SENATE BILL NO. 208–SENATOR FARLEY

FEBRUARY 27, 2017

Referred to Committee on Commerce, Labor and Energy

SUMMARY—Revises provisions relating to health care. (BDR 57-24)

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 health care; authorizing the use of direct primary care agreements; exempting direct primary care agreements from the provisions of the Nevada Insurance Code; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law sets forth the provisions of the Nevada Insurance Code, which regulates the conduct of the business of insurance in this State. (Title 57 of NRS) Under existing law, certain entities and programs are specifically exempted from the application of the Nevada Insurance Code. (NRS 679A.160)

Sections 2-12 of this bill authorize the use of direct primary care agreements, which are agreements to provide medical or dental services and are entered into directly between primary care providers and patients. **Section 9** of this bill sets forth the information that must be included in a direct primary care agreement. **Section 9** establishes the procedure a patient, representative of a patient or provider of primary care should follow in order to terminate a direct primary care agreement. **Section 10** of this bill prohibits a patient, representative of a patient and provider of primary care from submitting a bill to an insurer for the direct primary care services that were provided under a direct primary care agreement. **Section 11** of this bill requires a direct primary care agreement to contain a disclaimer that states that the agreement does not provide health insurance coverage. **Section 12** of this bill sets forth the requirements concerning the selling or transferring by a provider of primary care of a direct primary care agreement.

Section 13 of this bill exempts direct primary care agreements from the provisions of the Nevada Insurance Code.

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

Section 1. Chapter 679A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 12, inclusive, of this act.

Sec. 2. *As used in sections 2 to 12, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 8, inclusive, of this act have the meanings ascribed to them in those sections.*

Sec. 3. *"Direct fee" means a fee:*

1. Charged by a provider of primary care in the amount agreed upon by:

(a) A patient or the representative of a patient; and

(b) The provider of primary care; and

2. That is the consideration a provider of primary care receives in connection with the provision of direct primary care services as described in a direct primary care agreement.

Sec. 4. *"Direct primary care agreement" means an express written contract:*

1. Between a provider of primary care and a patient or the representative of a patient; and

2. In which the provider of primary care agrees to provide direct primary care services to the patient:

(a) Within a specified period of time; and

(b) For payment of a direct fee.

Sec. 5. *1. "Direct primary care services" means those services that a provider of primary care is legally authorized to provide, and may include, without limitation:*

(a) Screening, assessment, diagnosis and treatment for the purpose of promoting health;

(b) Detection, management and care of disease or injury; or

(c) Routine preventive or diagnostic dental treatment.

2. The services described in subsection 1 may be provided in:

(a) The office of a provider of primary care;

(b) The home of the patient; or

(c) Any other location appropriate for a patient visit with the provider of primary care.

Sec. 6. *"Patient" means a person who receives direct primary care services under a direct primary care agreement.*

Sec. 7. *"Provider of primary care" means a person who:*

1. Is licensed pursuant to chapter 630, 631, 632 or 633 of NRS and is legally authorized to provide primary health care services to a patient in this State in the area of pediatrics, family medicine, internal medicine or dentistry;

2. Provides the services described in subsection 1 either alone or in professional association with any other person in a form permitted by the licensure or legal authorization for the provision of such services; and

3. Enters into a direct primary care agreement with a patient.

Sec. 8. *"Representative of the patient" means:*

1. A guardian of the patient as appointed by the court pursuant to chapter 159 or 160 of NRS;

2. A person named as the power of attorney for the patient pursuant to NRS 162A.200 to 162A.600, inclusive, or 162A.700 to 162A.865, inclusive;

3. The spouse of the patient;

4. The adult child of the patient; or

5. Any relative of the patient by blood or legal adoption or connection by marriage.

Sec. 9. *1. A direct primary care agreement must include:*

(a) The identity of the provider of primary care and the patient;

(b) The scope of the direct primary care services that the provider of primary care is to provide to the patient;

(c) The location or locations where the direct primary care services are to be provided;

(d) The amount of the direct fee and the schedule of payments at which the direct fee is to be paid by the patient;

(e) The term of the agreement; and

(f) The condition upon which the agreement may be terminated by the provider of primary care.

2. The patient or the representative of the patient may terminate a direct primary care agreement for any reason by providing a written notice of termination to the provider of primary care.

3. If the patient or the representative of the patient provides a written notice of termination of the direct primary care agreement, the provider of primary care shall refund to the patient all unearned direct fees within 30 days after receipt of the written notice of termination. Unless otherwise provided in the direct primary care agreement, the amount of the unearned direct fees equals the percentage of the total fees which is the same as the percentage of days remaining after the date of termination through the original contract end date.

Sec. 10. *Neither a patient or the representative of a patient nor a provider of primary care shall submit a bill to an insurer for any direct primary care services provided under a direct primary care agreement.*

Sec. 11. *A direct primary care agreement must contain a clear and conspicuous written disclaimer on its face that states, in substance:*

NOTICE

This agreement does not provide health insurance coverage, including, without limitation, the minimal essential coverage required by applicable federal law. This agreement provides only the services described herein. It is recommended that health insurance be obtained to cover the cost of medical services that are not included in this direct primary care agreement.

Sec. 12. *1. A direct primary care agreement may only be sold or transferred by the provider of primary care with the written consent of the patient or the representative of the patient.*

2. A direct primary care agreement:

(a) May only be transferred to another provider of primary care; and

(b) May not be sold to a group, employer or a reciprocal insurer.

3. The limitations of this section do not prohibit the presentation of marketing materials to any potential patient or the representative of a potential patient. The marketing materials are subject to NRS 228.300 to 228.390, inclusive.

Sec. 13. NRS 679A.160 is hereby amended to read as follows:

679A.160 Except as otherwise provided by specific statute, no provision of this Code applies to:

1. Fraternal benefit societies, as identified in chapter 695A of NRS, except as stated in chapter 695A of NRS.

2. Hospital, medical or dental service corporations, as identified in chapter 695B of NRS, except as stated in chapter 695B of NRS.

3. Motor clubs, as identified in chapter 696A of NRS, except as stated in chapter 696A of NRS.

4. Bail agents, as identified in chapter 697 of NRS, except as stated in NRS 680B.025 to 680B.039, inclusive, and chapter 697 of NRS.

5. Risk retention groups, as identified in chapter 695E of NRS, except as stated in chapter 695E of NRS.

6. Captive insurers, as identified in chapter 694C of NRS, with respect to their activities as captive insurers, except as stated in chapter 694C of NRS.

7. Health and welfare plans arising out of collective bargaining under chapter 288 of NRS, except that the Commissioner may

review the plan to ensure that the benefits are reasonable in relation to the premiums and that the fund is financially sound.

8. Programs established pursuant to subsection 1 of NRS 315.725 and the entities administering those programs, except as stated in NRS 315.725.

9. Direct primary care agreements established pursuant to sections 2 to 12, inclusive, of this act.

Sec. 14. This act becomes effective upon passage and approval.