Assembly Bill No. 452–Assemblywoman Giunchigliani

CHAPTER.....

AN ACT relating to insurance; requiring certain providers of individual or group health insurance to contract with federally qualified health centers as providers of certain health care services under certain circumstances; providing a penalty; 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 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An individual carrier that offers a health benefit plan that includes a provision for a restricted network shall use its best efforts to contract with at least one health center in each established geographic service area to provide health care services to persons covered by the plan if the health center:

(a) Meets all conditions imposed by the carrier on similarly situated providers of health care with which the carrier contracts, including, without limitation:

(1) Certification for participation in the Medicaid or Medicare program; and

(2) Requirements relating to the appropriate credentials for providers of health care; and

(b) Agrees to reasonable reimbursement rates that are generally consistent with those offered by the carrier to similarly situated providers of health care with which the carrier contracts.

2. As used in this section, "health center" has the meaning ascribed to it in 42 U.S.C. § 254b.

Sec. 2. NRS 689A.470 is hereby amended to read as follows:

689A.470 As used in NRS 689A.470 to 689A.740, inclusive, ***and section 1 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 689A.475 to 689A.605, inclusive, have the meanings ascribed to them in those sections.

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

1. A carrier that offers coverage through a network plan shall use its best efforts to contract with at least one health center in each established geographic service area of the carrier or geographic area for which the carrier is authorized to transact insurance to provide medical care for enrollees if the health center:

(a) Meets all conditions imposed by the carrier on similarly situated providers of health care with which the carrier contracts, including, without limitation:

(1) Certification for participation in the Medicaid or Medicare program; and

(2) Requirements relating to the appropriate credentials for providers of health care; and

(b) Agrees to reasonable reimbursement rates that are generally consistent with those offered by the carrier to similarly situated providers of health care with which the carrier contracts.

2. As used in this section:

(a) "Health center" has the meaning ascribed to it in 42 U.S.C. § 254b.

(b) "Network plan" has the meaning ascribed to it in NRS 689B.570.

Sec. 4. NRS 689B.340 is hereby amended to read as follows:

689B.340 As used in NRS 689B.340 to 689B.600, inclusive, ***and section 3 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 689B.350 to 689B.460, inclusive, have the meanings ascribed to them in those sections.

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

1. A carrier that offers a network plan shall use its best efforts to contract with at least one health center in each established geographic service area to provide health care as a member of the carrier's defined set of providers under the network plan if the health center:

(a) Meets all conditions imposed by the carrier on similarly situated providers of health care that are members of the carrier's defined set of providers, including, without limitation:

(1) Certification for participation in the Medicaid or Medicare program; and

(2) Requirements relating to the appropriate credentials for providers of health care; and

(b) Agrees to reasonable reimbursement rates that are generally consistent with those offered by the carrier to similarly situated providers of health care that are members of the carrier's defined set of providers.

2. As used in this section, "health center" has the meaning ascribed to it in 42 U.S.C. § 254b.

Sec. 6. NRS 695A.152 is hereby amended to read as follows:

695A.152 1. To the extent reasonably applicable, a fraternal benefit society shall comply with the provisions of NRS 689B.340 to 689B.600, inclusive, ***and section 3 of this act*** and chapter 689C of NRS relating to the portability and availability of health insurance offered by the society to its members. If there is a conflict between the provisions of this chapter and the provisions of NRS 689B.340 to 689B.600, inclusive, ***and section 3 of this act*** and chapter 689C of NRS, the provisions of NRS 689B.340 to 689B.600, inclusive, ***and section 3 of this act*** and chapter 689C of NRS control.

2. For the purposes of subsection 1, unless the context requires that a provision apply only to a group health plan or a carrier that provides coverage under a group health plan, any reference in those sections to "group health plan" or "carrier" must be replaced by "fraternal benefit society."

Sec. 7. NRS 695B.318 is hereby amended to read as follows:

695B.318 1. Nonprofit hospital, medical or dental service corporations are subject to the provisions of NRS 689B.340 to 689B.600, inclusive, ***and section 3 of this act*** and chapter 689C of NRS relating to the portability and availability of health insurance offered by such organizations. If there is a conflict between the provisions of this chapter and the provisions of NRS 689B.340 to 689B.600, inclusive, ***and section 3 of this act*** and chapter 689C of NRS, the provisions of NRS 689B.340 to

689B.600, inclusive, ***and section 3 of this act*** and chapter 689C of NRS control.

2. For the purposes of subsection 1, unless the context requires that a provision apply only to a group health plan or a carrier that provides coverage under a group health plan, any reference in those sections to:

(a) "Carrier" must be replaced by "corporation."

(b) "Group health plan" must be replaced by "group contract for hospital, medical or dental services."

Sec. 8. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in NRS 422.273, a health maintenance organization that furnishes health care services through providers which are under contract with the organization shall use its best efforts to contract with at least one health center in each geographic area served by the organization to provide such services to enrollees if the health center:

(a) Meets all conditions imposed by the organization on similarly situated providers of health care that are under contract with the organization, including, without limitation:

(1) Certification for participation in the Medicaid or Medicare program; and

(2) Requirements relating to the appropriate credentials for providers of health care; and

(b) Agrees to reasonable reimbursement rates that are generally consistent with those offered by the organization to similarly situated providers of health care that are under contract with the organization.

