Amendment No. 587

Assembly Amendment to Assembly Bill No. 469	(BDR 40-704)
Proposed by: Assembly Committee on Health and Human Services	
Amendment Box: Replaces Amendment No. 427.	
Amends: Summary: No 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.

EWR/RBL Date: 4/22/2019

A.B. No. 469—Revises provisions governing billing for certain medically necessary emergency services. (BDR 40-704)

ASSEMBLY BILL NO. 469–COMMITTEE ON HEALTH AND HUMAN SERVICES

MARCH 25, 2019

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions governing billing for certain medically necessary emergency services. (BDR 40-704)

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

~

EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [omitted material] is material to be omitted.

AN ACT relating to health care; limiting the amount a provider of health care may charge a person who has health insurance for certain medically necessary emergency services provided when the provider is out-of-network; requiring [a health care facility to] **an insurer to arrange for the** transfer **of** a person who has health insurance to [another] **an in-network** facility under certain circumstances; prescribing procedures for determining the amount that an insurer is required to pay a provider of health care which is out-of-network for certain medically necessary emergency services provided to an insured; **requiring the reporting of certain information related to that process;** and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Under existing law, a hospital is required to provide emergency services and care and to admit certain patients where appropriate, regardless of the financial status of the patient. (NRS 439B.410) Existing law also requires certain major hospitals to reduce total billed charges by at least 30 percent for hospital services provided to certain patients who have no insurance or other contractual provision for the payment of the charges by a third party, which is an insurer. (NRS 439B.260) **Section 7** of this bill defines the term "out-of-network provider" to mean, for a particular person covered by a policy of health insurance, a provider of health care [, hospital or independent center for emergency medical care] **or medical facility** that has not entered into a contract with a third party for the provision of health care to persons who are covered by a policy of insurance [which provides coverage to the patient and which is] issued by that third party. **Section 11 of this bill exempts services provided to recipients of Medicaid from the provisions of this bill.** **Section 14** of this bill prohibits an out-of-network provider from [charging] **collecting from** a person covered by a policy of health insurance an amount for medically necessary emergency services that exceeds the copayment, coinsurance or deductible required by that policy. **Section 14** also requires an out-of-network [facility] **hospital or independent center for emergency medical care** that provides medically necessary emergency services to a covered person to [: (1)] notify the third party that provides coverage for the person that **: (1)** the person is receiving such services at the facility; and (2) [transfer the covered person to an in-network facility not later than 24 hours after] the person's emergency medical condition is stabilized [,] **not later than 24 hours after such**

stabilization occurs. Section 14 requires the third party to arrange for such a transfer to an in-network hospital or independent center for emergency medical care not later than 24 hours after receiving such notice.

If an out-of-network ~~[provider]~~ **hospital or independent center for emergency medical care** had a contract as an in-network ~~[provider]~~ **hospital or independent center for emergency medical care** with the third party that provides coverage for the covered person within the 24 months immediately preceding the provision of medically necessary emergency services to a covered person, **section 15** of this bill requires the third party to pay, and the ~~[provider]~~ **hospital or independent center for emergency medical care** to accept, as compensation for those services an amount based on the amount that would have been paid for those services under the most recent contract between the third party and the ~~[provider.]~~ **hospital or independent center for emergency medical care.** If an out-of-network ~~[provider]~~ **hospital or independent center for emergency medical care** did not have a contract as with the third party that provides coverage for the covered person as an in-network ~~[provider]~~ **hospital or independent center for emergency medical care** during that time, **section 15** requires the third party to make ~~[a final]~~ **an** offer of payment **in full** to the provider for the medically necessary emergency services. **Section 16 of this bill has similar provisions applicable to out-of-network providers, other than hospitals and independent centers for emergency medical care. Specifically, if an out-of-network provider had a contract as an in-network provider with the third party that provides coverage for the covered person within the 12 months immediately preceding the provision of medically necessary emergency services to a covered person that was not terminated by the third party for cause, section 16 of this bill requires the third party to pay, and the provider to accept, as compensation for those services an amount based on the amount that would have been paid for those services under the most recent contract between the third party and the provider. If an out-of-network provider did not have a contract with the third party that provides coverage for the covered person as an in-network provider during that time or if such a contract was terminated by the third party for cause, section 16 requires the third party to make an offer of payment in full to the provider for the medically necessary emergency services.**

If the provider does not accept ~~[the]~~ **an** offer ~~[,]~~ **made pursuant to section 15 or 16, section 17 of this bill** requires **the out-of-network provider to make a counter-offer in an amount the out-of-network provider is willing to accept as payment in full and, if not accepted,** the parties **are required** to submit the dispute to binding arbitration. **Section 13** of this bill exempts a critical access hospital and a person covered by a policy of insurance sold outside this State from the provisions of this bill. **Section 17 provides that interest does not accrue on a claim during the arbitration process, and sections 21-27 of this bill make conforming changes. Section 18 of this bill authorizes certain health insurers not included in this bill to opt in to the provisions of the bill. Section 19 of this bill provides for the annual reporting of certain information concerning arbitration conducted pursuant to section 17. Sections 17, 19 and 20 of this bill provide for the confidentiality of the decisions of arbitrators and documents associated with arbitration.**

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

Section 1. Chapter 439B of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to ~~[15,]~~ **19,** inclusive, of this act.

