ASSEMBLY BILL NO. 230–COMMITTEE
ON COMMERCE AND LABOR

(ON BEHALF OF THE LEGISLATIVE COMMITTEE
ON HEALTH CARE)

MARCH 5, 2015

Referred to Committee on Commerce and Labor

SUMMARY—Requires certain insurers to contract with any qualified provider of health care in certain circumstances. (BDR 57-65)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: 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 health insurers to contract with certain providers of health care whose availability is limited in certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Commissioner of Insurance to make an annual determination concerning the availability and accessibility of health care service of any network plan made available for sale in this State. (NRS 687B.490) Federal regulations authorize the Secretary of the United States Department of Health and Human Services to designate a geographic area as a health professional shortage area based on certain data. (42 C.F.R. § 5.3) **Sections 1, 3, 4, 7-9, 13 and 16** of this bill provide that the providers of health care included in a network plan are inadequate if: (1) the Commissioner has determined that health care services are not adequately accessible and available; or (2) the Secretary has designated a geographic area in which the network plan is offered as a health professional shortage area. If a network plan is inadequate, this bill requires an insurer to contract with any health care provider who: (1) is willing to accept the terms and conditions established by the insurer for other similar providers of health care; and (2) provides the health care services for which the network is inadequate. **Sections 10 and 14** of this bill exclude Medicaid from these requirements. **Sections 2, 5, 6, 11, 12 and 15** make conforming changes.

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. If the providers of health care included in the network plan of a policy of health insurance are inadequate to ensure that health care services will be available and accessible to insureds, the insurer must enter into an agreement with any provider of health care who:

(a) Is willing to accept the terms and conditions established by the insurer for other similar providers of health care included in the network plan; and

(b) Provides the type of health care services for which there are an inadequate number of providers of health care in the network plan.

2. The providers of health care included in a network plan shall be deemed inadequate for the purposes of this section if:

(a) The Commissioner has determined pursuant to NRS 687B.490 that the network plan does not ensure that health care services will be adequately accessible and available to insureds; or

(b) The United States Secretary of Health and Human Services has designated a geographic area in which the network plan is offered as a health professional shortage area pursuant to 42 C.F.R. § 5.3.

3. As used in this section, "network plan" has the meaning ascribed to it in NRS 689B.570.

Sec. 2. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~[.]~~ ***, and section 1 of this act.***

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

1. If the providers of health care included in the network plan of a policy of group health insurance are inadequate to ensure that health care services will be available and accessible to insureds, the insurer must enter into an agreement with any provider of health care who:

(a) Is willing to accept the terms and conditions established by the insurer for other similar providers of health care included in the network plan; and

(b) Provides the type of health care services for which there are an inadequate number of providers of health care in the network plan.

2. The providers of health care included in a network plan shall be deemed inadequate for the purposes of this section if:

(a) The Commissioner has determined pursuant to NRS 687B.490 that the network plan does not ensure that health care services will be adequately accessible and available to insureds; or

(b) The United States Secretary of Health and Human Services has designated a geographic area in which the network plan is offered as a health professional shortage area pursuant to 42 C.F.R. § 5.3.

3. As used in this section, "network plan" has the meaning ascribed to it in NRS 689B.570.

Sec. 4. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. If the providers of health care included in the network plan of a health benefit plan are inadequate to ensure that health care services will be available and accessible to insureds, the carrier must enter into an agreement with any provider of health care who:

(a) Is willing to accept the terms and conditions established by the carrier for other similar providers of health care included in the network plan; and

(b) Provides the type of health care services for which there are an inadequate number of providers of health care in the network plan.

2. The providers of health care included in a network plan shall be deemed inadequate for the purposes of this section if:

(a) The Commissioner has determined pursuant to NRS 687B.490 that the network plan does not ensure that health care services will be adequately accessible and available to insureds; or

(b) The United States Secretary of Health and Human Services has designated a geographic area in which the network plan is offered as a health professional shortage area pursuant to 42 C.F.R. § 5.3.

3. As used in this section, "network plan" has the meaning ascribed to it in NRS 689B.570.

Sec. 5. NRS 689C.360 is hereby amended to read as follows:

689C.360 As used in NRS 689C.360 to 689C.600, inclusive, ***and section 4 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 689C.380 to 689C.420, inclusive, have the meanings ascribed to them in those sections.

Sec. 6. NRS 689C.430 is hereby amended to read as follows:

689C.430 Every insurer, fraternal benefit society, corporation providing hospital or medical services or health maintenance organization, whose policies or activities relating to health insurance are governed by the provisions of chapter 689B, 695A, 695B or 695C of NRS, may offer contracts to voluntary purchasing groups and, if it does so, shall comply with the provisions of NRS 689C.360 to 689C.600, inclusive ~~[.]~~ ***, and section 4 of this act.***

Sec. 7. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. If the providers of health care included in the network plan of a benefit contract are inadequate to ensure that health care services will be available and accessible to insureds, the society must enter into an agreement with any provider of health care who:

(a) Is willing to accept the terms and conditions established by the society for other similar providers of health care included in the network plan; and

(b) Provides the type of health care services for which there are an inadequate number of providers of health care in the network plan.

