ASSEMBLY BILL NO. 293–ASSEMBLYMEN NOLAN, BEERS, BROWER, DE BRAGA, CHOWNING, EVANS, LESLIE, HETTRICK, CEGAVSKE, GUSTAVSON AND ANGLE

FEBRUARY 22, 1999

Referred to Committee on Commerce and Labor

SUMMARY—Makes various changes concerning health insurers. (BDR 57-1429)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

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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; requiring certain health insurers to inform a claimant immediately when a claim is denied and to inform the claimant of the reason for the denial; requiring a managed care organization to provide coverage for medically necessary emergency services provided to an insured at any hospital; and providing other matters properly relating thereto.

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

Section 1. NRS 689A.410 is hereby amended to read as follows:

689A.410 1. Except as otherwise provided in subsection 2, an insurer shall approve or deny a claim relating to a policy of health insurance within 30 days after the insurer receives the claim. ***If the claim is denied, the insurer shall immediately notify the claimant and inform the claimant of the reason for the denial.*** If the claim is approved, the insurer shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the insurer shall pay interest on the claim at the rate of interest established pursuant to NRS 99.040. The interest must be calculated from the date the payment is due until the claim is paid.

2. If the insurer requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for the additional information within 20 days after it receives the claim. The insurer shall notify the provider of health care of the reason for the delay in approving or denying the claim. The insurer shall approve or deny the

claim within 30 days after receiving the additional information. ***If the claim is denied, the insurer shall immediately notify the claimant and inform the claimant of the reason for the denial.*** If the claim is approved, the insurer shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the insurer shall pay interest on the claim in the manner prescribed in subsection 1.

Sec. 2. NRS 689B.255 is hereby amended to read as follows:

689B.255 1. Except as otherwise provided in subsection 2, an insurer shall approve or deny a claim relating to a policy of group health insurance or blanket insurance within 30 days after the insurer receives the claim. ***If the claim is denied, the insurer shall immediately notify the claimant and inform the claimant of the reason for the denial.*** If the claim is approved, the insurer shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the insurer shall pay interest on the claim at the rate of interest established pursuant to NRS 99.040. The interest must be calculated from the date the payment is due until the claim is paid.

2. If the insurer requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for the additional information within 20 days after it receives the claim. The insurer shall notify the provider of health care of the reason for the delay in approving or denying the claim. The insurer shall approve or deny the claim within 30 days after receiving the additional information. ***If the claim is denied, the insurer shall immediately notify the claimant and inform the claimant of the reason for the denial.*** If the claim is approved, the insurer shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the insurer shall pay interest on the claim in the manner prescribed in subsection 1.

Sec. 3. NRS 695A.188 is hereby amended to read as follows:

695A.188 1. Except as otherwise provided in subsection 2, a society shall approve or deny a claim relating to a certificate of health insurance within 30 days after the society receives the claim. ***If the claim is denied, the insurer shall immediately notify the claimant and inform the claimant of the reason for the denial.*** If the claim is approved, the society shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the society shall pay interest on the claim at the rate of interest established pursuant to NRS 99.040. The interest must be calculated from the date the payment is due until the claim is paid.

2. If the society requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for

the additional information within 20 days after it receives the claim. The society shall notify the provider of health care of the reason for the delay in approving or denying the claim. The society shall approve or deny the claim within 30 days after receiving the additional information. ***If the claim is denied, the insurer shall immediately notify the claimant and inform the claimant of the reason for the denial.*** If the claim is approved, the society shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the society shall pay interest on the claim in the manner prescribed in subsection 1.

Sec. 4. NRS 695B.2505 is hereby amended to read as follows:

695B.2505 1. Except as otherwise provided in subsection 2, a corporation subject to the provisions of this chapter shall approve or deny a claim relating to a contract for dental, hospital or medical services within 30 days after the corporation receives the claim. ***If the claim is denied, the insurer shall immediately notify the claimant and inform the claimant of the reason for the denial.*** If the claim is approved, the corporation shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the corporation shall pay interest on the claim at the rate of interest established pursuant to NRS 99.040. The interest must be calculated from the date the payment is due until the claim is paid.

2. If the corporation requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for the additional information within 20 days after it receives the claim. The corporation shall notify the provider of dental, hospital or medical services of the reason for the delay in approving or denying the claim. The corporation shall approve or deny the claim within 30 days after receiving the additional information. ***If the claim is denied, the insurer shall immediately notify the claimant and inform the claimant of the reason for the denial.*** If the claim is approved, the corporation shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the corporation shall pay interest on the claim in the manner prescribed in subsection 1.

Sec. 5. NRS 695C.185 is hereby amended to read as follows:

695C.185 1. Except as otherwise provided in subsection 2, a health maintenance organization shall approve or deny a claim relating to a health care plan within 30 days after the health maintenance organization receives the claim. ***If the claim is denied, the insurer shall immediately notify the claimant and inform the claimant of the reason for the denial.*** If the claim is approved, the health maintenance organization shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the health maintenance organization shall pay interest on the claim at the rate of interest established pursuant to NRS 99.040. The

interest must be calculated from the date the payment is due until the claim is paid.

2. If the health maintenance organization requires additional information to determine whether to approve or deny the claim, it shall notify the claimant of its request for the additional information within 20 days after it receives the claim. The health maintenance organization shall notify the provider of health care services of the reason for the delay in approving or denying the claim. The health maintenance organization shall approve or deny the claim within 30 days after receiving the additional information. ***If the claim is denied, the insurer shall immediately notify the claimant and inform the claimant of the reason for the denial.*** If the claim is approved, the health maintenance organization shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the health maintenance organization shall pay interest on the claim in the manner prescribed in subsection 1.

Sec. 6. NRS 695G.170 is hereby amended to read as follows:

695G.170 1. Each managed care organization shall provide coverage for medically necessary emergency services ~~[.]~~ ***provided at any hospital. If the managed care organization does not have a contract with the hospital at which an insured receives medically necessary emergency services, the managed care organization shall reimburse the hospital in the same amount and manner that it reimburses a hospital with which it has a contract for the provision of medically necessary emergency services.***

2. A managed care organization shall not require prior authorization for medically necessary emergency services.

3. As used in this section, "medically necessary emergency services" means health care services that are provided to an insured by a provider of health care after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:

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

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

(c) Serious impairment of a bodily function; or

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

4. A health care plan subject to the provisions of this section that is delivered, issued for delivery or renewed on or after October 1, ~~[1997,]~~ ***1999,*** has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.