Sec. 2. ***As used in sections 2 to ~~[15,]~~ 19, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 12, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"Covered person" means a ~~[patient who has health insurance coverage issued]~~ policyholder, subscriber, enrollee or other person covered by a third party.***

Sec. 4. ***"Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.***

Sec. 4.5. *"In-network emergency facility" means a hospital or independent center for emergency medical care that is an in-network provider.*

Sec. 5. *"In-network provider" means, for a particular covered person, a provider of health care ~~[, hospital or independent center for emergency medical care]~~ that has entered into a provider contract with a third party for the provision of health care to ~~[persons who are covered by a policy of insurance or other contractual agreement which provides coverage to the patient and which is issued by that third party.]~~ the covered person.*

Sec. 6. *"Medically necessary emergency services" ~~[means health care services that are provided by a provider of health care to screen and to stabilize a covered person after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent layperson would believe that the absence of immediate medical attention could result in:~~*

~~1. Serious jeopardy to the health of the covered person;~~

~~2. Serious jeopardy to the health of an unborn child of the covered person;~~

~~3. Serious impairment of a bodily function of the covered person; or~~

~~4. Serious dysfunction of any bodily organ or part of the covered person.]~~ has the meaning ascribed to it in subsection 3 of NRS 695G.170.

Sec. 6.5. *"Out-of-network emergency facility" means a hospital or independent center for emergency medical care that is an out-of-network provider.*

Sec. 7. *"Out-of-network provider" means, for a particular covered person, a provider of health care ~~[, hospital or independent center for emergency medical care]~~ that has not entered into a provider contract with a third party for the provision of health care to ~~[persons who are covered by a policy of insurance which provides coverage to the patient and which is issued by that third party.]~~ the covered person.*

Sec. 7.5. *"Provider contract" means a contract between a third party and a provider of health care to provide health care services to a covered person. The term does not include an agreement that provides for a discount based on timing of payment.*

Sec. 8. *"Provider of health care" has the meaning ascribed to it in NRS ~~[629.031.]~~ 695G.070.*

Sec. 9. ~~*["Prudent layperson" means a person who:*~~

~~*1. Is not a provider of health care;*~~

~~*2. Possesses an average knowledge of health and medicine; and*~~

~~*3. Is acting reasonably under the circumstances.]~~* **(Deleted by amendment.)**

Sec. 10. *"Screen" means to conduct the medical screening examination required to be provided to a patient in the emergency department of a hospital pursuant to 42 U.S.C. § 1395dd.*

Sec. 11. *1. "Third party" includes, without limitation:*

~~[1. An insurer, as defined in NRS 679B.540;~~

~~2. A]~~

(a) The issuer of a health benefit plan, as defined in NRS ~~[689A.540, for employees]~~ 695G.019, which provides coverage for medically necessary emergency services;

~~[3. A participating public agency, as defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of such officers and employees, pursuant to chapter 287 of NRS;~~

~~4.]~~ (b) The Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043; and

~~[5.]~~ (c) Any other ~~[insurer or]~~ organization ~~[providing health coverage or benefits in accordance with state or federal law,]~~ that elects pursuant to section 18 of this act for the provisions of sections 2 to 19, inclusive, of this act to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons.

2. The term does not include the State Plan for Medicaid, the Children's Health Insurance Program or a health maintenance organization, as defined in NRS 695C.030, or managed care organization, as defined in NRS 695G.050, when providing 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.

Sec. 12. ***"To stabilize" and "stabilized" have the meanings ascribed to them in 42 U.S.C. § 1395dd(e)(3).***

Sec. 13. ***The provisions of sections 14 and 15 of this act do not apply to:***

1. A hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. § 1395i-4(e) or any medically necessary emergency services provided at such a hospital;

2. A person who is covered by a policy of health insurance that was sold outside this State; or

3. Any health care services provided more than 24 hours after notification is provided pursuant to section 14 of this act that a person has been stabilized.

Sec. 14. ***1. An out-of-network provider shall not ~~[charge]~~ collect from a covered person for medically necessary emergency services , and a covered person is not responsible for paying, an amount that exceeds the copayment, coinsurance or deductible required for ~~[the]~~ such services provided by an in-network provider by the coverage for that person.***

2. An out-of-network emergency facility that provides medically necessary emergency services to a covered person shall:

(a) When possible, notify the third party that provides coverage for the covered person not later than ~~[2]~~ 8 hours after ~~[admitting the covered person that]~~ the covered person ~~[is receiving medically necessary emergency services]~~ presents at the out-of-network emergency facility ~~[.]~~ to receive medically necessary emergency services; and

(b) ~~[Transfer]~~ Notify the third party that the condition of the covered person has stabilized to such a degree that the person may be transferred to an in-network emergency facility not later than 24 hours after the person's emergency medical condition is stabilized.