2. As used in this section, "health center" has the meaning ascribed to it in 42 U.S.C. § 254b.

Sec. 9. 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 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.035, 689A.410 and 689A.413.

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.

12. Section 1 of this act, concerning health centers.

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

1. A managed care organization that delivers health care services by using independently contracted providers of health care shall use its best efforts to contract with at least one health center in each geographic area served by the organization to provide such services to insureds if the health center:

(a) Meets all conditions imposed by the organization on similarly situated providers of health care that are under contract with the organization, including, without limitation:

(1) Certification for participation in the Medicaid or Medicare program; and

(2) Requirements relating to the appropriate credentials for providers of health care; and

(b) Agrees to reasonable reimbursement rates that are generally consistent with those offered by the organization to similarly situated providers of health care that are under contract with the organization.

2. As used in this section, "health center" has the meaning ascribed to it in 42 U.S.C. § 254b.

Sec. 11. NRS 287.010 is hereby amended to read as follows:

287.010 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other public agency of the State of Nevada may:

(a) Adopt and carry into effect a system of group life, accident or health insurance, or any combination thereof, for the benefit of its officers and employees, and the dependents of officers and employees who elect to accept the insurance and who, where necessary, have authorized the governing body to make deductions from their compensation for the payment of premiums on the insurance.

(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of

chapter 683A of NRS, and must be a resident of this state. Any contract with an independent administrator must be approved by the commissioner of insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of ***section 3 of this act and*** NRS 689B.030 to 689B.050, inclusive, apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0359 do not apply to such coverage.

(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation, political subdivision, public corporation or other public agency of the State of Nevada.

2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.

Sec. 12. NRS 287.045 is hereby amended to read as follows:

287.045 1. Except as otherwise provided in this section, every officer or employee of the state is eligible to participate in the program on the first day of the month following the completion of 90 days of full-time employment.

2. Professional employees of the University and Community College System of Nevada who have annual employment contracts are eligible to participate in the program on:

(a) The effective dates of their respective employment contracts, if those dates are on the first day of a month; or

(b) The first day of the month following the effective dates of their respective employment contracts, if those dates are not on the first day of a month.

3. Every officer or employee who is employed by a participating public agency on a permanent and full-time basis on the date the agency enters into an agreement to participate in the program, and every officer or employee who commences his employment after that date, is eligible to participate in the program on the first day of the month following the completion of 90 days of full-time employment.

4. Every senator and assemblyman is eligible to participate in the program on the first day of the month following the 90th day after his initial term of office begins.

5. An officer or employee of the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other public agency of the State of Nevada who retires under the conditions set forth in NRS 286.510 or 286.620 and was not participating in the program at the time of his retirement is eligible to participate in the program 60 days after notice of the selection to participate is given pursuant to NRS 287.023 or 287.0235. The board shall make a separate accounting for these retired persons. For the first year following enrollment, the rates charged must be the full actuarial costs determined by the actuary based upon the expected claims experience with these retired

persons. The claims experience of these retired persons must not be commingled with the retired persons who were members of the program before their retirement, nor with active employees of the state. After the first year following enrollment, the rates charged must be the full actuarial costs determined by the actuary based upon the past claims experience of these retired persons since enrolling.

6. Notwithstanding the provisions of subsections 1, 3 and 4, if the board does not, pursuant to NRS 689B.580, elect to exclude the program from compliance with NRS 689B.340 to 689B.600, inclusive, ***and section 3 of this act*** and if the coverage under the program is provided by a health maintenance organization authorized to transact insurance in this state pursuant to chapter 695C of NRS, any affiliation period imposed by the program may not exceed the statutory limit for an affiliation period set forth in NRS 689B.500.

Sec. 12.5. NRS 422.273 is hereby amended to read as follows:

422.273 1. For any Medicaid managed care program established in the State of Nevada, the department shall contract only with a health maintenance organization that has:

(a) Negotiated in good faith with a federally-qualified health center to provide health care services for the health maintenance organization;

(b) Negotiated in good faith with the University Medical Center of Southern Nevada to provide inpatient and ambulatory services to recipients of Medicaid; and

(c) Negotiated in good faith with the University of Nevada School of Medicine to provide health care services to recipients of Medicaid.

Nothing in this section shall be construed as exempting a federally-qualified health center, the University Medical Center of Southern Nevada or the University of Nevada School of Medicine from the requirements for contracting with the health maintenance organization.

2. During the development and implementation of any Medicaid managed care program, the department shall cooperate with the University of Nevada School of Medicine by assisting in the provision of an adequate and diverse group of patients upon which the school may base its educational programs.

3. The University of Nevada School of Medicine may establish a nonprofit organization to assist in any research necessary for the development of a Medicaid managed care program, receive and accept gifts, grants and donations to support such a program and assist in establishing educational services about the program for recipients of Medicaid.

4. For the ~~[purposes]~~ ***purpose*** of ***contracting with a Medicaid managed care program pursuant to*** this section ~~[.]~~ ***, a health maintenance organization is exempt from the provisions of section 8 of this act.***

5. As used in this section, unless the context otherwise requires:

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

(b) "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

Sec. 13. The amendatory provisions of this act apply to all policies, contracts and plans for health insurance, managed care or the provision of health care services entered into or renewed on or after January 1, 2002.

Sec. 14. The amendatory provisions of this act do not apply to offenses committed before January 1, 2002.

Sec. 15. This act becomes effective on January 1, 2002.