Amendment No. 569

Senate Amendment to Senate Bill No. 137	(BDR 57-575)
Proposed by: Senate Committee on Commerce, Labor and Energy	
Amendment Box: Replaces Amendment No. 198.	
Amends: Summary: Yes Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes	

ASSEMBLY ACTION		Initial and Date	SENATE ACTION		Initial and Date
Adopted ☐	Lost ☐		Adopted ☐	Lost ☐	
Concurred In ☐	Not ☐		Concurred In ☐	Not ☐	
Receded ☐	Not ☐		Receded ☐	Not ☐	

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

RAE/JRS Date: 4/16/2015

S.B. No. 137—Enacts provisions governing certain plans for dental care.
(BDR 57-575)

SENATE BILL NO. 137–SENATOR HARDY

FEBRUARY 11, 2015

Referred to Committee on Commerce, Labor and Energy

SUMMARY—Enacts provisions governing ~~[certain plans for dental]~~ **stand-alone dental benefits and policies of health** care. (BDR 57-575)

FISCAL NOTE: Effect on Local Government: No.
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 insurance; designating a ~~[plan for dental care]~~ **stand-alone dental benefit** as the primary policy for certain dental ~~[procedures;]~~ **care;** prohibiting ~~[an]~~ **a health** insurer ~~[or organization for dental care]~~ from denying ~~[a claim]~~ **certain claims** on the basis that another **health** insurer has liability to pay the claim; prohibiting ~~[an insurer or organization for dental care]~~ **a health insurer** from requiring that a claim be submitted directly to a secondary **health** insurer under certain circumstances; ~~[requiring that a joint determination be made on a claim within a certain period; prohibiting the purchase or sale of a qualified health care plan on the Silver State Health Insurance Exchange if the plan includes an embedded pediatric dental plan;]~~ **requiring the Commissioner of Insurance to adopt certain regulations;** and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Certain procedures performed by ~~[oral and maxillofacial surgeons]~~ **dentists** may be covered by both ~~[plans for dental care]~~ **stand-alone dental benefits** and policies of health insurance. Existing law regulates policies of health insurance and ~~[plans for dental care]~~ **stand-alone dental benefits** separately, but provides for no coordination of claims between the two. (Chapters 686C, 689A, 689B, 689C, 695A, 695B, 695C and 695D of NRS) ~~[Section 1 of this]~~ **This** bill **defines a "stand-alone dental benefit" to mean any policy of insurance which only pays for or reimburses the costs of certain dental care and which is not embedded in or included as part of any other policy of health insurance. This bill also** requires that for an insurance claim for a procedure provided by ~~[an oral and maxillofacial surgeon]~~ **a dentist** which may be covered by both the patient's ~~[plan for dental care]~~ **stand-alone dental benefit** and policy of health insurance, the **stand-alone** dental ~~[plan]~~ **benefit** must provide primary coverage. ~~[Section 1]~~ **This bill** also prohibits a ~~[dental]~~ **health** insurer from: (1) denying ~~[a claim]~~ **certain claims** for which it has liability on the basis that another **health** insurer has liability; or (2) requiring a separate claim be filed with the other **health** insurer. Finally, ~~[section 1]~~ **this bill** requires ~~[that a determination of benefits on the claim be made within 30 days after the claim is filed and, as a punitive measure, automatically apportions liability between insurers who fail to provide a determination within the required time limit.~~

~~The Patient Protection and Affordable Care Act requires health plans to include dental coverage for children. (42 U.S.C. § 18022(b)(1)) The Board of Directors of the Silver State Health Insurance Exchange oversees the Exchange and approves any health plan that will be made available for purchase or sale on the Exchange. (NRS 695I.210) During its May 16, 2013, meeting, the Board approved three options for purchasing the required pediatric dental coverage on the Exchange: (1) a stand-alone dental plan which is separate from a health insurance plan; (2) a dental plan which is bundled with a health plan so that the consumer pays a single premium but has separate deductibles for each plan; or (3) a qualified health plan that has pediatric dental benefits embedded within the plan and a single deductible.~~

~~Section 3 of this bill prohibits the purchase or sale of qualified health plans with embedded pediatric dental plans.~~ **the Commissioner of Insurance to adopt regulations necessary to carry out the provisions of this bill.**

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

Section 1. Chapter 686A of NRS is hereby amended by adding thereto a new section to read as follows:

1. The following provisions apply to a claim for payment submitted for services provided by ~~[an oral and maxillofacial surgeon]~~ a dentist which may be covered, in whole or in part, by a ~~[plan for dental care]~~ stand-alone dental benefit and a policy of health insurance:

(a) If a claimant is covered by a ~~[plan for dental care]~~ stand-alone dental benefit and a policy of health insurance, the ~~[plan for dental care is]~~ stand-alone dental benefit is the primary policy and the claim must be first submitted to the health insurer ~~[or organization for dental care]~~ that issued the ~~[plan for]~~ stand-alone dental ~~[care.]~~ benefit. The issuer of the secondary policy may not reduce benefits based upon payments under the primary policy, except to avoid overpayment to the dentist.

(b) ~~[An]~~ Except as otherwise provided in paragraph (a), a health insurer ~~[or organization for dental care]~~ may not deny a claim for which it has liability solely on the basis that another health insurer ~~[or organization for dental care]~~ has liability to pay the claim.

(c) ~~[An]~~ A health insurer ~~[or organization for dental care]~~ with partial liability for paying a claim may not require the claimant to file a separate claim directly with a secondary health insurer.

~~[(d) The insurers or organizations for dental care must make a joint determination of liability on a claim within 30 days after the claim is submitted to the primary insurer, regardless of the number of insurers sharing liability for the claim. Each claim must be paid within 30 days after the determination of liability is made. Beginning 30 days after the claim is submitted, for every 30 calendar days or portion thereof that a determination of liability is not made, each insurer or organization for dental care automatically incurs liability to the claimant in the amount of 10 percent of the claim, until such time as the claim is fully apportioned.]~~

2. The Commissioner shall adopt regulations necessary to carry out the provisions of this section.

3. As used in this section:

(a) ~~["Oral and maxillofacial surgeon" means a dentist who has been issued a specialist's license to practice oral and maxillofacial surgery pursuant to NRS 631.250 and who provides any of the services described in paragraph (c) of subsection 1 of NRS 631.215.]~~ "Health insurer" means a person who is the

holder of a certificate of authority issued pursuant to chapter 680A, 695C, 695D or 695F of NRS or a corporation that is the holder of a certificate of authority issued pursuant to chapter 695B of NRS.

(b) ~~["Organization for dental care" has the meaning ascribed to it in NRS 695D.060.~~

~~(c) "Plan for dental care" has the meaning ascribed to it in NRS 695D.070.]~~ "Stand-alone dental benefit" means any policy which only pays for or reimburses any part of the cost of dental care, as defined in NRS 695D.030. The term does not include such coverage embedded in or included as part of any other policy of health insurance.

Sec. 2. ~~[NRS 695D.215 is hereby amended to read as follows:~~

~~695D.215 1. Except as otherwise provided in subsection 2 [,] *and section 1 of this act,* an organization for dental care shall approve or deny a claim relating to a plan for dental care within 30 days after the organization for dental care receives the claim. If the claim is approved, the organization for dental care shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the organization for dental care shall pay interest on the claim at the rate of interest established pursuant to NRS 99.040. The interest must be calculated from the date the payment is due until the claim is paid.~~

~~2. If the organization for dental care 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 organization for dental care shall notify the provider of dental care of the reason for the delay in approving or denying the claim. The organization for dental care shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the organization for dental care shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the organization for dental care shall pay interest on the claim in the manner prescribed in subsection 1.]~~ **(Deleted by amendment.)**

Sec. 3. ~~[Chapter 695I of NRS is hereby amended by adding thereto a new section to read as follows:~~

~~1. The Board shall not allow to be purchased or sold on the Exchange any qualified health plan which includes an embedded pediatric dental plan.~~

~~2. As used in this section "embedded pediatric dental plan" means any pediatric dental coverage included within a qualified health plan for the purpose of satisfying the essential health benefits requirement of the Federal Act. The term does not include a stand-alone pediatric dental plan which is bundled with a qualified health plan for sale on the Exchange.]~~ **(Deleted by amendment.)**

Sec. 3.5. **The Commissioner of Insurance shall, on or before January 1, 2016, adopt regulations to carry out the amendatory provisions of this act.**

Sec. 4. This act becomes effective:

1. Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks necessary to carry out the provisions of this act; and

2. On January 1, 2016, for all other purposes.