~~[3. As used in this section:~~

~~(a) "In-network facility" means, for a particular covered person, a hospital or independent center for emergency medical care that has entered into a contract with a third party for the provision of health care to persons who are covered by a policy of insurance or other contractual agreement which provides coverage to the patient and which is issued by that third party.~~

~~(b) "Out-of-network facility" means, for a particular covered person, a hospital or independent center for emergency medical care that has not entered into a contract with a third party for the provision of health care to persons who are covered by a policy of insurance or other contractual agreement which provides coverage to the patient and which is issued by that third party.~~] Not later than 24 hours after the third party receives such notice, the third party shall arrange for the transfer of the person to such a facility.

Sec. 15. ***1. If an out-of-network ~~[provider]~~ emergency facility had a provider contract as an in-network ~~[provider]~~ emergency facility within the 24***

months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person, the third party that provides coverage for the covered person shall pay to the out-of-network ~~[provider]~~ emergency facility for those services, and the out-of-network ~~[provider]~~ emergency facility shall accept as payment in full for those services ~~[:]~~ , except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network emergency facility:

(a) If the out-of-network ~~[provider]~~ emergency facility was an in-network ~~[provider]~~ emergency facility within the 12 months immediately preceding the provision of medically necessary emergency services, 108 percent of the amount that would have been paid for those services pursuant to the most recent applicable provider contract between the third party and the out-of-network ~~[provider.]~~ emergency facility, less the amount of the copayment, coinsurance or deductible, if applicable.

(b) If the out-of-network ~~[provider]~~ emergency facility was an in-network ~~[provider]~~ emergency facility within the 24 months immediately preceding the provision of medically necessary emergency services, but not within the 12 months immediately preceding the provision of those services, 115 percent of the amount that would have been paid for those services pursuant to the most recent applicable provider contract between the third party and the out-of-network ~~[provider.]~~ emergency facility, less the amount of the copayment, coinsurance or deductible, if applicable.

2. If an out-of-network ~~[provider]~~ emergency facility did not have a provider contract as an in-network ~~[provider]~~ emergency facility within the 24 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person, the third party that provides coverage to the covered person shall submit to the out-of-network ~~[provider]~~ emergency facility an offer of payment in full for the medically necessary emergency services ~~[. The out-of-network provider shall accept or reject the offer of payment within 30 days after receiving the offer. If the offer is accepted, the third party must pay the claim within 30 days after the acceptance.~~

~~3. An offer made by a third party pursuant to subsection 2 as payment in full for medically necessary emergency services must include a statement of the provisions of subsections 4 to 7, inclusive.~~

~~4. If an out-of-network provider rejects the amount offered as payment in full by the third party to compensate the out-of-network provider for the medically necessary emergency services, the out-of-network provider must submit to the third party a counter-offer in an amount which the out-of-network provider is willing to accept as payment in full for the medically necessary emergency services.~~

~~5. If the third party rejects the counter-offer submitted by the out-of-network provider pursuant to subsection 4 or fails to accept such a counter-offer within 30 days after receiving the counter-offer, the out-of-network provider must request a list of five randomly selected arbitrators from the voluntary program for the use of binding arbitration established in the judicial district pursuant to NRS 38.255 or, if no such program has been established in the judicial district, from the program established in the nearest judicial district that has established such a program.~~

~~6. Upon receiving the list of randomly selected arbitrators pursuant to subsection 5, the out-of-network provider and the third party shall each strike two arbitrators from the list. If one arbitrator remains, that arbitrator must arbitrate the dispute concerning the amount to be paid for the medically necessary~~

~~*emergency services. If more than one arbitrator remains, an arbitrator randomly selected from the remaining arbitrators by the voluntary program for the use of binding arbitration that provided the list of arbitrators pursuant to subsection 5 must arbitrate that dispute.*~~

~~*7. The out-of-network provider and the third party shall participate in binding arbitration of the dispute concerning the amount to be paid for the medically necessary emergency services conducted by the arbitrator selected pursuant to subsection 6. The arbitrator shall require the third party to pay the out-of-network provider, and the out-of-network provider to accept as payment in full for the provision of the medically necessary emergency services:*~~

~~*(a) The amount offered by the third party pursuant to subsection 2; or*~~

~~*(b) The amount counter-offered by the out-of-network provider pursuant to subsection 4.*~~

~~*8. If the arbitrator requires:*~~

~~*(a) The out-of-network provider to accept as payment in full for the medically necessary emergency services the offer made by the third party pursuant to subsection 2, the out-of-network provider must pay the costs of the arbitration.*~~

~~*(b) The third party to pay to the out-of-network provider as payment in full for the medically necessary emergency services the amount counter-offered by the out-of-network provider pursuant to subsection 4, the third party must pay the costs of the arbitration.*~~

