SENATE BILL NO. 269–SENATORS KIECKHEFER;
AND SEEVERS GANSERT

MARCH 17, 2021

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to dental insurance. (BDR 57-817)

FISCAL NOTE: Effect on Local Government: May have Fiscal Effect.
Effect on the State: No.

~

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

AN ACT relating to insurance; imposing requirements governing the recovery of overpayments under a plan that provides dental coverage; prohibiting a dental insurer or the administrator of a plan that provides dental coverage from denying a claim for which prior authorization has been granted except in certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law imposes certain requirements relating to the operation of health benefit plans and stand-alone dental plans. (NRS 687B.470-687B.850, chapter 695D of NRS) **Sections 2, 3 and 9** of this bill define certain relevant terms. **Sections 4 and 10** of this bill require a dental insurer or an administrator who recovers overpayments under an insurance plan that includes dental coverage to: (1) provide written notice to a dentist of any attempt to recover an overpayment; and (2) establish written procedures by which a dentist may challenge such an attempt. **Sections 4 and 10** also prohibit such an insurer or administrator from attempting to recover an overpayment more than 12 months after the date of the overpayment except in certain circumstances. **Sections 5 and 11** of this bill prohibit a dental insurer or an administrator of an insurance plan that includes dental coverage from denying a claim for which preauthorization was granted except in certain circumstances. **Sections 6, 7 and 12** of this bill make conforming changes to indicate the placement of certain provisions added by this bill in the Nevada Revised Statutes. **Sections 13-15** of this bill make the requirements of **sections 4 and 5** applicable to dental benefits provided by employers, including the State and local governments.

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

Section 1. Chapter 687B of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 5, inclusive, of this act.

Sec. 2. ***"Administrator" has the meaning ascribed to it in NRS 683A.025.***

Sec. 3. ***"Dental care" has the meaning ascribed to it in NRS 695D.030.***

Sec. 4. ***1. A health carrier who provides dental coverage or any administrator who recovers overpayments under a health benefit plan that includes dental coverage shall provide written notice to a dentist of any attempt to recover an overpayment, other than a duplicate payment. The notice must include, without limitation:***

(a) A description of the error that justifies the recovery; and

(b) The date on which the dental care for which the overpayment was made was provided and the name of the patient to whom the dental care was provided.

2. A health carrier who provides dental coverage or an administrator who recovers overpayments under a health benefit plan that includes dental coverage shall establish written procedures by which a dentist may challenge an attempt to recover an overpayment. Those procedures must include, without limitation, procedures for sharing information concerning a disputed claim with the dentist.

3. Except as otherwise provided in this subsection, a health carrier who provides dental coverage or an administrator who recovers overpayments under a health benefit plan that includes dental coverage shall not attempt to recover an overpayment more than 12 months after the date of the overpayment. This subsection does not apply to an attempt to recover an overpayment that is:

(a) Based on a reasonable belief that the overpayment involved fraud, abuse or other intentional misconduct;

(b) Initiated by or at the request of a self-insured employer; or

(c) Based on dental care that is covered by the Public Employees' Benefits Program or a system of health insurance for the benefit of local officers and employees, and the dependents of local officers and employees, pursuant to chapter 287 of NRS.

4. Any provision of a contract that conflicts with this section is against public policy, void and unenforceable.

Sec. 5. *1. A health carrier who provides dental coverage or an administrator of a health benefit plan that includes dental coverage shall not refuse to pay a claim for dental care for which the health carrier or administrator, as applicable, has granted prior authorization unless:*

(a) A limitation on coverage provided under the applicable health benefit plan, including, without limitation, a limitation on total costs or frequency of services:

(1) Did not apply at the time the prior authorization was granted; and

(2) Applied at the time of the provision of the dental care for which the prior authorization was granted because additional covered dental care was provided to the insured after the prior authorization was granted and before the provision of the dental care for which prior authorization was granted;

(b) The documentation provided by the person submitting the claim clearly fails to support the claim for which prior authorization was originally granted;

(c) After the prior authorization was granted, additional dental care was provided to the insured or the condition of the insured otherwise changed such that:

(1) The dental care for which prior authorization was granted is no longer medically necessary; or

