SENATE BILL NO. 278–SENATORS HORSFORD AND HARDY

MARCH 18, 2011

Referred to Committee on Commerce, Labor and Energy

SUMMARY—Revises provisions relating to health care and health insurance. (BDR 57-253)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Yes.

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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 health care; requiring the Commissioner of Insurance to establish a task force to study the use in this State of electronic identification cards that contain certain health insurance information; setting forth the powers and duties of the task force and the requirements of the study; requiring the Division of Insurance of the Department of Business and Industry to provide administrative support for the task force; prohibiting certain insurers and certain self-insured governmental entities from requiring prior authorization for medical and dental care under certain circumstances; revising provisions governing the modification of contracts between insurers and providers of health care under certain circumstances; requiring the Director of the Department of Health and Human Services to prescribe a minimum reimbursement rate for care and services provided pursuant to state plans which provide medical assistance; revising the requirement that certain insurers and health care facilities accept a standardized form to obtain information relating to the credentials of a provider of health care; requiring a report concerning the results of the study of electronic identification cards by the task force and any recommendations for legislation to be provided to the Legislature; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Section 2 of this bill requires the Commissioner of Insurance to establish a task force on the use in this State of electronic identification cards that contain information relating to health insurance. The task force must consist of the Commissioner, the Director of the Department of Health and Human Services and three other members with knowledge and experience concerning health insurance or health care in this State who are appointed by the Commissioner. **Section 3** of this bill requires the task force to study the use in this State of electronic identification cards which contain in an electronic format the information that is necessary to process a claim for coverage under a health care plan and specifies the issues that must be included in the study. **Section 5** of this bill requires the Division of Insurance of the Department of Business and Industry to provide administrative support for the task force. **Section 22** of this bill requires the Commissioner of Insurance, on or before January 31, 2013, to submit to the Director of the Legislative Counsel Bureau for transmittal to the next regular session of the Legislature a written report concerning the results of the study conducted by the task force and any recommendations for legislation.

Sections 6 and 18 of this bill prohibit certain insurers and self-insured governmental entities from requiring an insured to obtain prior authorization for medical and dental care if certain conditions are met including that: (1) the insured has been diagnosed with a severe or chronic condition by a specialized health care provider; (2) the insurer or entity has confirmed the diagnosis; (3) the medical or dental service is covered by the contract or plan of insurance; (4) the medical or dental service is clinically appropriate; (5) the medical or dental service is medically necessary; and (6) the medical or dental service is not more costly than and is equally effective as other services. The Commissioner is required to adopt regulations for carrying out the provisions of **section 6**.

Sections 8-12, 14 and 15 of this bill require written notice of a contract modification between certain insurers and a provider of health care to be sent to the provider at least 90 days before the proposed modification will take effect.

Section 16 of this bill requires the Director of the Department of Health and Human Services to include in each state plan which provides medical assistance a rate for reimbursing providers of health care which is not lower than the rate offered by Medicare in 2002. **Section 16** also requires the Director to publish such rates on an Internet website maintained by the Department.

Existing law requires the Commissioner to prescribe a single, standardized form for use by insurers, carriers, societies, corporations, health maintenance organizations and managed care organizations to obtain any information relating to the credentials of a provider of health care. (NRS 629.095) **Section 21** of this bill requires the Commissioner to prescribe that form for use by insurers that provide medical malpractice insurance, hospitals, medical facilities and other facilities that provide health care.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 679B of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 5, inclusive, of this act.

Sec. 2. ***1. The Commissioner shall establish a task force on the use in this State of electronic identification cards that contain information relating to health insurance.***

2. The task force must consist of the Commissioner, the Director of the Department of Health and Human Services and three other members with knowledge and experience concerning health insurance or health care in this State who are appointed by the Commissioner. A vacancy in the membership of the task force must be filled in the same manner as the original appointment.

3. The Commissioner is the Chair of the task force.

4. The task force shall meet at the call of the Commissioner. The task force shall prescribe regulations for its management and government.

5. A majority of the members of the task force constitutes a quorum, and a quorum may exercise all the powers conferred on the task force.

6. The appointed members of the task force serve at the pleasure of the Commissioner.

7. Except as otherwise provided in this subsection, the members of the task force serve without compensation. The members of the task force who are state employees must be relieved from their duties without loss of their regular compensation to perform their duties relating to the task force in the most timely manner practicable. The state employees may not be required to make up the time they are absent from work to fulfill their obligations as members of the task force or take annual leave or compensatory time for the absence. While engaged in the business of the task force, each member is entitled to receive the per diem allowance and travel expenses provided for state officers and employees generally.

