

Assembly Bill No. 515—Assemblymen de Braga, Segerblom, Neighbors, Collins, McClain, Chowning, Buckley, Lee, Berman, Gibbons, Price, Ohrenschall, Mortenson, Claborn, Freeman, Evans, Parnell and Koivisto

CHAPTER.....

AN ACT relating to health insurance; providing that a policy of health insurance must include a provision allowing a woman who is covered by the policy to have direct access to certain health care services for women; prohibiting a managed care organization from committing certain acts that limit the accessibility of its insureds to services provided at certain hospitals and other licensed health care facilities with which the managed care organization has contracted; 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. (Deleted by amendment.)

Sec. 1.5. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689B.0374, 695B.1912, 695C.1735 and 695G.170, *and sections 4.5, 7.5, 13.5 and 16.5 of this act*, any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care 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 shall:

(a) File its procedure for obtaining approval of care pursuant to this section for approval by the commissioner; and

(b) Respond to any request for approval by the insured or member pursuant to this section within 20 days after it receives the request.

2. The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

Sec. 2. Chapter 689A of NRS is hereby amended by adding thereto the provisions set forth as sections 3, 4 and 4.5 of this act.

Secs. 3 and 4. (Deleted by amendment.)

Sec. 4.5. 1. *A policy of health insurance must include a provision authorizing a woman covered by the policy to obtain covered gynecological or obstetrical services without first receiving authorization or a referral from her primary care physician.*

2. The provisions of this section do not authorize a woman covered by a policy of health insurance to designate an obstetrician or gynecologist as her primary care physician.

3. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by this section, and any

provision of the policy or the renewal which is in conflict with this section is void.

4. As used in this section, "primary care physician" has the meaning ascribed to it in NRS 695G.060.

Sec. 5. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 6, 7 and 7.5 of this act.

Secs. 6 and 7. (Deleted by amendment.)

Sec. 7.5. 1. *A policy of group health insurance must include a provision authorizing a woman covered by the policy to obtain covered gynecological or obstetrical services without first receiving authorization or a referral from her primary care physician.*

2. The provisions of this section do not authorize a woman covered by a policy of group health insurance to designate an obstetrician or gynecologist as her primary care physician.

3. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. As used in this section, "primary care physician" has the meaning ascribed to it in NRS 695G.060.

Secs. 8-10. (Deleted by amendment.)

Sec. 11. Chapter 695B of NRS is hereby amended by adding thereto the provisions set forth as sections 12, 13 and 13.5 of this act.

Secs. 12 and 13. (Deleted by amendment.)

Sec. 13.5. 1. *A contract for hospital or medical service must include a provision authorizing a woman covered by the contract to obtain covered gynecological or obstetrical services without first receiving authorization or a referral from her primary care physician.*

2. The provisions of this section do not authorize a woman covered by a contract for hospital or medical service to designate an obstetrician or gynecologist as her primary care physician.

3. A contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by this section, and any provision of the contract or the renewal which is in conflict with this section is void.

4. As used in this section, "primary care physician" has the meaning ascribed to it in NRS 695G.060.

Sec. 14. Chapter 695C of NRS is hereby amended by adding thereto the provisions set forth as sections 15, 16 and 16.5 of this act.

Secs. 15 and 16. (Deleted by amendment.)

Sec. 16.5. 1. *A health care plan must include a provision authorizing a woman covered by the plan to obtain covered gynecological or obstetrical services without first receiving authorization or a referral from her primary care physician.*

2. The provisions of this section do not authorize a woman covered by a health care plan to designate an obstetrician or gynecologist as her primary care physician.

3. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

4. As used in this section, "primary care physician" has the meaning ascribed to it in NRS 695G.060.

Sec. 17. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this Title, the provisions of this Title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this Title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

4. The provisions of NRS 695C.110, 695C.170 to 695C.200, inclusive, 695C.250 and 695C.265 *and sections 15, 16 and 16.5 of this act* do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid pursuant to a contract with the welfare division of the department of human resources. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 17.5. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. If a managed care organization contracts for the provision of emergency medical services, outpatient services or inpatient services with a hospital or other licensed health care facility that provides acute care and is located in a city whose population is less than 45,000 or a county whose population is less than 100,000, the managed care organization shall not:

(a) Prohibit an insured from receiving services covered by the health care plan of the insured at that hospital or licensed health care facility if the services are provided by a provider of health care with whom the managed care organization has contracted for the provision of the services;

(b) Refuse to provide coverage for services covered by the health care plan of an insured that are provided to the insured at that hospital or licensed health care facility if the services were provided by a provider of health care with whom the managed care organization has contracted for the provision of the services;

(c) Refuse to pay a provider of health care with whom the managed care organization has contracted for the provision of services for providing services to an insured at that hospital or licensed health care facility if the services are covered by the health care plan of the insured;

(d) Discourage a provider of health care with whom the managed care organization has contracted for the provision of services from providing services to an insured at that hospital or licensed health care facility that are covered by the health care plan of the insured; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care:

(1) To provide services to an insured that are covered by the health care plan of the insured at another hospital or licensed health care facility; or

(2) Not to provide services to an insured at that hospital or licensed health care facility that are covered by the health care plan of the insured.

2. Nothing in this section prohibits a managed care organization from informing an insured that enhanced health care services are available at a hospital or licensed health care facility other than the hospital or licensed health care facility described in subsection 1 with which the managed care organization contracts for the provision of emergency medical services, outpatient services or inpatient services.

Secs. 18-21. (Deleted by amendment.)

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