

Assembly Bill No. 52—Committee
on Commerce and Labor

CHAPTER.....

AN ACT relating to insurance; requiring the Commissioner of Insurance to establish programs to inform providers of health care and insureds under health insurance policies of certain information relating to the payment of claims; revising provisions governing the payment of claims under policies of health insurance; establishing certain administrative penalties; requiring a health carrier to provide certain information to participating providers of health care and covered persons; requiring a health carrier to establish certain procedures for challenging the denial of a claim; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

In most cases, existing law requires the administrators of health insurance plans and certain health insurers to approve or deny a claim within 30 days after the insurer receives the claim. If the administrator or insurer approves the claim, existing law requires the administrator or insurer to pay the claim within 30 days after the claim is approved. If the administrator or insurer requires additional information to determine whether to approve or deny the claim, existing law requires the administrator or insurer to notify the claimant of its request for additional information within 20 days after the administrator or insurer receives the claim. If the administrator or insurer approves the claim after receiving such additional information from the claimant, existing law requires the administrator or insurer to pay the claim within 30 days after receiving such information. Existing law requires an administrator or insurer that fails to pay a claim within the required time period to pay interest on the claim at a prescribed rate. (NRS 287.04335, 683A.0879, 689A.410, 689B.255, 689C.335, 695A.188, 695B.2505, 695C.185, 695D.215, 695F.090)

Sections 2, 5, 8-11, 14 and 16 of this bill replace those requirements with uniform requirements governing the time periods for the payment of health insurance claims that apply to administrators of health insurance plans and all private health insurers in this State. Specifically, **sections 2, 5, 8-11, 14 and 16** require each such administrator or insurer to approve or deny a claim and, if the claim is approved, pay the claim within: (1) twenty-one days after receiving the claim, if the claim is submitted electronically; or (2) thirty days after receiving the claim, if the claim is not submitted electronically. **Sections 2, 5, 8-11, 14 and 16** require an administrator or insurer that needs additional information to determine whether to approve or deny a claim to request such information within 20 working days after receiving the claim. If, after receiving such additional information, the administrator or insurer approves the claim, **sections 2, 5, 8-11, 14 and 16** require the administrator or insurer, as applicable, to pay the claim within: (1) twenty-one days after receiving the additional information, if the additional information is submitted electronically; or (2) thirty days after receiving the additional information, if the additional information is not submitted electronically. **Sections 2, 5, 8-11, 14 and 16** prohibit an administrator or insurer from denying a claim without a reasonable basis for doing so. **Sections 2, 5, 8-11, 14 and 16** require an administrator or insurer to annually report to the Commissioner of



Insurance certain information relating to compliance with those requirements. **Section 25** of this bill repeals certain provisions applicable to health maintenance organizations that are no longer necessary because existing law makes the provisions of **section 16** applicable to all managed care organizations, including health maintenance organizations. (NRS 695C.055) **Sections 13 and 18** of this bill update references to a section repealed by **section 25** with a reference to **section 16**.

Existing law authorizes the Commissioner to: (1) impose an administrative penalty upon determining that the administrator of a health insurance plan or certain health insurers are not in substantial compliance with the provisions of existing law governing the schedule for paying claims; and (2) suspend or revoke the certificate of registration or authority of such an administrator or insurer upon a second or subsequent determination that such an administrator or insurer is not in substantial compliance with those provisions. (NRS 287.04335, 683A.0879, 689A.410, 689B.255, 689C.335, 695B.2505, 695C.185, 695F.090) **Sections 10, 14 and 16** of this bill extend those penalties to apply to fraternal benefit societies, issuers of plans for dental care and managed care organizations. **Sections 2, 5, 8-11, 14 and 16** additionally authorize the Commissioner to: (1) impose an administrative penalty upon determining that the administrator of a health insurance plan or a health insurer has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim; and (2) suspend or revoke the certificate of registration or authority of an administrator or insurer upon a second or subsequent such determination.