Sec. 3. ***1. The task force shall study the use in this State of electronic identification cards which contain in an electronic format the information that is necessary to process a claim for coverage under a health care plan, including, without limitation:***

(a) Issues relating to the security, privacy, data content, storage and confidentiality of information contained on or in an electronic identification card and methods to ensure the security, privacy and confidentiality of such information.

(b) The issuance, usage and contents of electronic identification cards.

(c) The standards for technology and tools through which information contained on or in electronic identification cards may be electronically recognized, exchanged, transmitted and stored using machine-readable technology, which may include, without limitation, bar codes, magnetic strips or radio frequency identification.

(d) The information that may be electronically recognized, exchanged, transmitted and stored on electronic identification cards.

(e) The methods for verifying coverage and eligibility for benefits, requirements for processing requests for prior authorization and requirements for denying coverage through the use of electronic data interchange.

(f) The structure and format of the information contained on or in an electronic identification card.

(g) The insurers, providers of health care and other persons who should be required to issue or accept electronic identification cards.

(h) The effect of all applicable state and federal laws on any program used to produce or use electronic identification cards.

(i) The advisability of requiring the use of electronic identification cards in this State.

(j) If the task force determines that the use of electronic identification cards in this State should be required, the most efficient and cost-effective manner in which a program requiring the use of electronic identification cards could be implemented in this State.

2. The task force may also include in the study an evaluation of the use of any other technological device similar to an electronic identification card.

Sec. 4. ***The task force may apply for any available grants and accept any gifts, grants or donations to assist the task force in carrying out its duties pursuant to sections 2 to 5, inclusive, of this act.***

Sec. 5. ***The Division shall provide the personnel, facilities, equipment and supplies required by the task force to carry out its duties pursuant to sections 2 to 5, inclusive, of this act.***

Sec. 6. Chapter 687B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A contract for group, blanket or individual health insurance or any contract issued by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for the payment of a certain part of medical or dental care must not require an insured or member who has been diagnosed with a severe or chronic condition by a provider of health care who is specialized in the care or treatment of the severe or chronic condition to obtain prior authorization for a medical or dental service for the care of that condition if:

(a) The insurer or organization has confirmed the diagnosis of the severe or chronic condition made by the provider of health care;

(b) The provider of health care is ordering a medical or dental service that is covered by the contract as a service for the severe or chronic condition;

(c) The type, frequency, dosage and duration of the medical or dental service is considered effective for the severe or chronic condition;

(d) The medical or dental service is medically necessary for the severe or chronic condition; and

(e) The medical or dental service is not more costly than an alternative medical or dental service or sequence of services and is at least as likely to produce an equivalent therapeutic or diagnostic result.

2. The Commissioner shall adopt such regulations as are necessary to carry out the provisions of this section, including, without limitation, regulations:

(a) Identifying the severe or chronic conditions to which the provisions of this section apply, which must include, without limitation, cancer, pulmonary disease and heart disease;

(b) Determining the qualifications for a provider of health care to be considered specialized in the treatment of a particular severe or chronic condition for the purposes of this section, which may include, without limitation, certification by a specialty board of the American Board of Medical Specialties or by the American Osteopathic Association or any similar organization;

(c) Identifying the types of medical or dental services for which prior authorization is not required pursuant to this section; and

(d) Defining the term "medically necessary" as that term is used in this section.

3. The insurer or organization shall:

(a) File its procedure for confirming a diagnosis of a severe or chronic condition pursuant to this section for approval by the Commissioner; and

(b) Respond to any request for the confirmation of a diagnosis of a severe or chronic condition by the insured or member pursuant to this section within 20 days after it receives the request.

4. As used in this section, "medical or dental service" means any care, treatment, monitoring or evaluation of a medical or dental condition, including, without limitation, the provision of testing, imaging services, medication, medical supplies and devices, therapy and any other professional or technical service which is used to provide medical or dental care.

Sec. 7. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0413, 689A.044, 689A.0445, 689B.031, 689B.0313, 689B.0317, 689B.0374, 695B.1912, 695B.1914,

695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1745, 695C.1751, 695G.170, 695G.171 and 695G.177, ***and section 6 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. 8. NRS 689A.035 is hereby amended to read as follows:

689A.035 1. An insurer shall not 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.