(2) The health carrier or administrator, as applicable, would be required to deny prior authorization under the terms and conditions of the applicable health benefit plan that were in effect at the time of the provision of the dental care for which prior authorization was granted;

(d) Another person or entity is responsible for the payment;

(e) The dentist has previously been paid for the procedures covered by the claim;

(f) The claim was fraudulent or the prior authorization was based, in whole or in part, on materially false information provided by the dentist or insured or another person who is not affiliated with the health carrier or administrator, as applicable; or

(g) The insured was not eligible to receive the dental care for which the claim was made on the date that the dental care was provided and the health carrier or administrator, as applicable:

(1) Did not know of the eligibility status of the insured; and

(2) Could not have discovered the eligibility status of the insured through reasonable care.

2. Any provision of a contract that conflicts with this section is against public policy, void and unenforceable.

3. As used in this section:

(a) "Medically necessary" means dental care that a prudent dentist would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that is necessary and:

(1) Provided in accordance with generally accepted standards of dental practice;

(2) Clinically appropriate with regard to type, frequency, extent, location and duration;

(3) Not primarily provided for the convenience of the patient or dentist;

(4) Required to improve a specific dental condition of a patient or to preserve the existing state of oral health of the patient; and

(5) The most clinically appropriate level of dental care that may be safely provided to the patient.

(b) "Prior authorization" means any communication issued by a health carrier who provides dental coverage or an administrator of a health benefit plan that includes dental coverage in response to a request by a dentist in the form prescribed by the health carrier or administrator, as applicable, which indicates that specific dental care provided to an insured is:

(1) Covered under the health benefit plan issued to the insured; and

(2) Reimbursable in a specific amount, subject to applicable deductibles, copayments and coinsurance.

Sec. 6. NRS 687B.600 is hereby amended to read as follows:

687B.600 As used in NRS 687B.600 to 687B.850, inclusive, ***and sections 2 to 5, inclusive, of this act,*** unless the context otherwise requires, the words and terms defined in NRS 687B.605 to 687B.665, inclusive, ***and sections 2 and 3 of this act*** have the meanings ascribed to them in those sections.

Sec. 7. NRS 687B.670 is hereby amended to read as follows:

687B.670 If a health carrier offers or issues a network plan, the health carrier shall, with regard to that network plan:

1. Comply with all applicable requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~[.]~~ ***, and sections 2 to 5, inclusive, of this act;***

2. As applicable, ensure that each contract entered into for the purposes of the network plan between a participating provider of health care and the health carrier complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~[.]~~ ***, and sections 2 to 5, inclusive, of this act;*** and

3. As applicable, ensure that the network plan complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~[.]~~ ***, and sections 2 to 5, inclusive, of this act.***

Sec. 8. Chapter 695D of NRS is hereby amended by adding thereto the provisions set forth as sections 9, 10 and 11 of this act.

Sec. 9. ***"Administrator" has the meaning ascribed to it in NRS 683A.025.***

Sec. 10. ***1. An organization for dental care or an administrator who recovers overpayments under a plan for dental care shall provide written notice to a dentist of any attempt to recover an overpayment, other than a duplicate payment. The notice must include, without limitation:***

(a) A description of the error that justifies the recovery; and

(b) The date on which the dental care for which the overpayment was made was provided and the name of the insured to whom the dental care was provided.

2. An organization for dental care or an administrator who recovers overpayments under a plan for dental care shall establish written procedures by which a dentist may challenge an attempt to recover an overpayment. Those procedures must include, without limitation, procedures for sharing information concerning a disputed claim with the dentist.

3. Except as otherwise provided in this subsection, an organization for dental care or an administrator who recovers overpayments under a plan for dental care shall not attempt to recover an overpayment more than 12 months after the date of the overpayment. This subsection does not apply to an attempt to recover an overpayment that is:

(a) Based on a reasonable belief that the overpayment involved fraud, abuse or other intentional misconduct; or

(b) Initiated by or at the request of a self-insured employer.

