ASSEMBLY BILL NO. 213–ASSEMBLYMAN OHRENSCHALL

PREFILED FEBRUARY 13, 2017

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to dental care. (BDR 57-288)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
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 dental care; revising provisions governing certain policies of health insurance and health care plans that provide coverage for dental services; requiring a dentist to post certain notices relating to fees for services; repealing provisions which limit the amount that may be charged by dentists in certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law prohibits certain dental plans and contracts for dental care from requiring a dentist to accept a fee for dental care that is set by or subject to the approval of an organization for dental care unless the fee is for a covered service. Existing law further prohibits certain dental plans and third-party administrators from including any dentists in a network for a plan for dental care that sets fees for any dental care other than covered services. (NRS 695D.227) **Sections 2, 6, 9, 12, 15, 22 and 26** of this bill extend these restrictions to other insurers. **Sections 2, 6, 9, 12, 15, 22 and 26** also require that dental care only be deemed a covered service if the rate of reimbursement is the reasonable rate for such care, rather than a nominal or de minimis fee. **Section 20** of this bill revises the definition of "covered service" to mean any service for which reimbursement is provided through a dental procedure code published by the American Dental Association in its *Code on Dental Procedures and Nomenclature* also known as the *CDT Code*.

Sections 3, 7, 10, 13, 16, 19, 23 and 27 of this bill require certain insurers to provide notice that a dental provider may charge his or her usual and customary rate to an insured for dental care not covered by the insurer. **Section 30** of this bill prohibits a dentist from charging more than his or her usual and customary rate for dental care that is not covered by a patient's insurance plan. **Section 30** also requires a dentist to post a notice in his or her practice setting, stating that a patient receiving dental care that is not covered by an insurance plan may be subject to the dentist's usual and customary rate for such care.

Existing law provides that, under certain circumstances, when reimbursement for a covered service is not available to a patient because the patient has exceeded the benefit provided for the calendar year, the dentist is required to charge the same fees that would be charged had the benefit not been exceeded. (NRS 631.389) **Section 31** of this bill repeals this provision.

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 the provisions set forth as sections 2 and 3 of this act.

Sec. 2. ***1. No policy of health insurance and no contract between an insurer and a dentist may require, directly or indirectly, that a dentist provide dental care to an insured at a fee set by or subject to the approval of the insurer unless the dental care is a covered service.***

2. Dental care shall be deemed a covered service only if the negotiated rate agreed to by the dentist and the insurer is an amount that is reasonable and is not nominal or de minimis.

3. An insurer, a third-party administrator or any other person providing services as a third-party administrator shall not make available any dentist in its network of dentists to a policy of health insurance that sets fees for any dental care except covered services.

4. As used in this section, "covered service" has the meaning ascribed to it in NRS 695D.227.

Sec. 3. ***At the time an insurer provides evidence of coverage to an insured, the insurer shall provide to the insured the following notice:***

> ***IMPORTANT: If you opt to receive dental services or procedures that are not benefits covered under this policy, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Before providing dental services or procedures that are not benefits covered under this policy, the dental provider must provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your policy of health insurance.***

Sec. 4. 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 sections 2 and 3 of this act.***

Sec. 5. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 6 and 7 of this act.

Sec. 6. ***1. No policy of group health insurance and no contract between an insurer and a dentist may require, directly or indirectly, that a dentist provide dental care to an insured at a fee set by or subject to the approval of the insurer unless the dental care is a covered service.***

2. Dental care shall be deemed a covered service only if the negotiated rate agreed to by the dentist and the insurer is an amount that is reasonable and is not nominal or de minimis.

3. An insurer, a third-party administrator or any other person providing services as a third-party administrator shall not make available any dentist in its network of dentists to a policy of group health insurance that sets fees for any dental care except covered services.

4. As used in this section, "covered service" has the meaning ascribed to it in NRS 695D.227.

Sec. 7. ***At the time an insurer provides evidence of coverage to an insured, the insurer shall provide to the insured the following notice:***

> ***IMPORTANT: If you opt to receive dental services or procedures that are not benefits covered under this policy, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Before providing dental services or procedures that are not benefits covered under this policy, the dental provider must provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your policy of group health insurance.***

Sec. 8. Chapter 689C of NRS is hereby amended by adding thereto the provisions set forth as sections 9 and 10 of this act.

Sec. 9. ***1. No health benefit plan and no contract between a carrier and a dentist may require, directly or indirectly, that a dentist provide dental care to a person covered by the health benefit plan at a fee set by or subject to the approval of the carrier unless the dental care is a covered service.***

2. Dental care shall be deemed a covered service only if the negotiated rate agreed to by the dentist and the carrier is an amount that is reasonable and is not nominal or de minimis.

3. A carrier, a third-party administrator or any other person providing services as a third-party administrator shall not make available any dentist in its network of dentists to a health benefit plan that sets fees for any dental care except covered services.