2. An insurer shall not contract with a provider of health care to provide health care to an insured unless the insurer uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between an insurer and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the insurer upon giving to the provider ~~[30]~~ ***90*** days' written notice of the modification ~~[.]~~ ***pursuant to subsection 4.*** If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. ***An insurer that wishes to modify a contract pursuant to paragraph (b) of subsection 3 shall mail by certified or registered mail, return receipt requested, to the provider of health care written notice of a modification to the contract between the insurer and the provider. The exterior of the notice must bear a statement, in at least 12-point bold type or font, in substantially the following form:***

OFFICIAL NOTICE OF CONTRACT MODIFICATION

5. If an insurer contracts with a provider of health care to provide health care to an insured, the insurer shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

~~[5.]~~ ***6.*** As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 9. NRS 689B.015 is hereby amended to read as follows:

689B.015 1. An insurer that issues a policy of group health insurance shall not 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.

2. An insurer specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the insurer uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between an insurer specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the insurer upon giving to the provider ~~[30]~~ ***90*** days' written notice of the modification ~~[.]~~ ***pursuant to subsection 4.*** If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. ***An insurer that wishes to modify a contract pursuant to paragraph (b) of subsection 3 shall mail by certified or registered mail, return receipt requested, to the provider of health care written notice of a modification to the contract between the insurer and the provider. The exterior of the notice must bear a statement, in at least 12-point bold type or font, in substantially the following form:***

OFFICIAL NOTICE OF CONTRACT MODIFICATION

5. If an insurer specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the insurer shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

~~[5.]~~ ***6.*** As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 10. NRS 689C.435 is hereby amended to read as follows:

689C.435 1. A carrier serving small employers and a carrier that offers a contract to a voluntary purchasing group shall not 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.

2. A carrier specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the carrier uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between a carrier specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the carrier upon giving to the provider ~~[30]~~ ***90*** days' written notice of the modification ~~[.]~~ ***pursuant to subsection 4.*** If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. ***A carrier that wishes to modify a contract pursuant to paragraph (b) of subsection 3 shall mail by certified or registered mail, return receipt requested, to the provider of health care written notice of a modification to the contract between the carrier and the provider. The exterior of the notice must bear a statement, in at least 12-point bold type or font, in substantially the following form:***

OFFICIAL NOTICE OF CONTRACT MODIFICATION

5. If a carrier specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the carrier shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

~~[5.]~~ ***6.*** As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 11. NRS 695A.095 is hereby amended to read as follows:

695A.095 1. A society shall not 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.

2. A society shall not contract with a provider of health care to provide health care to an insured unless the society uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between a society and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the society upon giving to the provider ~~[30]~~ ***90*** days' written notice of the modification ~~[.]~~ ***pursuant to subsection 4.*** If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. ***A society that wishes to modify a contract pursuant to paragraph (b) of subsection 3 shall mail by certified or registered mail, return receipt requested, to the provider of health care written notice of a modification to the contract between the society and the provider. The exterior of the notice must bear a statement, in at least 12-point bold type or font, in substantially the following form:***

OFFICIAL NOTICE OF CONTRACT MODIFICATION

5. If a society contracts with a provider of health care to provide health care to an insured, the society shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

~~[5.]~~ ***6.*** As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 12. NRS 695B.035 is hereby amended to read as follows:

695B.035 1. A corporation subject to the provisions of this chapter shall not 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.

2. A corporation specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the corporation uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between a corporation specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the corporation upon giving to the provider ~~[30]~~ ***90*** days' written notice of the modification ~~[.]~~ ***pursuant to subsection 4.*** If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. ***A corporation specified in subsection 1 that wishes to modify a contract pursuant to paragraph (b) of subsection 3 shall mail by certified or registered mail, return receipt requested, to the provider of health care written notice of a modification to the contract between the corporation and the provider. The exterior of the notice must bear a statement, in at least 12-point bold type or font, in substantially the following form:***

OFFICIAL NOTICE OF CONTRACT MODIFICATION

5. If a corporation specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the corporation shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

~~[5.]~~ ***6.*** As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 13. NRS 695B.320 is hereby amended to read as follows:

695B.320 Nonprofit hospital and medical or dental service corporations are subject to the provisions of this chapter, and to the provisions of chapters 679A and 679B of NRS, NRS 686A.010 to 686A.315, inclusive, 687B.010 to 687B.040, inclusive, 687B.070 to 687B.140, inclusive, 687B.150, 687B.160, 687B.180, 687B.200 to 687B.255, inclusive, ***and section 6 of this act,*** 687B.270, 687B.310 to 687B.380, inclusive, 687B.410, 687B.420, 687B.430, and chapters 692C and 696B of NRS, to the extent applicable and not in conflict with the express provisions of this chapter.