Existing law requires certain health insurers to provide certain notice to an insured within 10 days after denying coverage. (NRS 689A.755, 689B.0295, 695B.400, 695G.230) **Sections 2, 6, 7, 9, 10, 12, 14, 15 and 18** of this bill require health insurers and administrators of health insurance plans to provide notice of the denial of a claim within 21 days after receiving all information necessary to make a determination concerning the claim if the information is submitted electronically, or if the information is not received electronically, within 30 days after receiving the necessary information. **Sections 2, 6, 7, 9, 10, 12, 14, 15 and 18** also require the inclusion of certain additional information in such a notice. **Sections 10, 14 and 16** make certain other provisions relating to the payment of claims that currently apply to most health insurers also apply to fraternal benefit societies, organizations for dental care and managed care organizations so that the requirements governing the payment of claims are uniform for all health insurers. **Sections 2, 12.5, 17.5 and 18.5** of this bill exempt coverage under Medicaid, the Children's Health Insurance Program and the Public Employees' Benefits Program from the requirements of **sections 2, 8, 13, 16 and 18**.

Existing law requires a health carrier which offers or issues a network plan to notify each participating provider of health care in the network of the responsibilities of the provider of health care with respect to any applicable administrative policies and programs of the health carrier. (NRS 687B.730) **Section 3** of this bill additionally requires such a health carrier to provide to each participating provider of health care and each covered person at least annually an explanation of the process by which the health carrier will provide remittances to or pay claims submitted by participating providers of health care. **Section 3** exempts coverage by managed care organizations under Medicaid, the Children's Health Insurance Program and the Public Employees' Benefits Program from all such notification requirements.

Existing law requires a health carrier which offers or issues a network plan to establish procedures for the resolution of disputes between the health carrier and a participating provider of health care. (NRS 687B.820) **Section 4** of this bill requires those procedures to include an efficient process by which a participating provider



of health care may challenge the denial by a health carrier of a claim. **Section 4** exempts coverage by managed care organizations under Medicaid, the Children’s Health Insurance Program and the Public Employees’ Benefits Program from the requirement to establish such procedures. **Section 1** of this bill requires the Division of Insurance of the Department of Business and Industry to establish and carry out certain programs to facilitate public knowledge and use of the provisions of this bill.

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

WHEREAS, Ensuring timely reimbursement for providers of health care will enhance the business environment in this State for providers of health care and improve access to health care for residents of this State; and

WHEREAS, Prompt payment of claims by health insurers will create a more stable and attractive landscape for new medical practices, thereby improving the health care infrastructure of this State; and

WHEREAS, Delayed payments by insurers have a disproportionate negative effect on minority communities, whose residents are less likely to have the means to pay out of pocket for health care services; now, therefore,

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

Section 1. NRS 679B.550 is hereby amended to read as follows:

679B.550 The Division shall:

1. Establish a toll-free telephone service for receiving inquiries and complaints from consumers of health care in this State concerning health care plans;

2. Provide answers to inquiries of consumers of health care concerning health care plans, or refer the consumers to the appropriate agency, department or other entity that is responsible for addressing the specific type of inquiry;

3. Refer consumers of health care to the appropriate agency, department or other entity that is responsible for addressing the specific type of complaint of the consumer;

4. Provide counseling and assistance to consumers of health care concerning health care plans;

5. Educate consumers of health care concerning health care plans in this State; ~~and~~

6. *Establish and carry out:*



(a) A campaign to inform providers of health care and insureds of the provisions of NRS 683A.0879, 687B.730, 687B.820, 689A.410, 689A.755, 689B.0295, 689B.255, 689C.335, 695A.188, 695B.2505, 695B.400, 695D.215 and 695G.230 and sections 15 and 16 of this act; and

(b) A program to provide additional support and resources to assist providers of health care who operate small health care practices or are new to operating a health care practice in:

(1) Navigating the process for seeking reimbursement from insurers; and

(2) Ensuring that insurers comply with the requirements of NRS 683A.0879, 687B.730, 687B.820, 689A.410, 689A.755, 689B.0295, 689B.255, 689C.335, 695A.188, 695B.2505, 695B.400, 695D.215 and 695G.230 and sections 15 and 16 of this act; and

7. Take such actions as are necessary to ensure public awareness of the existence and purpose of the services provided by the Division pursuant to this section.