~~*9. A third party that provides coverage for emergency medical services pursuant to Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 et seq., may elect for the provisions of this section to apply to the provision of medically necessary emergency services by out of network providers to covered persons. The Commissioner shall:*~~

~~*(a) Publish on an Internet website maintained by the Commissioner a list of third parties that have made such an election; and*~~

~~*(b) Adopt regulations governing such an election, which may include, without limitation, regulations that establish the procedure by which a third party may make such an election.]*~~ *, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network emergency facility.*

Sec. 16. *1. If an out-of-network provider, other than an out-of-network emergency facility, had a provider contract as an in-network provider within the 12 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person and:*

(a) The out-of-network provider terminated the most recent applicable provider contract between the third party that provides coverage for the covered person and the out-of-network provider without cause before it was scheduled to expire, the third party shall pay to the out-of-network provider for those services, and the out-of-network provider shall accept as payment in full for those services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the amount that would have been paid for those services pursuant to that provider contract, less the amount of the copayment, coinsurance or deductible, if applicable.

(b) The out-of-network provider terminated the most recent applicable provider contract between the third party that provides coverage for the covered person and the out-of-network provider for cause before it was scheduled to expire or the third party terminated the contract without cause, the third party shall pay to the out-of-network provider for those services, and the out-of-

network provider shall accept as payment in full for those services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, 108 percent of the amount that would have been paid for those services pursuant to the provider contract, less the amount of the copayment, coinsurance or deductible, if applicable.

(c) The third party that provides coverage for the covered person terminated the most recent applicable provider contract between the third party and the out-of-network provider for cause before it was scheduled to expire, the third party shall submit to the out-of-network provider an offer of payment in full for the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider.

(d) The contract was not terminated by either party, the third party that provides coverage for the covered person shall pay to the out-of-network provider for those services, and the out-of-network provider shall accept as payment in full for those services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider, the amount that would have been paid for those services pursuant to the most recent applicable provider contract between the third party and the out-of-network provider plus an amount equal to the percentage of increase in the Consumer Price Index, Medical Care Component, during the immediately preceding calendar year, less the amount of the copayment, coinsurance or deductible, if applicable.

2. If an out-of-network provider, other than an out-of-network emergency facility, did not have a provider contract as an in-network provider within the 12 months immediately preceding the date on which the medically necessary emergency services were rendered to a covered person, the third party that provides coverage to the covered person shall submit to the out-of-network provider an offer of payment in full for the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider.

Sec. 17. *1. An out-of-network provider shall accept or reject an offer of payment made pursuant to subsection 2 of section 15 of this act or paragraph (c) of subsection 1 or subsection 2 of section 16 of this act within 30 days after receiving the offer. If the offer is accepted, the third party must pay the claim within 30 days after the acceptance. If an out-of-network provider fails to comply with the requirements of this section, the offer shall be deemed accepted 30 days after the out-of-network provider received the offer.*

2. If an out-of-network provider rejects the offer of payment, the out-of-network provider must make a counter-offer in an amount which the out-of-network provider is willing to accept as payment in full for the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider.

3. If the third party rejects the counter-offer submitted by the out-of-network provider pursuant to subsection 2 or fails to accept such a counter-offer within 30 days after receiving the counter-offer, the out-of-network provider must request a list of five randomly selected arbitrators from an entity authorized by regulations of the Director of the Department to provide such arbitrators. Such regulations must require:

(a) For claims of less than $5,000 in value, the use of arbitrators who will conduct the arbitration in an economically efficient manner. Such arbitrators may include, without limitation, qualified employees of the State and arbitrators from the voluntary program for the use of binding arbitration established in the judicial district pursuant to NRS 38.255 or, if no such program has been established in the judicial district, from the program established in the nearest judicial district that has established such a program.

(b) For claims of $5,000 or more in value, the use of arbitrators from nationally recognized providers of arbitration services, which may include, without limitation, the American Arbitration Association, JAMS or their successor organizations.

4. Upon receiving the list of randomly selected arbitrators pursuant to subsection 3, the out-of-network provider and the third party shall each strike two arbitrators from the list. If one arbitrator remains, that arbitrator must arbitrate the dispute concerning the amount to be paid for the medically necessary emergency services. If more than one arbitrator remains, an arbitrator randomly selected from the remaining arbitrators by the entity that provided the list of arbitrators pursuant to subsection 3 must arbitrate that dispute.

5. The out-of-network provider and the third party shall participate in binding arbitration of the dispute concerning the amount to be paid for the medically necessary emergency services conducted by the arbitrator selected pursuant to subsection 4. The out-of-network provider or third party may provide the arbitrator with any relevant information to assist the arbitrator in making a determination.

6. The arbitrator shall require the third party to pay the out-of-network provider, and the out-of-network provider to accept as payment in full for the provision of the medically necessary emergency services, except for any copayment, coinsurance or deductible that the coverage requires the covered person to pay for the services when provided by an in-network provider:

(a) The amount offered by the third party pursuant to subsection 2 of section 15 of this act or paragraph (c) of subsection 1 or subsection 2 of section 16 of this act, as applicable; or

(b) The amount counter-offered by the out-of-network provider pursuant to subsection 2.