Sec. 14. NRS 695C.125 is hereby amended to read as follows:

695C.125 1. A health maintenance organization shall not contract with a provider of health care to provide health care to an insured unless the health maintenance organization uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

2. A contract between a health maintenance organization and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the health maintenance organization upon giving to the provider ~~[30]~~ ***90*** days' written notice of the modification ~~[.]~~ ***pursuant to subsection 3.*** If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

3. ***A health maintenance organization that wishes to modify a contract pursuant to paragraph (b) of subsection 2 shall mail by certified or registered mail, return receipt requested, to the provider of health care written notice of a modification to the contract between the health maintenance organization and the provider. The exterior of the notice must bear a statement, in at least 12-point bold type or font, in substantially the following form:***

OFFICIAL NOTICE OF CONTRACT MODIFICATION

4. If a health maintenance organization contracts with a provider of health care to provide health care to an enrollee, the health maintenance organization shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

~~[4.]~~ ***5.*** As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 15. NRS 695G.430 is hereby amended to read as follows:

695G.430 1. A managed care organization shall not contract with a provider of health care to provide health care to an insured unless the managed care organization uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

2. A contract between a managed care organization and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the managed care organization upon giving to the provider ~~[30]~~ ***90*** days' written notice of the modification ~~[.]~~ ***pursuant to subsection 3.*** If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***90-day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

3. ***A managed care organization that wishes to modify a contract pursuant to paragraph (b) of subsection 2 shall mail by certified or registered mail, return receipt requested, to the***

provider of health care written notice of a modification to the contract between the managed care organization and the provider. The exterior of the notice must bear a statement, in at least 12-point bold type or font, in substantially the following form:

OFFICIAL NOTICE OF CONTRACT MODIFICATION

4. If a managed care organization contracts with a provider of health care to provide health care services pursuant to chapter 689A, 689B, 689C, 695A, 695B or 695C of NRS, the managed care organization shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments specified in paragraph (a) within 7 days after receiving the request.

~~[4.]~~ ***5.*** As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 16. Chapter 232 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Director shall provide in each state plan adopted by the Director which provides medical assistance, including, without limitation, the State Plan for Medicaid and the Children's Health Insurance Program and any waiver to such plans, a rate of reimbursement for providers of health care which is not lower than the rate offered by Medicare on January 1, 2002, for care and services provided pursuant to the state plan.

2. The Director shall post on an Internet website maintained by the Department a schedule of the rates provided by each state plan adopted by the Director which provides medical assistance.

Sec. 17. NRS 232.290 is hereby amended to read as follows:

232.290 As used in NRS 232.290 to 232.484, inclusive, ***and section 16 of this act,*** unless the context requires otherwise:

1. "Department" means the Department of Health and Human Services.

2. "Director" means the Director of the Department.

Sec. 18. Chapter 287 of NRS is hereby amended by adding thereto a new section to read as follows:

1. If the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada provides health insurance through a plan of self-insurance, the plan must not require an insured who has been diagnosed with a severe or

chronic condition by a provider of health care who is specialized in the care or treatment of the severe or chronic condition to obtain prior authorization for a medical or dental service for the care of that condition if:

(a) The insurer has confirmed the diagnosis of the severe or chronic condition made by the provider of health care;

(b) The provider of health care is ordering a medical or dental service that is covered by the plan as a service for the severe or chronic condition;

(c) The type, frequency, dosage and duration of the medical or dental service is considered effective for the severe or chronic condition;

(d) The medical or dental service is medically necessary for the severe or chronic condition; and

(e) The medical or dental service is not more costly than an alternative medical or dental service or sequence of services and is at least as likely to produce an equivalent therapeutic or diagnostic result.

2. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance shall, as part of its plan of self-insurance and in a manner consistent with the regulations adopted by the Commissioner of Insurance pursuant to section 6 of this act:

(a) Identify the severe or chronic conditions to which the provisions of this section apply, which must include, without limitation, cancer, pulmonary disease and heart disease;

(b) Determine the qualifications for a provider of health care to be considered specialized in the treatment of a particular severe or chronic condition for the purposes of this section, which may include, without limitation, certification by a specialty board of the American Board of Medical Specialties or by the American Osteopathic Association or any similar organization;

(c) Identify the types of medical or dental services for which prior authorization is not required pursuant to this section; and

(d) Define the term "medically necessary" as that term is used in this section.

3. As used in this section, "medical or dental service" means any care, treatment, monitoring or evaluation of a medical or dental condition, including, without limitation, the provision of testing, imaging services, medication, medical supplies and devices, therapy and any other professional or technical service which is used to provide medical or dental care.