Sec. 2. NRS 683A.0879 is hereby amended to read as follows:

683A.0879 1. Except as otherwise provided in subsection ~~[2]~~ 3 and NRS 439B.754, an administrator shall approve or deny a claim relating to health insurance coverage *and, if the administrator:*

(a) Approves the claim, pay the claim within [30] :

(1) Twenty-one 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.]~~, *if the claim is submitted electronically; or*

(2) Thirty days after the administrator receives the claim, if the claim is not submitted electronically.

(b) Denies the claim, notify the claimant in writing of the denial within 21 days after the administrator receives the claim, if the claim is submitted electronically, or 30 days after the administrator receives the claim, if the claim is not submitted electronically. The notice must include, without limitation:

(1) All reasons for denying the claim, including, without limitation, the specific facts and provisions of the policy relied upon by the administrator as a basis to deny the claim;

(2) The criteria by which the administrator determines whether to approve or deny the claim and a description of the manner in which the administrator applied those criteria to the claim; and

(3) A summary of any applicable process established pursuant to NRS 687B.820 for challenging the denial of the claim.



2. Except as otherwise provided in this section, if the approved claim is not paid within ~~[that]~~ *the* period ~~[.]~~ *specified in subsection 1*, 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]~~ *10* percent ~~[.]~~ *per annum*. The interest must be calculated from ~~[30 days after]~~ the date on which *payment of* the claim is ~~[approved]~~ *due pursuant to subsection 1* until the date on which the claim is paid.

~~[2.]~~ 3. 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 *working* days after receiving the claim. The administrator shall notify the ~~[provider of health care]~~ *claimant* of all the specific reasons for the delay in approving or denying the claim. The administrator shall approve or deny the claim *and, if the administrator:*

(a) *Approves the claim, pay the claim* within ~~[30]~~ *:*

(1) *Twenty-one days after receiving the additional information, if the information is submitted electronically; or*

(2) *Thirty* 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 information is not submitted electronically.*

(b) *Denies the claim, provide notice of the denial in the manner prescribed in paragraph (b) of subsection 1 within 21 days after receiving the additional information, if the information is submitted electronically, or 30 days after receiving the additional information, if the information is not submitted electronically.*

4. If ~~[the]~~ *a claim* approved ~~[elaim]~~ *pursuant to subsection 3* is not paid within ~~[that]~~ *the* period ~~[.]~~ *specified in that subsection*, the administrator shall pay interest on the claim in the manner prescribed in subsection ~~[.]~~ *2*.

~~[3.]~~ 5. An administrator shall not ~~[request]~~ *:*

(a) *Deny a claim relating to health insurance coverage without a reasonable basis for the denial.*

(b) *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.]~~ 6. An administrator shall not pay only part of a claim that has been approved and is fully payable.

~~[5.]~~ 7. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

~~[6.]~~ 8. 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.]~~ 9. 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]~~ *the time periods specified by this section* of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

~~[8.]~~ 10. If the Commissioner determines that an administrator is not in substantial compliance with the requirements set forth in this section ~~[.]~~ *or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim*, 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 ~~[.]~~ *or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim*, the Commissioner may suspend or revoke the certificate of registration of the administrator.

11. On or before February 1 of each year, an administrator that was responsible for the approval and denial of claims relating to health insurance coverage in this State during the immediately preceding calendar year shall submit to the Commissioner a report concerning the compliance of the administrator with the requirements of this section during that calendar year. The report must include, without limitation:

(a) The number of claims for which the administrator failed to comply with the requirements of subsections 1 and 3 during the immediately preceding calendar year; and

(b) The total amount of interest paid by the administrator pursuant to subsections 2 and 4 during the immediately preceding calendar year.

