

Senate Bill No. 145—Senators O’Connell and Townsend

CHAPTER.....

AN ACT relating to insurance; requiring an administrator to pay claims relating to health insurance coverage in a certain manner; limiting the amount that a health insurer may charge providers of health care to be included on a list of providers that is given to insureds of the insurer; making various changes concerning payment of claims by health insurers; 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 683A of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 2, an administrator shall approve or deny a claim relating to health insurance coverage within 30 days after the administrator receives the claim. If the claim is approved, the administrator shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the administrator shall pay interest on the claim at the rate of interest established pursuant to NRS 99.040 unless a different rate of interest is established pursuant to an express written contract between the administrator and the provider of health care. The interest must be calculated from 30 days after the date on which the claim is approved until the claim is paid.

2. If the administrator requires additional information to determine whether to approve or deny the claim, he shall notify the claimant of his request for the additional information within 20 days after he receives the claim. The administrator shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The administrator shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the administrator shall pay the claim within 30 days after he receives the additional information. If the approved claim is not paid within that period, the administrator shall pay interest on the claim in the manner prescribed in subsection 1.

3. An administrator shall not request a claimant to resubmit information that the claimant has already provided to the administrator, unless the administrator provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. An administrator shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney’s fees to the prevailing party in an action brought pursuant to this section.

Sec. 2. NRS 683A.086 is hereby amended to read as follows:

683A.086 1. No person may act as an administrator unless he has entered into a written agreement with an insurer, and the written agreement contains provisions to effectuate the requirements contained in NRS 683A.0867 to 683A.0883, inclusive, *and section 1 of this act* which apply to the duties of the administrator.

2. A copy of an agreement entered into under the provisions of this section must be retained in the records of the administrator and of the insurer for a period of 5 years after the termination of the agreement.

3. When a policy is issued to a trustee or trustees, a copy of the trust agreement and amendments must be obtained by the administrator and a copy forwarded to the insurer. Each agreement must be retained by the administrator and by the insurer for a period of 5 years after the termination of the policy.

4. The commissioner may adopt regulations which specify the functions an administrator may perform on behalf of an insurer.

Sec. 3. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

An insurer may charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the insurer to its insureds. The amount of the fee must be reasonable and must not exceed an amount that is directly related to the administrative costs of the insurer to include the provider on the list.

Sec. 4. 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 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 ~~[-]~~ *unless a different rate of interest is established pursuant to an express written contract between the insurer and the provider of health care.* The interest must be calculated from *30 days after* the date ~~{the payment is due}~~ *on which the claim is approved* 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 *all* the ~~{reason}~~ *specific reasons* 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 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.

3. *An insurer shall not request a claimant to resubmit information that the claimant has already provided to the insurer, unless the insurer provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.*

4. *An insurer shall not pay only part of a claim that has been approved and is fully payable.*

5. *A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.*

Sec. 5. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

An insurer that issues a policy of group health insurance may charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the insurer to its insureds. The amount of the fee must be reasonable and must not exceed an amount that is directly related to the administrative costs of the insurer to include the provider on the list.

Sec. 6. 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 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 ~~[-]~~ *unless a different rate of interest is established pursuant to an express written contract between the insurer and the provider of health care.* The interest must be calculated from *30 days after* the date ~~[the payment is due]~~ *on which the claim is approved* 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 *all* the ~~[reason]~~ *specific reasons* 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 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.

3. *An insurer shall not request a claimant to resubmit information that the claimant has already provided to the insurer, unless the insurer provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.*

4. *An insurer shall not pay only part of a claim that has been approved and is fully payable.*

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

Sec. 7. Chapter 689C of NRS is hereby amended by adding thereto the provisions set forth as sections 8 and 9 of this act.