7. If the arbitrator requires:

(a) The out-of-network provider to accept the offer made by the third party pursuant to subsection 2 of section 15 of this act or paragraph (c) of subsection 1 or subsection 2 of section 16 of this act, as applicable, the out-of-network provider must pay the costs of the arbitrator.

(b) The third party to pay the amount counter-offered by the out-of-network provider pursuant to subsection 2, the third party must pay the costs of the arbitrator.

8. An out-of-network provider or a third party must pay any attorney's fees incurred by the out-of-network provider or third party, as applicable, during the process prescribed by this section.

9. Interest does not accrue on any claim for which an offer of payment is rejected pursuant to subsection 1 for the period beginning on the date of the rejection and ending 30 days after the arbitrator renders a decision.

10. Except as otherwise provided in this subsection and section 19 of this act, any decision of an arbitrator pursuant to this section and any documents associated with such a decision are confidential and are not admissible as evidence during a legal proceeding, including, without limitation, a legal proceeding between the third party and the out-of-network provider. The decision

of an arbitrator and any documents associated with such a decision may be disclosed and are admissible as evidence during a legal proceeding to enforce the decision.

Sec. 18. *Any organization, not otherwise subject to the provisions of sections 2 to 19, inclusive, of this act, that provides coverage for emergency medical services may elect for the provisions of sections 2 to 19, inclusive, of this act to apply to the provision of medically necessary emergency services by out-of-network providers to covered persons. The Director of the Department of Health and Human Services shall:*

1. Publish on an Internet website maintained by the Department a list of third parties that have made such an election; and

2. Adopt regulations governing such an election, which may include, without limitation, regulations that establish the procedure by which a third party may make such an election.

Sec. 19. *1. On or before December 31 of each year, an arbitrator who arbitrated a matter pursuant to section 17 of this act during the immediately preceding 12 months shall report to the Department of Health and Human Services in the form prescribed by the Department:*

(a) The number of cases arbitrated by the arbitrator;

(b) The types of providers of health care and third parties involved in those cases;

(c) The prevailing party in each such arbitration;

(d) Information concerning the geographic location of the provider of health care that provided medically necessary emergency services; and

(e) Any other information requested by the Department.

2. A provider of health care or third party shall provide to the Department any information requested by the Department to complete the report required by subsection 3.

3. On or before January 31 of each year, the Department shall:

(a) Compile a report which must include, without limitation:

(1) Aggregated information provided to the Department pursuant to subsections 1 and 2, presented in a manner that does not reveal the identity of any provider of health care, third party or patient;

(2) An analysis of any identifiable trends in the information described in subparagraph (1); and

(3) An analysis of the impact of actions taken pursuant to sections 2 to 19, inclusive, of this act on provider contracts and the provision of health care in this State;

(b) Post the report on an Internet website maintained by the Department; and

(c) Submit the report to the Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the Legislative Committee on Health Care; and

(2) In odd-numbered years, the next regular session of the Legislature.

4. Any information disclosed to the Department pursuant to this section is confidential.

Sec. 20. **NRS 239.010 is hereby amended to read as follows:**

239.010 1. Except as otherwise provided in this section and NRS 1.4683, 1.4687, 1A.110, 3.2203, 41.071, 49.095, 49.293, 62D.420, 62D.440, 62E.516, 62E.620, 62H.025, 62H.030, 62H.170, 62H.220, 62H.320, 75A.100, 75A.150, 76.160, 78.152, 80.113, 81.850, 82.183, 86.246, 86.54615, 87.515, 87.5413, 87A.200, 87A.580, 87A.640, 88.3355, 88.5927, 88.6067, 88A.345, 88A.7345,