12. The provisions of this section do not apply to a claim relating to health coverage under Medicaid, the Children's Health Insurance Program or the Public Employees' Benefits Program.



Sec. 3. NRS 687B.730 is hereby amended to read as follows:

687B.730 **1.** A health carrier which offers or issues a network plan shall ~~notify~~:

(a) Notify each participating provider of health care in the network of the responsibilities of the participating provider of health care with respect to any applicable administrative policies and programs of the health carrier including, without limitation, any applicable administrative policies and programs concerning:

~~[1.]~~ **(1)** Terms of payment;

~~[2.]~~ **(2)** Utilization review;

~~[3.]~~ **(3)** Quality assessment and improvement;

~~[4.]~~ **(4)** Credentialing;

~~[5.]~~ **(5)** Procedures for grievances and appeals;

~~[6.]~~ **(6)** Requirements for data reporting;

~~[7.]~~ **(7)** Requirements for timely notice to the health carrier of changes in the practices of the participating provider of health care, such as discontinuance of accepting new patients;

~~[8.]~~ **(8)** Requirements for confidentiality; and

~~[9.]~~ **(9)** Any applicable federal or state programs.

(b) Provide to each participating provider of health care in the network and each covered person at least annually a detailed explanation of the process by which the health carrier will pay claims submitted by participating providers of health care, including, without limitation, the contact information for the department of the health carrier that is responsible for reviewing claims that have been denied in accordance with the process established pursuant to NRS 687B.820.

2. The provisions of this section do not apply to the provision of health care services by a managed care organization to:

(a) 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; or

(b) Members of the Public Employees' Benefits Program.

3. As used in this section, "managed care organization" has the meaning ascribed to it in NRS 695G.050.

Sec. 4. NRS 687B.820 is hereby amended to read as follows:

687B.820 **1.** A health carrier which offers or issues a network plan shall establish procedures for the resolution of administrative, payment or other disputes between a participating provider of health care in the network and the health carrier. **Those procedures must include, without limitation, an efficient process by which a**



participating provider of health care may challenge the denial of a claim by the health carrier. The process must allow for the clear resolution of each challenge within a reasonable time.

2. *The provisions of this section do not apply to the provision of health care services by a managed care organization to:*

(a) 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; or

(b) Members of the Public Employees' Benefits Program.

3. *As used in this section, "managed care organization" has the meaning ascribed to it in NRS 695G.050.*

Sec. 5. NRS 689A.410 is hereby amended to read as follows:

689A.410 1. Except as otherwise provided in subsection 2 and NRS 439B.754, an insurer shall approve or deny a claim relating to a policy of health insurance within *21 days after the insurer receives the claim, if the claim is submitted electronically, or 30 days after the insurer receives the claim* ~~[]~~, *if the claim is not submitted electronically.* If the claim is approved, the insurer shall *also* pay the claim within ~~[30 days after it is approved.]~~ *that period.* 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]~~ *10* percent ~~[]~~ *per annum.* The interest must be calculated from ~~[30 days after]~~ the date on which *payment of* the claim is ~~[approved]~~ *due pursuant to this subsection* 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 *working* days after it receives the claim. The insurer shall notify the ~~[provider of health care]~~ *claimant* of all the specific reasons for the delay in approving or denying the claim. The insurer shall approve or deny the claim within *21 days after receiving the additional information, if the additional information is submitted electronically, or 30 days after receiving the additional information* ~~[]~~, *if the additional information is not submitted electronically.* If the claim is approved, the insurer shall *also* pay the claim within ~~[30 days after it receives the additional information.]~~ *that period.* 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) *Deny a claim without a reasonable basis for the denial.*

(b) *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}~~ *the time periods specified by this section* 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 ~~{}~~ *or that the insurer has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim*, 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 ~~{}~~ *or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim*, the Commissioner may suspend or revoke the certificate of authority of the insurer.

