** of this bill requires the Department to annually compile and publish a similar report containing information relating to requests for prior authorization for care provided to recipients of Medicaid during the immediately preceding calendar year.

Section 8 of this bill prescribes procedures for investigating and imposing penalties against a private sector insurer that: (1) fails to submit a report required by **section 7**; or (2) fails to comply with the requirements for making determinations on requests for prior authorization during the periods of time established by **section 9**. **Section 8** also prescribes the amount of the civil penalty that the Commissioner must impose for such violations and authorizes the Commissioner to adopt regulations prescribing additional sanctions for repeated noncompliance.

Sections 3-5 and 16 of this bill define certain terms, and **section 2** of this bill establishes the applicability of the definitions set forth in **sections 3-5**. **Section 10** of this bill makes **sections 2-8** applicable to nonprofit medical or dental service corporations. **Section 11** of this bill makes a conforming change to require the Director of the Department of Health and Human Services to administer the provisions of **sections 15-19** in the same manner as other provisions governing Medicaid. **Sections 12, 13 and 21** 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 certain requirements of **sections 6 and 9**, to the extent applicable. **Section 15** of this bill provides that managed care organizations that provide services to recipients of Medicaid or the Children's Health Insurance Program are exempt from **sections 16-19**, which govern prior authorization under Medicaid and the Children's Health Insurance Program provided directly by the Department, but such managed care organizations must comply with **sections 3-9**, which govern prior authorization required by private sector health insurers. **Section 20** of this bill requires any policy or procedure established for prescription drug coverage under Medicaid relating to prior authorization to comply with the provisions of **sections 16-19**.

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 8, inclusive, of this act.

Sec. 2. ***As used in NRS 687B.225 and sections 2 to 8, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3, 4 and 5 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 health care service that is a covered benefit has been reviewed and, based on 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 service or payment for the service is therefore denied, reduced or terminated.***

Sec. 4. ***"Health carrier" has the meaning ascribed to it in NRS 695G.024, and includes, without limitation, an organization for dental care.***

Sec. 5. ***"Insured" means a policyholder, subscriber, enrollee or other person covered by a health carrier.***

Sec. 6. ***1. If a health carrier utilizes an artificial intelligence system or an automated decision tool to process requests for prior authorization, the health carrier shall transmit to each of its insureds, in writing:***

(a) A statement that the health carrier utilizes an artificial intelligence system or automated decision tool to process requests for prior authorization;

(b) A general description of how the artificial intelligence system or automated decision tool works; and

(c) A description of the specific types of information or data utilized by the artificial intelligence system or automated decision tool to enable the system or tool to generate an outcome.

2. Except as otherwise provided in subsection 3, a health carrier shall not utilize or employ an artificial intelligence system or automated decision tool to:

(a) Make an adverse determination on a request for prior authorization; or

(b) Terminate, reduce or modify coverage for medical or dental care that was previously approved by the health carrier.

3. A health carrier may utilize or employ an artificial intelligence system or automated decision tool for a purpose described in subsection 2 if, when the artificial intelligence system

or automated decision tool generates an outcome on a request for prior authorization described in subsection 2, the request for prior authorization is independently reviewed by a physician or, for a request 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) Holds a current certification by a specialty board of the American Board of Medical Specialties or, if a dentist, a certifying board approved by the Commission on Dental Accreditation of the American Dental Association, in the area or areas appropriate to the subject of the request; and

(c) Possesses the education, training and expertise to evaluate the specific clinical issues involved in the request.

4. As used in this section:

(a) "Artificial intelligence system" means a machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations or decisions influencing real or virtual environments.

(b) "Automated decision tool" means an automated or computerized system that is specifically developed or modified to make, or to be a controlling factor in making, consequential decisions.

Sec. 7. *1. On or before March 1 of each calendar year, a health carrier shall compile and transmit to the Commissioner and to the Director of the Department of Health and Human Services a report containing the following information for the immediately preceding calendar year:*

(a) The total number of requests for prior authorization for care provided in this State that were received by the health carrier.

(b) The average time that elapsed between the health carrier receiving a request described in paragraph (a) and the health carrier approving or making an adverse determination on the request.

(c) The percentage and total number of requests for prior authorization described in paragraph (a) that were approved upon initial review.

(d) The percentage and total number of requests for prior authorization described in paragraph (a) that resulted in an adverse determination upon initial review.

(e) The percentage and total number of the adverse determinations described in paragraph (d) that were appealed.

(f) The percentage and total number of appeals described in paragraph (e) that resulted in the reversal of an adverse determination.

2. The report compiled pursuant to subsection 1 must present the information described in that subsection:

(a) In aggregated form; and

(b) Disaggregated by the types of care at issue in the requests for prior authorization, which may include, without limitation, mental health, chronic care, preventive services and dental care.

