Senate Bill No. 278–Senators Horsford and Hardy

CHAPTER.....

AN ACT relating to health care; revising provisions governing the modification of contracts between insurers and providers of health care under certain circumstances; requiring the Department of Health and Human Services to report certain rates of reimbursement for physicians for care and services provided pursuant to certain state plans and programs which provide medical assistance; providing that certain requirements concerning health insurance shall be deemed not to apply to certain nonprofit entities; revising the requirement that certain insurers and health care facilities accept a standardized form to obtain information relating to the credentials of a provider of health care; requiring the Department to conduct a study concerning medical homes; requiring the Department to submit reports concerning certain studies to the Legislature; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Sections 8-12, 14 and 15 of this bill require written notice of a contract modification between certain insurers and a provider of health care which involves the insurer's schedule of payments to be sent to the provider at least 45 days before the proposed modification will take effect, and require such insurers, upon request, to submit to a provider of health care with whom they contract any changes to the fee schedule applicable to the provider's practice. **Section 14.5** of this bill imposes similar requirements with respect to contracts between an organization for dental care and a dentist and, consistent with similar provisions of law, provides that such a contract may be modified at any time pursuant to a written agreement executed by both parties.

Section 16 of this bill requires the Department of Health and Human Services, with respect to the State Plan for Medicaid and the Children's Health Insurance Program, to report every rate of reimbursement for physicians which is provided on a fee-for-service basis and which is lower than the rate provided on the current Medicare fee schedule for care and services provided by physicians. **Section 16** also requires the Director of the Department to publish a schedule of such rates of reimbursement on an Internet website maintained by the Department and to submit an annual report concerning such rates to the Legislature.

Section 17.5 of this bill provides that certain requirements concerning health insurance that are enacted after January 1, 2011, shall be deemed not to apply to certain nonprofit entities.

Existing law requires the Commissioner of Insurance to prescribe a single, standardized form for use by insurers, carriers, societies, corporations, health maintenance organizations and managed care organizations to obtain any information relating to the credentials of a provider of health care. (NRS 629.095) **Section 21** of this bill requires the Commissioner to prescribe that form for use by hospitals, medical facilities and other facilities that provide health care.

Section 24.5 of this bill requires the Department of Health and Human Services to conduct a study concerning medical homes and to submit certain reports

concerning the study to the Legislature. **Section 24.7** of this bill imposes similar reporting requirements on the Department with respect to its study of electronic identification cards that contain information relating to health insurance.

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

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

Sections 1-7. (Deleted by amendment.)

Sec. 8. NRS 689A.035 is hereby amended to read as follows:

689A.035 1. An insurer shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the insurer to its insureds.

2. An insurer shall not contract with a provider of health care to provide health care to an insured unless the insurer uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between an insurer and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the insurer upon giving to the provider ~~[30]~~ ***45*** days' written notice of the modification ~~[.]~~ ***of the insurer's schedule of payments, including any changes to the fee schedule applicable to the provider's practice.*** If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***45-day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***45-day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If an insurer contracts with a provider of health care to provide health care to an insured, the insurer shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments ***, including any changes to the fee schedule applicable to the provider's practice,*** specified in paragraph (a) within 7 days after receiving the request.

5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 9. NRS 689B.015 is hereby amended to read as follows:

689B.015 1. An insurer that issues a policy of group health insurance shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the insurer to its insureds.

2. An insurer specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the insurer uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between an insurer specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the insurer upon giving to the provider ~~[30]~~ ***45*** days' written notice of the modification ~~[.]~~ ***of the insurer's schedule of payments, including any changes to the fee schedule applicable to the provider's practice.*** If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***45-day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***45-day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If an insurer specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the insurer shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments ***, including any changes to the fee schedule applicable to the provider's practice,*** specified in paragraph (a) within 7 days after receiving the request.

5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 10. NRS 689C.435 is hereby amended to read as follows:

689C.435 1. A carrier serving small employers and a carrier that offers a contract to a voluntary purchasing group shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the carrier to its insureds.

2. A carrier specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the carrier uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between a carrier specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the carrier upon giving to the provider ~~[30]~~ ***45*** days' written notice of the modification ~~[.]~~ ***of the carrier's schedule of payments, including any changes to the fee schedule applicable to the provider's practice.*** If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***45 day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***45 day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If a carrier specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the carrier shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments ***, including any changes to the fee schedule applicable to the provider's practice,*** specified in paragraph (a) within 7 days after receiving the request.

5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 11. NRS 695A.095 is hereby amended to read as follows:

695A.095 1. A society shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the society to its insureds.

2. A society shall not contract with a provider of health care to provide health care to an insured unless the society uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between a society and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the society upon giving to the provider ~~[30]~~ ***45*** days' written notice of the modification ~~[.]~~ ***of the society's schedule of payments, including any changes to the fee schedule applicable to the provider's practice.*** If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***45-day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***45-day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If a society contracts with a provider of health care to provide health care to an insured, the society shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments ***, including any changes to the fee schedule applicable to the provider's practice,*** specified in paragraph (a) within 7 days after receiving the request.