89.045, 89.251, 90.730, 91.160, 116.757, 116A.270, 116B.880, 118B.026, 119.260, 119.265, 119.267, 119.280, 119A.280, 119A.653, 119B.370, 119B.382, 120A.690, 125.130, 125B.140, 126.141, 126.161, 126.163, 126.730, 127.007, 127.057, 127.130, 127.140, 127.2817, 128.090, 130.312, 130.712, 136.050, 159.044, 159A.044, 172.075, 172.245, 176.01249, 176.015, 176.0625, 176.09129, 176.156, 176A.630, 178.39801, 178.4715, 178.5691, 179.495, 179A.070, 179A.165, 179D.160, 200.3771, 200.3772, 200.5095, 200.604, 202.3662, 205.4651, 209.392, 209.3925, 209.419, 209.521, 211A.140, 213.010, 213.040, 213.095, 213.131, 217.105, 217.110, 217.464, 217.475, 218A.350, 218E.625, 218F.150, 218G.130, 218G.240, 218G.350, 228.270, 228.450, 228.495, 228.570, 231.069, 231.1473, 233.190, 237.300, 239.0105, 239.0113, 239B.030, 239B.040, 239B.050, 239C.140, 239C.210, 239C.230, 239C.250, 239C.270, 240.007, 241.020, 241.030, 241.039, 242.105, 244.264, 244.335, 247.540, 247.550, 247.560, 250.087, 250.130, 250.140, 250.150, 268.095, 268.490, 268.910, 271A.105, 281.195, 281.805, 281A.350, 281A.680, 281A.685, 281A.750, 281A.755, 281A.780, 284.4068, 286.110, 287.0438, 289.025, 289.080, 289.387, 289.830, 293.4855, 293.5002, 293.503, 293.504, 293.558, 293.906, 293.908, 293.910, 293B.135, 293D.510, 331.110, 332.061, 332.351, 333.333, 333.335, 338.070, 338.1379, 338.1593, 338.1725, 338.1727, 348.420, 349.597, 349.775, 353.205, 353A.049, 353A.085, 353A.100, 353C.240, 360.240, 360.247, 360.255, 360.755, 361.044, 361.610, 365.138, 366.160, 368A.180, 370.257, 370.327, 372A.080, 378.290, 378.300, 379.008, 379.1495, 385A.830, 385B.100, 387.626, 387.631, 388.1455, 388.259, 388.501, 388.503, 388.513, 388.750, 388A.247, 388A.249, 391.035, 391.120, 391.925, 392.029, 392.147, 392.264, 392.271, 392.315, 392.317, 392.325, 392.327, 392.335, 392.850, 394.167, 394.1698, 394.447, 394.460, 394.465, 396.3295, 396.405, 396.525, 396.535, 396.9685, 398A.115, 408.3885, 408.3886, 408.3888, 408.5484, 412.153, 416.070, 422.2749, 422.305, 422A.342, 422A.350, 425.400, 427A.1236, 427A.872, 432.028, 432.205, 432B.175, 432B.280, 432B.290, 432B.407, 432B.430, 432B.560, 432B.5902, 433.534, 433A.360, 437.145, 439.840, 439B.420, 440.170, 441A.195, 441A.220, 441A.230, 442.330, 442.395, 442.735, 445A.665, 445B.570, 449.209, 449.245, 449A.112, 450.140, 453.164, 453.720, 453A.610, 453A.700, 458.055, 458.280, 459.050, 459.3866, 459.555, 459.7056, 459.846, 463.120, 463.15993, 463.240, 463.3403, 463.3407, 463.790, 467.1005, 480.365, 480.940, 481.063, 481.091, 481.093, 482.170, 482.5536, 483.340, 483.363, 483.575, 483.659, 483.800, 484E.070, 485.316, 501.344, 503.452, 522.040, 534A.031, 561.285, 571.160, 584.655, 587.877, 598.0964, 598.098, 598A.110, 599B.090, 603.070, 603A.210, 604A.710, 612.265, 616B.012, 616B.015, 616B.315, 616B.350, 618.341, 618.425, 622.310, 623.131, 623A.137, 624.110, 624.265, 624.327, 625.425, 625A.185, 628.418, 628B.230, 628B.760, 629.047, 629.069, 630.133, 630.30665, 630.336, 630A.555, 631.368, 632.121, 632.125, 632.405, 633.283, 633.301, 633.524, 634.055, 634.214, 634A.185, 635.158, 636.107, 637.085, 637B.288, 638.087, 638.089, 639.2485, 639.570, 640.075, 640A.220, 640B.730, 640C.400, 640C.600, 640C.620, 640C.745, 640C.760, 640D.190, 640E.340, 641.090, 641.325, 641A.191, 641A.289, 641B.170, 641B.460, 641C.760, 641C.800, 642.524, 643.189, 644A.870, 645.180, 645.625, 645A.050, 645A.082, 645B.060, 645B.092, 645C.220, 645C.225, 645D.130, 645D.135, 645E.300, 645E.375, 645G.510, 645H.320, 645H.330, 647.0945, 647.0947, 648.033, 648.197, 649.065, 649.067, 652.228, 654.110, 656.105, 661.115, 665.130, 665.133, 669.275, 669.285, 669A.310, 671.170, 673.450, 673.480, 675.380, 676A.340, 676A.370, 677.243, 679B.122, 679B.152, 679B.159, 679B.190, 679B.285, 679B.690, 680A.270, 681A.440, 681B.260, 681B.410, 681B.540, 683A.0873, 685A.077, 686A.289, 686B.170, 686C.306, 687A.110, 687A.115, 687C.010, 688C.230, 688C.480, 688C.490, 689A.696, 692A.117,

692C.190, 692C.3507, 692C.3536, 692C.3538, 692C.354, 692C.420, 693A.480, 693A.615, 696B.550, 696C.120, 703.196, 704B.320, 704B.325, 706.1725, 706A.230, 710.159, 711.600, ***and sections 17 and 19 of this act,*** sections 35, 38 and 41 of chapter 478, Statutes of Nevada 2011 and section 2 of chapter 391, Statutes of Nevada 2013 and unless otherwise declared by law to be confidential, all public books and public records of a governmental entity must be open at all times during office hours to inspection by any person, and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. Any such copies, abstracts or memoranda may be used to supply the general public with copies, abstracts or memoranda of the records or may be used in any other way to the advantage of the governmental entity or of the general public. This section does not supersede or in any manner affect the federal laws governing copyrights or enlarge, diminish or affect in any other manner the rights of a person in any written book or record which is copyrighted pursuant to federal law.