3. On or before April 1 of each calendar year, the Director of the Department of Health and Human Services and the Commissioner of Insurance shall publish the reports submitted pursuant to subsection 1 for that calendar year on an Internet website maintained by the Department or the Commissioner, as applicable.

Sec. 8. ***1. The Commissioner, in consultation with the Director of the Department of Health and Human Services, shall adopt any regulations that are necessary to carry out the provisions of NRS 687B.225 and sections 2 to 8, inclusive, of this act.***

2. The Commissioner may delegate to the Director of the Department of Health and Human Services his or her authority under this chapter to audit or investigate the compliance of a health carrier with the provisions of NRS 687B.225 and sections 2 to 8, inclusive, of this act.

3. If an audit or investigation of a health carrier conducted by the Director of the Department of Health and Human Services causes the Director to believe that a health carrier has potentially violated the provisions of NRS 687B.225 or sections 2 to 8, inclusive, of this act, the Director shall immediately notify the Commissioner of the potential violation and transmit to the Commissioner any information collected as a part of the audit or investigation.

4. If the Commissioner determines, after conducting a hearing in accordance with NRS 679B.310 to 679B.370, inclusive, that a health carrier has violated paragraph (b) or (c) of subsection 2 of NRS 687B.225 or section 7 of this act, the Commissioner shall assess the civil penalty described in subsection 5 for each such violation.

5. A civil penalty assessed against a health carrier pursuant to subsection 4 must be equivalent to 5 percent of the gross income that the health carrier earned from conducting business in this State during the quarter during which a violation described in subsection 4 is determined to have occurred.

6. The Commissioner may examine the books and records of a health carrier in order to determine the amount of the civil penalty that must be assessed against the health carrier pursuant to subsection 5.

7. The Commissioner shall deposit any money recovered as a civil penalty pursuant to subsection 4 into the Fund for Hospital Care to Indigent Persons created by NRS 428.175.

8. The Commissioner may establish by regulation additional sanctions that may be imposed against a health carrier that is determined to have committed five or more violations of paragraph (b) or (c) of subsection 2 of NRS 687B.225 or section 7 of this act within any 18-month period.

Sec. 9. 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, any contract ~~[for group, blanket or individual]~~ ***or policy of*** health 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 8, 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 pursuant to this section 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]~~ 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 the request is received; or

(2) For urgent health care, within 48 hours after the request is received.

(c) If the health carrier requires from an insured or a provider of health care 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 is required by the health carrier; 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 48 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 makes an adverse determination on a request for prior authorization, the health carrier shall immediately transmit to the insured to which the request pertains and his or her provider of health care a written notice that contains:

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

(b) The specific clinical criteria and medical evidence that the health carrier relied upon to make the adverse determination; and

(c) A description of any mechanism available for the insured to appeal or challenge the adverse determination, which may include, without limitation:

(1) An internal appeals process established by the health carrier, if applicable; or

(2) Options for independent or external review, which may include, without limitation, the external review process established pursuant to NRS 695G.241 to 695G.310, inclusive, where applicable.

5. Except as otherwise provided in this subsection, if a health carrier approves a request for prior authorization for a continuous course of treatment that relates to a chronic or long-term condition which is specifically identified in the request for prior authorization, the approval remains valid for 12 months from the date on which the health carrier approved the request. A health carrier may require additional prior authorization for medical or dental care that represents a substantial deviation from the course

of treatment indicated in the previous request for prior authorization that was approved by the health carrier.

6. As used in this section:

(a) "Clinical criteria" means any written screening procedure, decision abstract, clinical protocol or practice guideline used by a health carrier to determine the necessity and appropriateness of medical or dental care.

(b) "Provider of health care" has the meaning ascribed to it in NRS 695G.070.

(c) "Urgent health care" means health care that, in the opinion of a provider of health care with knowledge of the medical condition of a patient, if not rendered to the patient within 48 hours could:

(1) Seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or

(2) Subject the patient to severe pain that cannot be adequately managed without receiving such care.

Sec. 10. 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 8, 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. 11. 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 15 to 19, 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. 12. 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 4 and 5 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 section 6 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. 13. 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 4 and 5 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 section 6 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. 14. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 15 to 19, inclusive, of this act.

Sec. 15. ***1. The provisions of sections 16 to 19, 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 8, inclusive, of this act.

Sec. 16. ***As used in sections 15 to 19, inclusive, of this act, unless the context otherwise requires, "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. 17. ***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 of Medicaid or the Children's Health Insurance Program, as applicable, 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 48 hours after receiving the request.

2. If the Department requires from a recipient or a provider of health care 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 is required by the Department; 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 48 hours after receiving the information.