Sec. 19. NRS 287.040 is hereby amended to read as follows:

287.040 The provisions of NRS 287.010 to 287.040, inclusive, ***and section 18 of this act*** do not make it compulsory upon any governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada, except as otherwise provided in NRS 287.021 or subsection 4 of NRS 287.023 or in an agreement entered into pursuant to subsection 3 of NRS 287.015, to pay any premiums, contributions or other costs for group insurance, a plan of benefits or medical or hospital services established pursuant to NRS 287.010, 287.015, 287.020 or paragraph (b), (c) or (d) of subsection 1 of NRS 287.025, for coverage under the Public Employees' Benefits Program, or to make any contributions to a trust fund established pursuant to NRS 287.017, or upon any officer or employee of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of this State to accept any such coverage or to assign his or her wages or salary in payment of premiums or contributions therefor.

Sec. 20. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 689B.255, 695G.150, 695G.160, 695G.164, 695G.1645, 695G.170, 695G.171, 695G.173, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and section 6 of this act*** in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 21. NRS 629.095 is hereby amended to read as follows:

629.095 1. Except as otherwise provided in subsection 2, the Commissioner of Insurance shall develop, prescribe for use and make available a single, standardized form for use by insurers, carriers, societies, corporations, health maintenance organizations ***,*** ~~[and]~~ managed care organizations ***, hospitals, medical facilities and other facilities that provide health care*** in obtaining any information related to the credentials of a provider of health care.

2. The provisions of subsection 1 do not prohibit the Commissioner of Insurance from developing, prescribing for use and making available:

(a) Appropriate variations of the form described in that subsection for use in different geographical regions of this State.

(b) Addenda or supplements to the form described in that subsection to address, until such time as a new form may be developed, prescribed for use and made available, any requirements newly imposed by the Federal Government, the State or one of its

agencies, or a body that accredits hospitals, medical facilities or health care plans.

3. With respect to the form described in subsection 1, the Commissioner of Insurance shall:

(a) Hold public hearings to seek input regarding the development of the form;

(b) Develop the form in consideration of the input received pursuant to paragraph (a);

(c) Ensure that the form is developed in such a manner as to accommodate and reflect the different types of credentials applicable to different classes of providers of health care;

(d) Ensure that the form is developed in such a manner as to reflect standards of accreditation adopted by national organizations which accredit hospitals, medical facilities and health care plans; and

(e) Ensure that the form is developed to be used efficiently and is developed to be neither unduly long nor unduly voluminous.

4. As used in this section:

(a) "Carrier" has the meaning ascribed to it in NRS 689C.025.

(b) "Corporation" means a corporation operating pursuant to the provisions of chapter 695B of NRS.

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

(d) "Insurer" means:

(1) An insurer that issues policies of individual health insurance in accordance with chapter 689A of NRS; ~~[and]~~

(2) An insurer that issues policies of group health insurance in accordance with chapter 689B of NRS ~~[.]~~ ***; and***

(3) An insurer that issues policies of insurance for medical malpractice, as defined in NRS 679B.144.

(e) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

(f) "Provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

(g) "Society" has the meaning ascribed to it in NRS 695A.044.

Sec. 22. The Commissioner of Insurance shall, on or before January 31, 2013, submit to the Director of the Legislative Counsel Bureau for transmittal to the next regular session of the Legislature a written report concerning the results of the study conducted by the task force established pursuant to section 2 of this act concerning the use in this State of electronic identification cards and any recommendations for legislation.

Sec. 23. 1. A contract for group, blanket or individual health insurance or any contract issued 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 which is delivered, issued for delivery or renewed on or after January 1, 2012, must comply with the provisions of section 6 of this act.

2. A plan of self-insurance governed by NRS 287.04335, as amended by section 20 of this act, must ensure that any plan which is delivered, issued for delivery or renewed on or after January 1, 2012, complies with the provisions of section 18 of this act.

Sec. 24. A provider of health care who provides care or services on or after January 1, 2012, pursuant to a state plan which provides medical assistance must be reimbursed at the rate:

1. Described in section 16 of this act; or
2. Provided in the state plan,

➥ whichever is higher.

Sec. 25. 1. This section and sections 1 to 5, inclusive, and 22 of this act become effective upon passage and approval.

2. Sections 6 to 15, inclusive, 18 to 21, inclusive, and 23 of this act become effective upon passage and approval for the purpose of adopting regulations and on January 1, 2012, for all other purposes.

3. Sections 16, 17 and 24 of this act become effective upon passage and approval for the purpose of amending state plans which provide medical assistance and on January 1, 2012, for all other purposes.

4. Sections 1 to 5, inclusive, and 22 of this act expire by limitation on February 1, 2013.

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