ASSEMBLY BILL NO. 383–ASSEMBLYMAN NEIGHBORS

MARCH 4, 1999

JOINT SPONSOR: SENATOR MCGINNESS

Referred to Committee on Commerce and Labor

SUMMARY—Requires managed care organizations to pay for medical services provided to insureds by certain providers in areas with low population densities. (BDR 57-617)

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 managed care organizations; requiring managed care organizations to pay for medical services provided to insureds by certain providers in areas with low population densities; 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.** Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

**Sec. 2.** ***1. Except as otherwise provided in section 3 of this act, a managed care organization shall provide reimbursement for services received by an insured at an independent hospital or a federally-qualified health center with which the managed care organization has not contracted with for the provision of services to its insureds if:***

***(a) The insured resides within 60 miles from the independent hospital or federally-qualified health center;***

***(b) The independent hospital or federally-qualified health center is located in a county whose population is less than 50,000;***

***(c) The insured has complied with the requirements of his contract with the managed care organization concerning prior authorization and utilization review; and***

*(d) The evidence of coverage of the insured provides coverage for the type of services received by the insured.*

*2. A managed care organization shall provide reimbursement for services provided to an insured pursuant to subsection 1 in a reasonable amount that is not less than the amount that it would otherwise reimburse if the services had been provided at a hospital or facility with which it has a contract. The managed care organization may provide reimbursement for services provided to an insured pursuant to subsection 1 at a discounted rate if it reimburses similar providers of health care with whom it has a contract for comparable services at the same discounted rate.*

*3. As used in this section:*

*(a) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).*

*(b) "Independent hospital" means a hospital:*

*(1) That is licensed pursuant to chapter 449 of NRS;*

*(2) In which more than one-half of the members of the board of directors of the hospital reside within the county where the hospital is located; and*

*(3) Either:*

*(I) The board of directors of the hospital is ultimately responsible for the policy and financial decisions of the hospital; or*

*(II) The hospital has 50 or fewer authorized or approved beds for acute care and, if the hospital has a contract with a managed care organization for the provision of services, the hospital is not owned by an entity that owns or operates the managed care organization.*

**Sec. 3.** *1. If an independent hospital or federally-qualified health center that does not have a contract with a managed care organization for the provision of services refers an insured of the managed care organization to another independent hospital or federally-qualified health center that does not have a contract with the managed care organization for the provision of services, the managed care organization shall provide reimbursement for services provided at the independent hospital or federally-qualified health center as set forth in section 2 of this act only if:*

*(a) The managed care organization gave prior authorization for the referral; or*

*(b) The independent hospital or federally-qualified health center to which the referral is made:*

*(1) Is located in a county whose population is less than 50,000; and*

*(2) Is located within 60 miles from:*

***(I) The residence of the insured; or***

***(II) An independent hospital or federally-qualified health center at which the insured is entitled to reimbursement for services pursuant to section 2 of this act.***

***2. As used in this section:***

***(a) "Federally-qualified health center" has the meaning ascribed to it in section 2 of this act.***

***(b) "Independent hospital" has the meaning ascribed to it in section 2 of this act.***

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