5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 12. NRS 695B.035 is hereby amended to read as follows:

695B.035 1. A corporation subject to the provisions of this chapter shall not charge a provider of health care a fee to include the name of the provider on a list of providers of health care given by the corporation to its insureds.

2. A corporation specified in subsection 1 shall not contract with a provider of health care to provide health care to an insured unless the corporation uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

3. A contract between a corporation specified in subsection 1 and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the corporation upon giving to the provider ~~[30]~~ ***45*** days' written notice of the modification ~~[.]~~ ***of the corporation's schedule of payments, including any changes to the fee schedule applicable to the provider's practice.*** If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***45-day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***45-day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

4. If a corporation specified in subsection 1 contracts with a provider of health care to provide health care to an insured, the corporation shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments ***, including any changes to the fee schedule applicable to the provider's practice,*** specified in paragraph (a) within 7 days after receiving the request.

5. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 13. (Deleted by amendment.)

Sec. 14. NRS 695C.125 is hereby amended to read as follows:

695C.125 1. A health maintenance organization shall not contract with a provider of health care to provide health care to an insured unless the health maintenance organization uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

2. A contract between a health maintenance organization and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the health maintenance organization upon giving to the provider ~~[30]~~ ***45*** days' written notice of the modification ~~[.]~~ ***of the health maintenance***

organization's schedule of payments, including any changes to the fee schedule applicable to the provider's practice. If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***45-day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***45-day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

3. If a health maintenance organization contracts with a provider of health care to provide health care to an enrollee, the health maintenance organization shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments ***, including any changes to the fee schedule applicable to the provider's practice,*** specified in paragraph (a) within 7 days after receiving the request.

4. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 14.5. Chapter 695D of NRS is hereby amended by adding thereto a new section to read as follows:

1. A contract between an organization for dental care and a dentist may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the organization for dental care upon giving to the dentist 45 days' written notice of the modification of the organization for dental care's schedule of payments, including any changes to the fee schedule applicable to the dentist's practice. If the dentist fails to object in writing to the modification within the 45-day period, the modification becomes effective at the end of that period. If the dentist objects in writing to the modification within the 45-day period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

2. If an organization for dental care contracts with a dentist, the organization for dental care shall:

(a) If requested by the dentist at the time the contract is made, submit to the dentist the schedule of payments applicable to the dentist; or

(b) If requested by the dentist at any other time, submit to the dentist the schedule of payments, including any changes to the fee schedule applicable to the dentist's practice, specified in paragraph (a) within 7 days after receiving the request.

3. The provisions of this section do not apply to an organization for dental care that provides 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 an organization for dental care from any provision of this chapter for services provided pursuant to any other contract.

Sec. 15. NRS 695G.430 is hereby amended to read as follows:

695G.430 1. A managed care organization shall not contract with a provider of health care to provide health care to an insured unless the managed care organization uses the form prescribed by the Commissioner pursuant to NRS 629.095 to obtain any information related to the credentials of the provider of health care.

2. A contract between a managed care organization and a provider of health care may be modified:

(a) At any time pursuant to a written agreement executed by both parties.

(b) Except as otherwise provided in this paragraph, by the managed care organization upon giving to the provider ~~[30]~~ ***45*** days' written notice of the modification ~~[.]~~ ***of the managed care organization's schedule of payments, including any changes to the fee schedule applicable to the provider's practice.*** If the provider fails to object in writing to the modification within the ~~[30-day]~~ ***45-day*** period, the modification becomes effective at the end of that period. If the provider objects in writing to the modification within the ~~[30-day]~~ ***45-day*** period, the modification must not become effective unless agreed to by both parties as described in paragraph (a).

3. If a managed care organization contracts with a provider of health care to provide health care services pursuant to chapter 689A, 689B, 689C, 695A, 695B or 695C of NRS, the managed care organization shall:

(a) If requested by the provider of health care at the time the contract is made, submit to the provider of health care the schedule of payments applicable to the provider of health care; or

(b) If requested by the provider of health care at any other time, submit to the provider of health care the schedule of payments **,**

including any changes to the fee schedule applicable to the provider's practice, specified in paragraph (a) within 7 days after receiving the request.

4. As used in this section, "provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

Sec. 16. Chapter 232 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Department, with respect to the State Plan for Medicaid and the Children's Health Insurance Program, shall report every rate of reimbursement for physicians which is provided on a fee-for-service basis and which is lower than the rate provided on the current Medicare fee schedule for care and services provided by physicians.

2. The Director shall post on an Internet website maintained by the Department a schedule of such rates of reimbursement.

3. The Director shall, on or before February 1 of each year, submit a report concerning the schedule of such rates of reimbursement to the Director of the Legislative Counsel Bureau for transmittal to the Legislature in odd-numbered years or to the Legislative Committee on Health Care in even-numbered years.