3. If the Department makes an adverse determination on a request for prior authorization, the Department shall immediately transmit to the recipient of Medicaid or insurance provided pursuant to the Children's Health Insurance Program, as applicable, to which the request pertains a written notice that contains:

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

(b) The specific clinical criteria and medical evidence that the Department relied upon to make the adverse determination; and

(c) A description of any mechanism available for the recipient to appeal or challenge the adverse determination.

4. Except as otherwise provided in this subsection, if the Department approves a request for prior authorization for a continuous course of treatment that relates to a chronic or long-term condition which is specifically identified in the request for prior authorization, the approval remains valid for 12 months from the date on which the Department approved the request. The Department may require additional prior authorization for medical or dental care that represents a substantial deviation from the course of treatment indicated in the previous request for prior authorization that was approved by the Department.

5. As used in this section:

(a) "Clinical 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.

(b) "Provider of health care" has the meaning ascribed to it in NRS 695G.070.

(c) "Urgent health care" means health care that, in the opinion of a provider of health care with knowledge of the medical condition of a patient, if not rendered to the patient within 48 hours could:

(1) Seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function; or

(2) Subject the patient to severe pain that cannot be adequately managed without receiving such care.

Sec. 18. *1. If the Department utilizes an artificial intelligence system or automated decision tool to process requests for prior authorization, the Department shall transmit to each recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program, in writing:*

(a) A statement that the Department utilizes an artificial intelligence system or automated decision tool to process requests for prior authorization;

(b) A general description of how the artificial intelligence system or automated decision tool works; and

(c) A description of the specific types of information or data utilized by the artificial intelligence system or automated decision tool which enables the system or tool to generate an outcome.

2. Except as otherwise provided in subsection 3, the Department shall not utilize or employ an artificial intelligence system or automated decision tool to:

(a) Make an adverse determination on a request for prior authorization; or

(b) Terminate, reduce or modify coverage for medical or dental care that was previously approved by the Department.

3. The Department may utilize or employ an artificial intelligence system or automated decision tool for the purposes described in subsection 2 if, when the artificial intelligence system or automated decision tool generates an outcome on a request for prior authorization described in subsection 2, the request for prior authorization is independently reviewed by a physician or, for a request 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) Holds a current certification by a specialty board of the American Board of Medical Specialties or, if a dentist, a certifying board approved by the Commission on Dental Accreditation of the American Dental Association, in the area or areas appropriate to the subject of the request; and

(c) Possesses the education, training and expertise to evaluate the specific clinical issues involved in the request.

4. As used in this section:

(a) "Artificial intelligence system" means a machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations or decisions influencing real or virtual environments.

(b) "Automated decision tool" means an automated or computerized system that is specifically developed or modified to make, or to be a controlling factor in making, consequential decisions.

Sec. 19. ***1. On or before March 1 of each calendar year, the Department shall compile and publish on an Internet website maintained by the Department a report containing the following information for the immediately preceding calendar year:***

(a) The total number of requests for prior authorization for care provided to recipients of Medicaid and recipients of insurance pursuant to the Children's Health Insurance Program that were received by the Department.

(b) The average time that elapsed between the Department receiving a request described in paragraph (a) and the Department approving or making an adverse determination on the request.

(c) The percentage and total number of requests for prior authorization described in paragraph (a) that were approved upon initial review.

(d) The percentage and total number of requests for prior authorization described in paragraph (a) that resulted in an adverse determination upon initial review.

(e) The percentage and total number of the adverse determinations described in paragraph (d) that were appealed.

(f) The percentage and total number of appeals described in paragraph (e) that resulted in the reversal of an adverse determination.

2. The report compiled pursuant to subsection 1 must present the information described in that subsection:

(a) In aggregated form; and

(b) Disaggregated by the types of health or dental care at issue in the requests for prior authorization, which may include, without limitation, mental health, chronic care, preventive services and dental care.

Sec. 20. 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 ***in a manner consistent with sections 16 to 19, 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. 21. 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 4 and 5 of NRS 687B.225,*** NRS 687B.409, 687B.723 and 687B.725 ~~[.]~~ ***and section 6 of this act.***

Sec. 22. 1. The amendatory provisions of this act do not apply to a request for prior authorization submitted:

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

(b) To the Department of Health and Human Services before January 1, 2026, for dental or medical care provided to a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program, as applicable.

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

(a) Develop a procedure for obtaining prior authorization that complies with NRS 687B.225, as amended by section 9 of this act, and section 6 of this act; and

(b) Obtain the approval of the Commissioner of Insurance pursuant to NRS 687B.225, as amended by section 9 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 4 of this act.

Sec. 23. 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. 24. 1. This section and section 22 of this act become effective upon passage and approval.

2. Sections 1 to 21, inclusive, and 23 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, 2026, for all other purposes.

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