4. Any provision of a contract that conflicts with this section is against public policy, void and unenforceable.

Sec. 11. ***1. An organization for dental care or an administrator of a dental plan shall not refuse to pay a claim for dental care for which the organization for dental care or administrator, as applicable, has granted prior authorization unless:***

(a) A limitation on coverage provided under the applicable plan for dental care, including, without limitation, a limitation on total costs or frequency of services:

(1) Did not apply at the time the prior authorization was granted; and

(2) Applied at the time of the provision of the dental care for which the prior authorization was granted because additional covered dental care was provided to the insured after the prior

authorization was granted and before the provision of the dental care for which prior authorization was granted;

(b) The documentation provided by the person submitting the claim clearly fails to support the claim for which prior authorization was originally granted;

(c) After the prior authorization was granted, additional dental care was provided to the insured or the condition of the insured otherwise changed such that:

(1) The dental care for which prior authorization was granted is no longer medically necessary; or

(2) The organization for dental care or administrator, as applicable, would be required to deny prior authorization under the terms and conditions of the applicable plan for dental care that were in effect at the time of the provision of the dental care for which prior authorization was granted;

(d) Another person or entity is responsible for the payment;

(e) The dentist has previously been paid for the procedures covered by the claim;

(f) The claim was fraudulent or the prior authorization was based, in whole or in part, on materially false information provided by the dentist or insured or another person who is not affiliated with the organization for dental care or administrator, as applicable; or

(g) The insured was not eligible to receive the dental care for which the claim was made on the date that the dental care was provided and the organization for dental care or administrator, as applicable:

(1) Did not know of the eligibility status of the insured; and

(2) Could not have discovered the eligibility status of the insured through reasonable care.

2. Any provision of a contract that conflicts with this section is against public policy, void and unenforceable.

3. As used in this section:

(a) "Medically necessary" means dental care that a prudent dentist would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that is necessary and:

(1) Provided in accordance with generally accepted standards of dental practice;

(2) Clinically appropriate with regard to type, frequency, extent, location and duration;

(3) Not primarily provided for the convenience of the patient or dentist;

(4) Required to improve a specific dental condition of a patient or to preserve the existing state of oral health of the patient; and

(5) The most clinically appropriate level of dental care that may be safely provided to the patient.

(b) "Prior authorization" means any communication issued by an organization for dental care or the administrator of a dental plan in response to a request by a dentist in the form prescribed by the organization for dental care or administrator, as applicable, which indicates that specific dental care provided to a patient is:

(1) Covered under the plan for dental care issued to the insured; and

(2) Reimbursable in a specific amount, subject to applicable deductibles, copayments and coinsurance.

Sec. 12. NRS 695D.010 is hereby amended to read as follows:

695D.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 695D.020 to 695D.080, inclusive, ***and section 9 of this act*** have the meanings ascribed to them in those sections.

Sec. 13. NRS 287.010 is hereby amended to read as follows:

287.010 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada may:

(a) Adopt and carry into effect a system of group life, accident or health insurance, or any combination thereof, for the benefit of its officers and employees, and the dependents of officers and employees who elect to accept the insurance and who, where necessary, have authorized the governing body to make deductions from their compensation for the payment of premiums on the insurance.

(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the

governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 687B.408, 689B.030 to 689B.050, inclusive, 689B.287 and 689B.500 ***and sections 4 and 5 of this act*** apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and 689B.500 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.

(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada.

2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.

4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local

governmental agency with which the legal services organization has contracted; and

(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.

5. A contract that is entered into pursuant to subsection 3:

(a) Must be submitted to the Commissioner of Insurance for approval not less than 30 days before the date on which the contract is to become effective.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

6. As used in this section, "legal services organization" means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.

Sec. 14. 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 687B.409, 689B.255, 695G.150, 695G.155, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.174, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and sections 4 and 5 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. 15. NRS 608.1555 is hereby amended to read as follows:

608.1555 Any employer who provides benefits for health care to his or her employees shall provide the same benefits and pay providers of health care in the same manner as a policy of insurance pursuant to chapters 689A and 689B of NRS, including, without limitation, as required by NRS 687B.409 ~~[.]~~ ***and sections 4 and 5 of this act.***

Sec. 16. 1. The amendatory provisions of sections 4, 5, 7, 10, 11, 13, 14 and 15 of this act apply to any dental care provided pursuant to a contract entered into between a health carrier or an organization for dental care and a dentist entered into on or after July 1, 2021.

2. As used in this section:

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

(b) "Health carrier" has the meaning ascribed to it in NRS 687B.625.

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

Sec. 17. This act becomes effective on July 1, 2021.

㉚