2. A governmental entity may not reject a book or record which is copyrighted solely because it is copyrighted.

3. A governmental entity that has legal custody or control of a public book or record shall not deny a request made pursuant to subsection 1 to inspect or copy or receive a copy of a public book or record on the basis that the requested public book or record contains information that is confidential if the governmental entity can redact, delete, conceal or separate the confidential information from the information included in the public book or record that is not otherwise confidential.

4. A person may request a copy of a public record in any medium in which the public record is readily available. An officer, employee or agent of a governmental entity who has legal custody or control of a public record:

(a) Shall not refuse to provide a copy of that public record in a readily available medium because the officer, employee or agent has already prepared or would prefer to provide the copy in a different medium.

(b) Except as otherwise provided in NRS 239.030, shall, upon request, prepare the copy of the public record and shall not require the person who has requested the copy to prepare the copy himself or herself.

Sec. 21. **NRS 683A.0879 is hereby amended to read as follows:**

683A.0879 1. Except as otherwise provided in subsection 2 ~~,~~ ***and section 17 of this act,*** an administrator shall approve or deny a claim relating to health insurance coverage within 30 days after the administrator receives the claim. If the claim is approved, the administrator shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the administrator shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

2. If the administrator requires additional information to determine whether to approve or deny the claim, the administrator shall notify the claimant of the administrator's request for the additional information within 20 days after receiving the claim. The administrator shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The administrator shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the administrator shall pay the claim within 30 days after receiving the additional information. If the approved claim is not paid

within that period, the administrator shall pay interest on the claim in the manner prescribed in subsection 1.

3. An administrator shall not request a claimant to resubmit information that the claimant has already provided to the administrator, unless the administrator provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. An administrator shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may be waived only if the payment was delayed because of an act of God or another cause beyond the control of the administrator.

7. The Commissioner may require an administrator to provide evidence which demonstrates that the administrator has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

8. If the Commissioner determines that an administrator is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the administrator to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that an administrator is not in substantial compliance with the requirements set forth in this section, the Commissioner may suspend or revoke the certificate of registration of the administrator.

Sec. 22. **NRS 689A.410 is hereby amended to read as follows:**

689A.410 1. Except as otherwise provided in subsection 2 **[,]** ***and section 17 of this act,*** an insurer shall approve or deny a claim relating to a policy of health insurance within 30 days after the insurer receives the claim. If the claim is approved, the insurer shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the insurer shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

2. If the insurer 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 insurer shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The insurer shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the insurer shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the insurer shall pay interest on the claim in the manner prescribed in subsection 1.

3. An insurer shall not request a claimant to resubmit information that the claimant has already provided to the insurer, unless the insurer provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. An insurer shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may be waived only if the payment was delayed because of an act of God or another cause beyond the control of the insurer.

7. The Commissioner may require an insurer to provide evidence which demonstrates that the insurer has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

8. If the Commissioner determines that an insurer is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the insurer to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that an insurer is not in substantial compliance with the requirements set forth in this section, the Commissioner may suspend or revoke the certificate of authority of the insurer.

Sec. 23. **NRS 689B.255 is hereby amended to read as follows:**

689B.255 1. Except as otherwise provided in subsection 2 ~~,~~ ***and section 17 of this act,*** an insurer shall approve or deny a claim relating to a policy of group health insurance or blanket insurance within 30 days after the insurer receives the claim. If the claim is approved, the insurer shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the insurer shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

2. If the insurer 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 insurer shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The insurer shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the insurer shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the insurer shall pay interest on the claim in the manner prescribed in subsection 1.

3. An insurer shall not request a claimant to resubmit information that the claimant has already provided to the insurer, unless the insurer provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. An insurer shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may be waived only if the payment was delayed because of an act of God or another cause beyond the control of the insurer.

7. The Commissioner may require an insurer to provide evidence which demonstrates that the insurer has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

8. If the Commissioner determines that an insurer is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the insurer to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that an insurer is not in substantial compliance with the requirements set forth in this section, the Commissioner may suspend or revoke the certificate of authority of the insurer.

Sec. 24. **NRS 689C.485 is hereby amended to read as follows:**

689C.485 1. Except as otherwise provided in subsection 2 ~~[,]~~ ***and section 17 of this act,*** a carrier serving small employers and a carrier that offers a contract to a voluntary purchasing group shall approve or deny a claim relating to a policy of health insurance within 30 days after the carrier receives the claim. If the claim is approved, the carrier shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the carrier shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

2. If the carrier 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 carrier shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The carrier shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the carrier shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the carrier shall pay interest on the claim in the manner prescribed in subsection 1.