2. The providers of health care included in a network plan shall be deemed inadequate for the purposes of this section if:

(a) The Commissioner has determined pursuant to NRS 687B.490 that the network plan does not ensure that health care services will be adequately accessible and available to insureds; or

(b) The United States Secretary of Health and Human Services has designated a geographic area in which the network plan is offered as a health professional shortage area pursuant to 42 C.F.R. § 5.3.

3. As used in this section, "network plan" has the meaning ascribed to it in NRS 689B.570.

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

1. If the providers of health care included in the network plan of a contract for hospital, medical or dental services are inadequate to ensure that health care services will be available and accessible to insureds, the nonprofit hospital, medical or dental service corporation must enter into an agreement with any provider of health care who:

(a) Is willing to accept the terms and conditions established by the nonprofit hospital, medical or dental service corporation for other similar providers of health care included in the network plan; and

(b) Provides the type of health care services for which there are an inadequate number of providers of health care in the network plan.

2. The providers of health care included in a network plan shall be deemed inadequate for the purposes of this section if:

(a) The Commissioner has determined pursuant to NRS 687B.490 that the network plan does not ensure that health care services will be adequately accessible and available to insureds; or

(b) The United States Secretary of Health and Human Services has designated a geographic area in which the network plan is offered as a health professional shortage area pursuant to 42 C.F.R. § 5.3.

3. As used in this section, "network plan" has the meaning ascribed to it in NRS 689B.570.

Sec. 9. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. If the providers of health care included in the network plan of a health care plan are inadequate to ensure that health care services will be available and accessible to enrollees, the health maintenance organization must enter into an agreement with any provider of health care who:

(a) Is willing to accept the terms and conditions established by the health maintenance organization for other similar providers of health care included in the network plan; and

(b) Provides the type of health care services for which there are an inadequate number of providers of health care in the network plan.

2. The providers of health care included in a network plan shall be deemed inadequate for the purposes of this section if:

(a) The Commissioner has determined pursuant to NRS 687B.490 that the network plan does not ensure that health care services will be adequately accessible and available to enrollees; or

(b) The United States Secretary of Health and Human Services has designated a geographic area in which the network plan is offered as a health professional shortage area pursuant to 42 C.F.R. § 5.3.

3. As used in this section, "network plan" has the meaning ascribed to it in NRS 689B.570.

Sec. 10. 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.125, 695C.1691, 695C.1693, 695C.170 to 695C.173, inclusive, 695C.1733 to 695C.200, inclusive, and 695C.265 ***and section 9 of this act*** do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694, 695C.1695 and 695C.1731 apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 11. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if the Commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, ***and section 9 of this act*** or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The Commissioner certifies that the health maintenance organization:

(1) Does not meet the requirements of subsection 1 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 12. 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.700.

7. Chapter 683A of NRS.

8. To the extent applicable, the provisions of NRS 689B.340 to 689B.580, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance.

9. NRS 689A.035, 689A.410, 689A.413 and 689A.415 ~~.~~ ***and section 1 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.

12. NRS 689A.637, concerning health centers.

Sec. 13. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. If the providers of health care included in the network plan of a health care plan are inadequate to ensure that health care services will be available and accessible to insureds, the managed care organization must enter into an agreement with any provider of health care who:

(a) Is willing to accept the terms and conditions established by the managed care organization for other similar providers of health care included in the network plan; and

(b) Provides the type of health care services for which there are an inadequate number of providers of health care in the network plan.

2. The providers of health care included in a network plan shall be deemed inadequate for the purposes of this section if:

(a) The Commissioner has determined pursuant to NRS 687B.490 that the network plan does not ensure that health care services will be adequately accessible and available to insureds; or

(b) The United States Secretary of Health and Human Services has designated a geographic area in which the network plan is offered as a health professional shortage area pursuant to 42 C.F.R. § 5.3.

3. As used in this section, "network plan" has the meaning ascribed to it in NRS 689B.570.

Sec. 14. NRS 695G.090 is hereby amended to read as follows:

695G.090 1. Except as otherwise provided in subsection 3, the provisions of this chapter apply to each organization and insurer that operates as a managed care organization and may include, without limitation, an insurer that issues a policy of health insurance, an insurer that issues a policy of individual or group health insurance, a carrier serving small employers, a fraternal benefit society, a hospital or medical service corporation and a health maintenance organization.

2. In addition to the provisions of this chapter, each managed care organization shall comply with:

(a) The provisions of chapter 686A of NRS, including all obligations and remedies set forth therein; and

(b) Any other applicable provision of this title.

3. The provisions of NRS 695G.164, 695G.1645, 695G.167, 695G.200 to 695G.230, inclusive, and 695G.430 ***and section 13 of this act*** do not apply to a managed care organization that provides health care services to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a managed care organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 15. 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 local governmental 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 NRS 687B.408, 689B.030 to 689B.050, inclusive, and 689B.287 ***and section 3 of this act*** apply to coverage provided pursuant to this paragraph.

(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 local governmental 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.

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school

district, municipal corporation, political subdivision, public corporation or other local governmental agency.

4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.

5. A contract that is entered into pursuant to subsection 3:

(a) Must be submitted to the Commissioner of Insurance for approval not less than 30 days before the date on which the contract is to become effective.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

6. As used in this section, "legal services organization" means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.

Sec. 16. 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.167, 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 13 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.

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