Sec. 8. *A carrier serving small employers and a carrier that offers a contract to a voluntary purchasing group may charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the carrier to its insureds. The amount of the fee must be reasonable and must not exceed an amount that is directly related to the administrative costs of the carrier to include the provider on the list.*

Sec. 9. *1. Except as otherwise provided in subsection 2, a carrier serving small employers and a carrier that offers a contract to a voluntary purchasing group shall approve or deny a claim relating to a policy of health insurance within 30 days after the carrier receives the claim. If the claim is approved, the carrier shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the carrier shall pay interest on the claim at the rate of interest established pursuant to NRS 99.040 unless a different rate of interest is established pursuant to an express written contract between the carrier and the provider of health care. The interest must be calculated from 30 days after the date on which the claim is approved until the claim is paid.*

2. If the carrier 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 carrier shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The carrier shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the carrier shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the carrier shall pay interest on the claim in the manner prescribed in subsection 1.

3. A carrier shall not request a claimant to resubmit information that the claimant has already provided to the carrier, unless the carrier provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. A carrier shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

Sec. 10. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

A society may charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the society to its insureds. The amount of the fee must be reasonable and

must not exceed an amount that is directly related to the administrative costs of the society to include the provider on the list.

Sec. 11. 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 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 ~~[-]~~ *unless a different rate of interest is established pursuant to an express written contract between the society and the provider of health care.* The interest must be calculated from *30 days after* the date ~~[the payment is due]~~ *on which the claim is approved* 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 *all* the ~~[reason]~~ *specific reasons* 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 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.

3. *A society shall not request a claimant to resubmit information that the claimant has already provided to the society, unless the society provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.*

4. *A society shall not pay only part of a claim that has been approved and is fully payable.*

5. *A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.*

Sec. 12. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

A corporation subject to the provisions of this chapter may charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the corporation to its insureds. The amount of the fee must be reasonable and must not exceed an amount that is directly related to the administrative costs of the corporation to include the provider on the list.

Sec. 13. 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 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 ~~[-]~~ *unless a different rate of interest is established pursuant to an express written contract between the corporation and the provider of health care.* The interest must be calculated from *30 days after* the date ~~[the payment is due]~~ *on which the claim is approved* 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 *all* the ~~[reason]~~ *specific reasons* 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 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.

3. *A corporation shall not request a claimant to resubmit information that the claimant has already provided to the corporation, unless the corporation provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.*

4. *A corporation shall not pay only part of a claim that has been approved and is fully payable.*

5. *A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.*

Sec. 14. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

A health maintenance organization may charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the health maintenance organization to its enrollees. The amount of the fee must be reasonable and must not exceed an amount that is directly related to the administrative costs of the health maintenance organization to include the provider on the list.

Sec. 15. 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 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 ~~[-]~~ *unless a different rate of interest is established pursuant to an express written contract between the health maintenance organization and the provider of health care.* The interest must be

calculated from **30 days after** the date ~~{the payment is due}~~ **on which the claim is approved** 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 **all** the ~~{reason}~~ **specific reasons** 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 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.

3. A health maintenance organization shall not request a claimant to resubmit information that the claimant has already provided to the health maintenance organization, unless the health maintenance organization provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. A health maintenance organization shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

Sec. 16. NRS 695F.090 is hereby amended to read as follows:

695F.090 Prepaid limited health service organizations are subject to the provisions of this chapter and to the following provisions, to the extent reasonably applicable:

1. NRS 687B.310 to 687B.420, inclusive, concerning cancellation and nonrenewal of policies.

2. NRS 687B.122 to 687B.128, inclusive, concerning readability of policies.

3. The requirements of NRS 679B.152.

4. The fees imposed pursuant to NRS 449.465.

5. NRS 686A.010 to 686A.310, inclusive, concerning trade practices and frauds.

6. The assessment imposed pursuant to subsection 3 of NRS 679B.158.

7. Chapter 683A of NRS.

8. To the extent applicable, the provisions of NRS 689B.340 to 689B.600, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance.

9. NRS **689A.410**, 689A.413 ~~{H}~~ **and section 3 of this act.**

10. NRS 680B.025 to 680B.039, inclusive, concerning premium tax, premium tax rate, annual report and estimated quarterly tax payments. For the purposes of this subsection, unless the context otherwise requires that a section apply only to insurers, any reference in those sections to "insurer"

must be replaced by a reference to “prepaid limited health service organization.”

11. Chapter 692C of NRS, concerning holding companies.

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