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 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 as the primary policy for certain dental procedures; prohibiting an insurer or organization for dental care from denying a claim on the basis that another insurer has liability to pay the claim; prohibiting an insurer or organization for dental care from requiring that a claim be submitted directly to a secondary 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; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Certain procedures performed by oral and maxillofacial surgeons may be covered by both plans for dental care and policies of health insurance. Existing law regulates policies of health insurance and plans for dental care 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 bill requires that for an insurance claim for a procedure provided by an oral and maxillofacial surgeon which may be covered by both the patient's plan for dental care and policy of health insurance, the dental plan must provide primary coverage. **Section 1** also prohibits a dental insurer from: (1) denying a claim for which it has liability on the basis that another insurer has liability; or (2) requiring a separate claim be filed with the other insurer. Finally, **section 1** 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 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 which may be covered, in whole or in part, by a plan for dental care and a policy of health insurance:

(a) If a claimant is covered by a plan for dental care and a policy of health insurance, the plan for dental care is the primary policy and the claim must be first submitted to the insurer or organization for dental care that issued the plan for dental care.

(b) An insurer or organization for dental care may not deny a claim for which it has liability solely on the basis that another insurer or organization for dental care has liability to pay the claim.

(c) An 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 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. 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.

(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.

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.

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.

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.

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