ASSEMBLY BILL NO. 585–COMMITTEE ON COMMERCE AND LABOR

MARCH 15, 1999

Referred to Committee on Commerce and Labor

SUMMARY—Makes various changes concerning managed care organizations. (BDR 57-1485)

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 a managed care organization to enter into a contract with a provider of health care to provide a limited service or course of care to an insured under certain circumstances; requiring a managed care organization to allow certain persons to designate a specialist as their primary care physician; providing that a managed care organization is liable for damages for harm to an insured under certain circumstances; 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 689C.950 is hereby amended to read as follows:

689C.950 ~~[Notwithstanding]~~ ***Except as otherwise provided in NRS 695G.090, notwithstanding*** any specific statute to the contrary, a statute that requires the coverage of a specific health care service or benefit, or the reimbursement, utilization or inclusion of a specific category of licensed health care practitioner, is not applicable to a basic health benefit plan delivered or issued for delivery to small employers or eligible persons in this state pursuant to this chapter or chapter 689A of NRS.

Sec. 2. NRS 695C.055 is hereby amended to read as follows:

695C.055 1. The provisions of NRS 449.465, 679B.158, subsections 2, 4, 18, 19 and 32 of NRS 680B.010, NRS 680B.025 to 680B.060, inclusive, and ~~[695G.010 to 695G.260, inclusive,]~~ ***chapter 695G of NRS*** apply to a health maintenance organization.

2. For the purposes of subsection 1, unless the context requires that a provision apply only to insurers, any reference in those sections to "insurer" must be replaced by "health maintenance organization."

Sec. 3. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 4, 5 and 6 of this act.

Sec. 4. ***1. A managed care organization shall enter into a contract with a provider of health care who is not a provider of health care under its health care plan for the limited purpose of providing health care services related to the chronic medical condition of an insured or of providing a continual course of health care to an insured who has a disability if:***

(a) The managed care organization previously had a contract with the provider of health care to provide services under the health care plan of the insured;

(b) The insured has been under the care of the provider of health care for his chronic medical condition or disability pursuant to his health care plan for at least 1 year;

(c) The provider of health care is qualified under the laws of this state to provide such care;

(d) The provider of health care agrees to accept the rates, terms and conditions established for other providers of similar health care services under the health care plan; and

(e) The insured submits a request in writing to the managed care organization to have the provider of health care continue to provide the specific services or course of care.

2. As used in this section, "chronic medical condition" means an illness or injury that requires continual medical attention.

Sec. 5. ***1. A managed care organization shall include in any health care plan it offers that requires the designation of a primary care physician a provision authorizing a person covered by the plan to designate a specialist as the primary care physician if the person regularly needs services provided by such a specialist.***

2. A health care plan subject to the provisions of this section 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 health care plan or the renewal which is in conflict with this section is void.

Sec. 6. ***1. A managed care organization shall exercise ordinary care when making a decision concerning health care services.***

2. A managed care organization is liable for damages for harm to an insured that is proximately caused by:

(a) The failure of the managed care organization to exercise ordinary care when making a decision concerning health care services.

(b) A decision concerning health care services made by:

(1) An employee of the managed care organization;

(2) An agent or ostensible agent of the managed care organization; or

(3) A representative who is acting on behalf of the managed care organization over whom the managed care organization has the right to exercise influence or control or has actually exercised influence or control,

that results in the failure to exercise ordinary care.

3. As used in this section, "decision concerning health care services" means a determination made when health care services are actually provided pursuant to the benefits offered under the health care plan or a decision which affects the quality of the diagnosis, care or treatment provided to an insured.

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