

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 ~~for omitted material~~ is material to be omitted.

AN ACT relating to insurance; making various changes concerning the notice required to be provided to an insured when an insurer denies coverage of a health care service; 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:

- 1 **Section 1.** NRS 689A.755 is hereby amended to read as follows:
2 689A.755 1. Following approval by the commissioner, each insurer
3 that issues a policy of health insurance in this state shall provide written
4 notice to an insured, in clear and comprehensible language that is
5 understandable to an ordinary layperson, explaining the right of the insured
6 to file a written complaint. Such notice must be provided to an insured:
7 (a) At the time he receives his evidence of coverage;
8 (b) Any time that the insurer denies coverage of a health care service or
9 limits coverage of a health care service to an insured; and
10 (c) Any other time deemed necessary by the commissioner.
11 2. Any time that an insurer denies coverage of a health care service to
12 an insured, ***, including, without limitation, denying a claim relating to a***
13 ***policy of health insurance pursuant to NRS 689A.410,*** it shall notify the
14 insured in writing ***within 10 working days after it denies coverage of the***
15 ***health care service*** of:
16 (a) The reason for denying coverage of the service;

1 (b) The criteria by which the insurer determines whether to authorize or
2 deny coverage of the health care service; and

3 (c) His right to file a written complaint ~~and~~ *and the procedure for filing*
4 *such a complaint.*

5 3. A written notice which is approved by the commissioner shall be
6 deemed to be in clear and comprehensible language that is understandable
7 to an ordinary layperson.

8 **Sec. 2.** NRS 689B.0295 is hereby amended to read as follows:

9 689B.0295 1. Following approval by the commissioner, each insurer
10 that issues a policy of group health insurance in this state shall provide
11 written notice to an insured, in clear and comprehensible language that is
12 understandable to an ordinary layperson, explaining the right of the insured
13 to file a written complaint. Such notice must be provided to an insured:

14 (a) At the time he receives his certificate of coverage or evidence of
15 coverage;

16 (b) Any time that the insurer denies coverage of a health care service or
17 limits coverage of a health care service to an insured; and

18 (c) Any other time deemed necessary by the commissioner.

19 2. Any time that an insurer denies coverage of a health care service ,
20 *including, without limitation, denying a claim relating to a policy of*
21 *group health insurance or blanket insurance pursuant to NRS 689B.255,*
22 *to an insured it shall notify the insured in writing within 10 working days*
23 *after it denies coverage of the health care service* of:

24 (a) The reason for denying coverage of the service;

25 (b) The criteria by which the insurer determines whether to authorize or
26 deny coverage of the health care service; and

27 (c) His right to file a written complaint ~~and~~ *and the procedure for filing*
28 *such a complaint.*

29 3. A written notice which is approved by the commissioner shall be
30 deemed to be in clear and comprehensible language that is understandable
31 to an ordinary layperson.

32 **Sec. 3.** NRS 695B.400 is hereby amended to read as follows:

33 695B.400 1. Following approval by the commissioner, each insurer
34 that issues a contract for hospital or medical services in this state shall
35 provide written notice to an insured, in clear and comprehensible language
36 that is understandable to an ordinary layperson, explaining the right of the
37 insured to file a written complaint. Such notice must be provided to an
38 insured:

39 (a) At the time he receives his certificate of coverage or evidence of
40 coverage;

41 (b) Any time that the insurer denies coverage of a health care service or
42 limits coverage of a health care service to an insured; and

43 (c) Any other time deemed necessary by the commissioner.

2. Any time that an ~~insured~~ *insurer* denies coverage of a health care service to a beneficiary or subscriber, *including, without limitation, denying a claim relating to a contract for dental, hospital or medical services pursuant to NRS 695B.2505*, it shall notify the beneficiary or subscriber in writing *within 10 working days after it denies coverage of the health care service* of:

(a) The reason for denying coverage of the service;

(b) The criteria by which the insurer determines whether to authorize or deny coverage of the health care service; and

(c) His right to file a written complaint ~~and~~ *and the procedure for filing such a complaint.*

3. A written notice which is approved by the commissioner shall be deemed to be in clear and comprehensible language that is understandable to an ordinary layperson.

Sec. 4. NRS 695G.230 is hereby amended to read as follows:

695G.230 1. Following approval by the commissioner, each managed care organization shall provide written notice to an insured, in clear and comprehensible language that is understandable to an ordinary layperson, explaining the right of the insured to file a written complaint and to obtain an expedited review pursuant to NRS 695G.210. Such notice must be provided to an insured:

(a) At the time he receives his certificate of coverage or evidence of coverage;

(b) Any time that the managed care organization denies coverage of a health care service or limits coverage of a health care service to an insured; and

(c) Any other time deemed necessary by the commissioner.

2. Any time that a managed care organization denies coverage of a health care service to an insured, *including, without limitation, a health maintenance organization that denies a claim related to a health care plan pursuant to NRS 695C.185*, it shall notify the insured in writing *within 10 working days after it denies coverage of the health care service* of:

(a) The reason for denying coverage of the service;

(b) The criteria by which the managed care organization or insurer determines whether to authorize or deny coverage of the health care service; and

(c) His right to file a written complaint ~~and~~ *and the procedure for filing such a complaint.*

3. A written notice which is approved by the commissioner shall be deemed to be in clear and comprehensible language that is understandable to an ordinary layperson.

1 **Sec. 5.** NRS 695G.170 is hereby amended to read as follows:
2 695G.170 1. Each managed care organization shall provide coverage
3 for medically necessary emergency services ~~+~~ **provided at any hospital.**
4 2. A managed care organization shall not require prior authorization
5 for medically necessary emergency services.
6 3. As used in this section, “medically necessary emergency services”
7 means health care services that are provided to an insured by a provider of
8 health care after the sudden onset of a medical condition that manifests
9 itself by symptoms of such sufficient severity that a prudent person would
10 believe that the absence of immediate medical attention could result in:
11 (a) Serious jeopardy to the health of an insured;
12 (b) Serious jeopardy to the health of an unborn child;
13 (c) Serious impairment of a bodily function; or
14 (d) Serious dysfunction of any bodily organ or part.
15 4. A health care plan subject to the provisions of this section that is
16 delivered, issued for delivery or renewed on or after October 1, ~~1997,~~
17 **1999**, has the legal effect of including the coverage required by this section,
18 and any provision of the plan or the renewal which is in conflict with this
19 section is void.