Sec. 17. NRS 232.290 is hereby amended to read as follows:

232.290 As used in NRS 232.290 to 232.484, inclusive, ***and section 16 of this act,*** unless the context requires otherwise:

1. "Department" means the Department of Health and Human Services.

2. "Director" means the Director of the Department.

Sec. 17.5. Chapter 287 of NRS is hereby amended by adding thereto a new section to read as follows:

Any provision of this chapter which is enacted after January 1, 2011, and requires coverage for screening, diagnosis or treatment of any specific medical condition, or specifies or limits exclusions, limitations or eligibility requirements therefor, shall be deemed not to apply to any nonprofit entity that qualifies under Section 501(c) of the Internal Revenue Code of 1986, 26 U.S.C. § 501(c), as amended.

Secs. 18-20. (Deleted by amendment.)

Sec. 21. NRS 629.095 is hereby amended to read as follows:

629.095 1. Except as otherwise provided in subsection 2, the Commissioner of Insurance shall develop, prescribe for use and make available a single, standardized form for use by insurers, carriers, societies, corporations, health maintenance organizations **,** ~~[and]~~ managed care organizations ***, hospitals, medical facilities and***

other facilities that provide health care in obtaining any information related to the credentials of a provider of health care.

2. The provisions of subsection 1 do not prohibit the Commissioner of Insurance from developing, prescribing for use and making available:

(a) Appropriate variations of the form described in that subsection for use in different geographical regions of this State.

(b) Addenda or supplements to the form described in that subsection to address, until such time as a new form may be developed, prescribed for use and made available, any requirements newly imposed by the Federal Government, the State or one of its agencies, or a body that accredits hospitals, medical facilities or health care plans.

3. With respect to the form described in subsection 1, the Commissioner of Insurance shall:

(a) Hold public hearings to seek input regarding the development of the form;

(b) Develop the form in consideration of the input received pursuant to paragraph (a);

(c) Ensure that the form is developed in such a manner as to accommodate and reflect the different types of credentials applicable to different classes of providers of health care;

(d) Ensure that the form is developed in such a manner as to reflect standards of accreditation adopted by national organizations which accredit hospitals, medical facilities and health care plans; and

(e) Ensure that the form is developed to be used efficiently and is developed to be neither unduly long nor unduly voluminous.

4. As used in this section:

(a) "Carrier" has the meaning ascribed to it in NRS 689C.025.

(b) "Corporation" means a corporation operating pursuant to the provisions of chapter 695B of NRS.

(c) "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

(d) "Insurer" means:

(1) An insurer that issues policies of individual health insurance in accordance with chapter 689A of NRS; and

(2) An insurer that issues policies of group health insurance in accordance with chapter 689B of NRS.

(e) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

(f) "Provider of health care" means a provider of health care who is licensed pursuant to chapter 630, 631, 632 or 633 of NRS.

(g) "Society" has the meaning ascribed to it in NRS 695A.044.

Secs. 22-24. (Deleted by amendment.)

Sec. 24.5. 1. The Department of Health and Human Services shall conduct a study concerning medical homes. The study must include, without limitation, an evaluation of:

(a) The progress made in the development of medical homes in this State;

(b) The manner in which insurers work with medical homes concerning the adequacy of health care networks; and

(c) Models for reimbursement of medical homes and any options for different methods of preauthorization for the care and services provided by medical homes.

2. The Department shall:

(a) During the calendar year 2012, submit such progress reports concerning the study to the Legislative Committee on Health Care as requested by the Committee; and

(b) On or before January 1, 2013, submit a final report concerning the findings of the study, including the potential cost to this State of such medical homes and any recommendations for legislation, to the Director of the Legislative Counsel Bureau for transmittal to the 77th Session of the Nevada Legislature.

3. As used in this section, "medical home" means a medical practice which utilizes a model for the delivery of health care:

(a) In which a patient establishes an ongoing relationship with a physician in a physician-directed team; and

(b) The purpose of which is to provide comprehensive, accessible and continuous evidence-based primary and preventive care and to coordinate the health care needs of the patient across the health care system to improve quality, safety, access and health outcomes in a cost-effective manner.

Sec. 24.7. The Department of Health and Human Services, with respect to the study being conducted by the Department concerning electronic identification cards that contain information relating to health insurance, shall:

1. During the calendar year 2012, submit such progress reports concerning the study to the Legislative Committee on Health Care as requested by the Committee; and

2. On or before January 1, 2013, submit a final report concerning the findings of the study, including the potential cost to this State of such electronic identification cards and any recommendations for legislation, to the Director of the Legislative Counsel Bureau for transmittal to the 77th Session of the Nevada Legislature.

Sec. 25. 1. This section and section 17.5 of this act become effective upon passage and approval.

2. Sections 1 to 17, inclusive, 18, 19, 20 and 22 to 24.7, inclusive, of this act become effective on July 1, 2011.

3. Section 21 of this act becomes effective on January 1, 2012.