4. As used in this section, "covered service" has the meaning ascribed to it in NRS 695D.227.

Sec. 10. ***At the time a carrier provides evidence of coverage to an insured, the carrier shall provide to the insured the following notice:***

> ***IMPORTANT: If you opt to receive dental services or procedures that are not benefits covered under this plan, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Before providing dental services or procedures that are not benefits covered under this plan, the dental provider must provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your health benefit plan.***

Sec. 11. Chapter 695B of NRS is hereby amended by adding thereto the provisions set forth as sections 12 and 13 of this act.

Sec. 12. ***1. No policy of health insurance and no contract between a hospital or medical services corporation and a dentist may require, directly or indirectly, that a dentist provide dental services to an insured at a fee set by or subject to the approval of the hospital or medical services corporation unless the dental service is a covered service.***

2. Dental services shall be deemed covered services only if the negotiated rate agreed to by the dentist and the hospital or medical services corporation is an amount that is reasonable and is not nominal or de minimis.

3. A hospital, medical services corporation, third-party administrator or any other person providing services as a third-party administrator shall not make available any dentist in its network of dentists to a policy of health insurance that sets fees for any dental service except covered services.

4. As used in this section, "covered service" has the meaning ascribed to it in NRS 695D.227.

Sec. 13. *At the time a hospital or medical services corporation provides evidence of coverage to an insured, the hospital or medical services corporation shall provide to the insured the following notice:*

> *IMPORTANT: If you opt to receive dental services or procedures that are not benefits covered under this policy, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Before providing dental services or procedures that are not benefits covered under this policy, the dental provider must provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your policy of health insurance.*

Sec. 14. Chapter 695C of NRS is hereby amended by adding thereto the provisions set forth as sections 15 and 16 of this act.

Sec. 15. *1. No health maintenance organization may require, directly or indirectly, that a dentist provide dental care to an enrollee at a fee set by or subject to the approval of the health maintenance organization unless the dental care is a covered service.*

2. Dental care shall be deemed a covered service only if the negotiated rate agreed to by the dentist and the health maintenance organization is an amount that is reasonable and is not nominal or de minimis.

3. A health maintenance organization, a third-party administrator or any other person providing services as a third-party administrator shall not make available any dentist in its network of dentists to a health care plan that sets fees for any dental care except covered services.

4. As used in this section, "covered service" has the meaning ascribed to it in NRS 695D.227.

Sec. 16. *At the time a health maintenance organization provides evidence of coverage to an enrollee, the health maintenance organization shall provide to the enrollee the following notice:*

> *IMPORTANT: If you opt to receive dental services or procedures that are not benefits covered under this plan, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Before providing dental services or procedures that are not benefits covered under this plan, the dental provider must*

provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage.

Sec. 17. 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, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, 695C.1735 to 695C.1755, 695C.176 to 695C.200, inclusive, ***and sections 15 and 16 of this act,*** and 695C.265 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, 695C.1708, 695C.1731, 695C.17345 and 695C.1757 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. 18. 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 15 or 16 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. 19. Chapter 695D of NRS is hereby amended by adding thereto a new section to read as follows:

At the time an organization for dental care provides evidence of coverage to a member, the organization for dental care shall provide to the member the following notice:

> ***IMPORTANT: If you opt to receive dental services or procedures that are not benefits covered under this plan, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Before providing dental services or procedures that are not benefits covered under this plan, the dental provider must provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your policy.***

Sec. 20. NRS 695D.227 is hereby amended to read as follows:

695D.227 1. No plan for dental care and no contract between an organization for dental care and a dentist may require, directly or indirectly, that the dentist provide dental care to a member at a fee set by or subject to the approval of the organization for dental care unless the dental care is a covered service.

2. ***Dental care shall be deemed a covered service only if the negotiated rate agreed to by the dentist and the plan for dental care or in the contract between an organization for dental care and a dentist is an amount that is reasonable and is not nominal or de minimis.***

3. An organization for dental care ***, a third-party administrator*** or any other person providing services as a third-party administrator shall not make available any dentists in its network of dentists to a plan for dental care that sets fees for any dental care except covered services.

~~[3.]~~ ***4.*** As used in this section, "covered service" means dental care for which reimbursement is ~~[available under a member's policy, or for which reimbursement would be available but for the application of a contractual limitation, including, without limitation, any deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment or any other limitation.]~~ ***provided on a dental procedure code published by the American Dental Association, or its successor organization, in the Code on Dental Procedures or Nomenclature Code, or any successor publication.***

Sec. 21. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 22 and 23 of this act.

Sec. 22. ***1. No health care plan and no contract between a managed care organization and a dentist may require, directly or indirectly, that a dentist provide dental care to a person covered by the health care plan at a fee set by or subject to the approval of the managed care organization unless the dental care is a covered service.***

2. Dental care shall be deemed a covered service only if the negotiated rate agreed to by the dentist and the managed care organization is an amount that is reasonable and is not nominal or de minimis.

3. A managed care organization, a third-party administrator or any other person providing services as a third-party administrator shall not make available any dentist in its network of dentists to a health care plan that sets fees for any dental care except covered services.