3. A carrier shall not request a claimant to resubmit information that the claimant has already provided to the carrier, unless the carrier provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. A carrier shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may be waived only if the payment was delayed because of an act of God or another cause beyond the control of the carrier.

7. The Commissioner may require a carrier to provide evidence which demonstrates that the carrier has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

8. If the Commissioner determines that a carrier is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the carrier to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that a carrier is not in substantial compliance with the requirements set forth in this section, the Commissioner may suspend or revoke the certificate of authority of the carrier.

Sec. 25. **NRS 695A.188 is hereby amended to read as follows:**

695A.188 1. Except as otherwise provided in subsection 2 ~~[,]~~ ***and section 17 of this act,*** a society shall approve or deny a claim relating to a certificate of

health insurance within 30 days after the society receives the claim. If the claim is approved, the society shall pay the claim within 30 days after it is approved. If the approved claim is not paid within that period, the society shall pay interest on the claim at the rate of interest established pursuant to NRS 99.040 unless a different rate of interest is established pursuant to an express written contract between the society and the provider of health care. The interest must be calculated from 30 days after the date on which the claim is approved until the claim is paid.

2. If the society 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 society shall notify the provider of health care of all the specific reasons for the delay in approving or denying the claim. The society shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the society shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the society shall pay interest on the claim in the manner prescribed in subsection 1.

3. A society shall not request a claimant to resubmit information that the claimant has already provided to the society, unless the society provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. A society shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

Sec. 26. **NRS 695B.2505 is hereby amended to read as follows:**

695B.2505 1. Except as otherwise provided in subsection 2 ~~,~~ ***and section 17 of this act,*** a corporation subject to the provisions of this chapter shall approve or deny a claim relating to a contract for dental, hospital or medical services within 30 days after the corporation receives the claim. If the claim is approved, the corporation shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the corporation shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

2. If the corporation 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 corporation shall notify the provider of dental, hospital or medical services of all the specific reasons for the delay in approving or denying the claim. The corporation shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the corporation shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the corporation shall pay interest on the claim in the manner prescribed in subsection 1.

3. A corporation shall not request a claimant to resubmit information that the claimant has already provided to the corporation, unless the corporation provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. A corporation shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may be waived only if the payment was delayed because of an act of God or another cause beyond the control of the corporation.

7. The Commissioner may require a corporation to provide evidence which demonstrates that the corporation has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

8. If the Commissioner determines that a corporation is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the corporation to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that a corporation is not in substantial compliance with the requirements set forth in this section, the Commissioner may suspend or revoke the certificate of authority of the corporation.

Sec. 27. **NRS 695C.185 is hereby amended to read as follows:**

695C.185 1. Except as otherwise provided in subsection 2 ~~[,]~~ ***and section 17 of this act,*** a health maintenance organization shall approve or deny a claim relating to a health care plan within 30 days after the health maintenance organization receives the claim. If the claim is approved, the health maintenance organization shall pay the claim within 30 days after it is approved. Except as otherwise provided in this section, if the approved claim is not paid within that period, the health maintenance organization shall pay interest on the claim at a rate of interest equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 6 percent. The interest must be calculated from 30 days after the date on which the claim is approved until the date on which the claim is paid.

2. If the health maintenance organization 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 health maintenance organization shall notify the provider of health care services of all the specific reasons for the delay in approving or denying the claim. The health maintenance organization shall approve or deny the claim within 30 days after receiving the additional information. If the claim is approved, the health maintenance organization shall pay the claim within 30 days after it receives the additional information. If the approved claim is not paid within that period, the health maintenance organization shall pay interest on the claim in the manner prescribed in subsection 1.

3. A health maintenance organization shall not request a claimant to resubmit information that the claimant has already provided to the health maintenance organization, unless the health maintenance organization provides a legitimate reason for the request and the purpose of the request is not to delay the payment of the claim, harass the claimant or discourage the filing of claims.

4. A health maintenance organization shall not pay only part of a claim that has been approved and is fully payable.

5. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

6. The payment of interest provided for in this section for the late payment of an approved claim may be waived only if the payment was delayed because of an

act of God or another cause beyond the control of the health maintenance organization.

7. The Commissioner may require a health maintenance organization to provide evidence which demonstrates that the health maintenance organization has substantially complied with the requirements set forth in this section, including, without limitation, payment within 30 days of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

8. If the Commissioner determines that a health maintenance organization is not in substantial compliance with the requirements set forth in this section, the Commissioner may require the health maintenance organization to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that a health maintenance organization is not in substantial compliance with the requirements set forth in this section, the Commissioner may suspend or revoke the certificate of authority of the health maintenance organization.

Sec. 28. **The provisions of subsection 1 of NRS 218D.380 do not apply to any provision of this act which adds or revises a requirement to submit a report to the Legislature.**

Sec. 29. **This act becomes effective:**

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

2. On January 1, 2020, for all other purposes.