4. As used in this section, "covered service" has the meaning ascribed to it in NRS 695D.227.

Sec. 23. ***At the time a managed care organization provides evidence of coverage to an insured, the managed care organization shall provide to the insured the following notice:***

> ***IMPORTANT: If you opt to receive dental services or procedures that are not benefits covered under this plan, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Before providing dental services or procedures that are not benefits covered under this plan, the dental provider must provide you with a treatment plan that includes each***

anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage.

Sec. 24. 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 sections 22 and 23 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. 25. Chapter 287 of NRS is hereby amended by adding thereto the provisions set forth as sections 26 and 27 of this act.

Sec. 26. ***1. No governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance may require, directly or indirectly, that a dentist provide dental care to a person covered by the plan of self-insurance at a fee set by or subject to the approval of the governing body unless the dental care is a covered service.***

2. Dental care shall be deemed a covered service only if the negotiated rate agreed to by the dentist and the governing body is an amount that is reasonable and is not nominal or de minimis.

3. A governing body, a third-party administrator or any other person providing services as a third-party administrator shall not make available any dentist in its network of dentists to a plan of

self-insurance that sets fees for any dental care except covered services.

4. As used in this section, "covered service" has the meaning ascribed to it in NRS 695D.227.

Sec. 27. ***At the time of providing evidence of coverage under a plan of self-insurance provided by the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local government agency of the State of Nevada, the following notice must be provided to the employee:***

> ***IMPORTANT: If you opt to receive dental services or procedures that are not benefits covered under this plan, a participating dental provider may charge you his or her usual and customary rate for such services or procedures. Before providing dental services or procedures that are not benefits covered under this plan, the dental provider must provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage.***

Sec. 28. NRS 287.015 is hereby amended to read as follows:

287.015 1. A local government employer and any employee organization that is recognized by the employer pursuant to chapter 288 of NRS may, by written agreement between themselves or with other local government employers and employee organizations, establish a trust fund to provide health and welfare benefits to active and retired employees of the participating employers and the dependents of those employees.

2. All contributions made to a trust fund established pursuant to this section must be held in trust and used:

(a) To provide, from principal or income, or both, for the benefit of the participating employees and their dependents, medical, hospital, dental, vision, death, disability or accident benefits, or any combination thereof, and any other benefit appropriate for an entity that qualifies as a voluntary employees' beneficiary association under Section 501(c)(9) of the Internal Revenue Code of 1986, 26 U.S.C. § 501(c)(9), as amended; and

(b) To pay any reasonable administrative expenses incident to the provision of these benefits and the administration of the trust.

3. The basis on which contributions are to be made to the trust must be specified in a collective bargaining agreement between each participating local government employer and employee organization

or in a written participation agreement between the employer and employee organization, jointly, and the trust.

4. The trust must be administered by a board of trustees on which participating local government employers and employee organizations are equally represented. The agreement that establishes the trust must:

(a) Set forth the powers and duties of the board of trustees, which must not be inconsistent with the provisions of this section;

(b) Establish a procedure for resolving expeditiously any deadlock that arises among the members of the board of trustees; and

(c) Provide for an audit of the trust, at least annually, the results of which must be reported to each participating employer and employee organization.

5. The provisions of paragraphs (b) and (c) of subsection 2 of NRS 287.029 apply to a trust fund established pursuant to this section by the governing body of a school district.

6. The provisions of NRS 287.0278 ***and sections 26 and 27 of this act*** do not apply to a trust fund established pursuant to this section before October 1, 2013.

7. As used in this section:

(a) "Employee organization" has the meaning ascribed to it in NRS 288.040.

(b) "Local government employer" has the meaning ascribed to it in NRS 288.060.

Sec. 29. 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.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and sections 22 and 23 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.

Sec. 30. Chapter 631 of NRS is hereby amended by adding thereto a new section to read as follows:

1. A dentist licensed pursuant to this chapter shall:

(a) Not charge more for dental care that is not a covered service than the usual and customary rate of the dentist for such dental care.

(b) Post, in a conspicuous place in his or her practice setting, a notice stating that dental care that is not a covered service available for reimbursement by an insurance policy may be

subject to the usual and customary rate of the dentist for such dental care.

2. As used in this section, "covered service" has the meaning ascribed to it in NRS 695D.227.

Sec. 31. NRS 631.389 is hereby repealed.

TEXT OF REPEALED SECTION

631.389 Limitation on fees for covered services in certain circumstances.

1. If a dentist accepts payment for the costs of dental care from a patient's plan for dental care and the dentist provides a covered service to the patient for which reimbursement is not available because the patient has exceeded the benefit provided for the calendar year under the terms of the patient's policy, the dentist shall charge the same fees to the patient for the covered service as the dentist would have charged the patient pursuant to the terms of the policy if the benefit provided for the calendar year under the terms of the policy had not been exceeded.

2. As used in this section:

(a) "Covered service" has the meaning ascribed to it in NRS 695D.227.

(b) "Dental care" has the meaning ascribed to it in NRS 695D.030.

(c) "Plan for dental care" has the meaning ascribed to it in NRS 695D.070.

(d) "Policy" has the meaning ascribed to it in NRS 695D.080.

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