9. *On or before February 1 of each year, an insurer shall submit to the Commissioner a report concerning the compliance of the insurer with the requirements of this section during the immediately preceding calendar year. The report must include, without limitation:*

(a) *The number of claims for which the insurer failed to comply with the requirements of subsections 1 and 2 during the immediately preceding calendar year; and*



(b) The total amount of interest paid by the insurer pursuant to subsections 1 and 2 during the immediately preceding calendar year.

Sec. 6. NRS 689A.755 is hereby amended to read as follows:

689A.755 1. Following approval by the Commissioner, each insurer that issues a policy of health insurance in this State shall provide written notice to an insured, in clear and comprehensible language that is understandable to an ordinary layperson, explaining the right of the insured to file a written complaint. Such notice must be provided to an insured:

(a) At the time the insured receives his or her evidence of coverage;

(b) Any time that the insurer denies coverage of a health care service or limits coverage of a health care service to an insured; and

(c) Any other time deemed necessary by the Commissioner.

2. Any time that an insurer denies coverage of a health care service to an insured, including, without limitation, denying a claim relating to a policy of health insurance pursuant to NRS 689A.410, it shall notify the insured *and, if applicable, the provider of health care who submitted the claim*, in writing within :

(a) *Twenty-one days after the insurer receives all information necessary to make a determination concerning the claim, if the information was submitted electronically;*

(b) *Thirty days after the insurer receives all information necessary to make a determination concerning the claim, if the information was not submitted electronically; or*

(c) *If no claim is received, within 10 working days after ~~the~~ the insurer denies coverage of the health care service . ~~of:~~*

3. *The notice required pursuant to subsection 2 must include, without limitation:*

(a) ~~The reason~~ *All reasons* for denying coverage of the service ~~the~~, *including, without limitation, the specific facts and provisions of the policy relied upon by the insurer as a basis to deny coverage of the service;*

(b) The criteria by which the insurer determines whether to authorize or deny coverage of the health care service ~~the~~ and *a description of the manner in which the insurer applied those criteria to the health care service;*

(c) *A summary of any applicable process established pursuant to NRS 687B.820 for challenging the denial of the claim; and*

(d) The right of the insured to file a written complaint and the procedure for filing such a complaint.



~~[3-]~~ 4. A written notice which is approved by the Commissioner *pursuant to subsection 1* shall be deemed to be in clear and comprehensible language that is understandable to an ordinary layperson.

Sec. 7. NRS 689B.0295 is hereby amended to read as follows:

689B.0295 1. Following approval by the Commissioner, each insurer that issues a policy of group health insurance in this State shall provide written notice to an insured, in clear and comprehensible language that is understandable to an ordinary layperson, explaining the right of the insured to file a written complaint. Such notice must be provided to an insured:

(a) At the time the insured receives his or her certificate of coverage or evidence of coverage;

(b) Any time that the insurer denies coverage of a health care service or limits coverage of a health care service to an insured; and

(c) Any other time deemed necessary by the Commissioner.

2. Any time that an insurer denies coverage of a health care service, including, without limitation, denying a claim relating to a policy of group health insurance or blanket insurance pursuant to NRS 689B.255, to an insured it shall notify the insured in writing within :

(a) *Twenty-one days after the insurer receives all information necessary to make a determination concerning the claim, if the information is submitted electronically;*

(b) *Thirty days after the insurer receives all information necessary to make a determination concerning the claim, if the information is not submitted electronically; or*

(c) *If no claim is received, within 10 working days after ~~[i]f~~ the insurer denies coverage of the health care service. ~~[of:]~~*

3. *The notice required pursuant to subsection 2 must include, without limitation:*

(a) ~~[The reason]~~ *All reasons* for denying coverage of the service ~~[:]~~, *including, without limitation, the specific facts and provisions of the policy relied upon by the insurer as a basis to deny coverage of the service;*

(b) The criteria by which the insurer determines whether to authorize or deny coverage of the health care service ~~[:]~~ and *a description of the manner in which the insurer applied those criteria to the health care service;*

(c) *A summary of any applicable process established pursuant to NRS 687B.820 for challenging the denial of the claim; and*

(d) The right of the insured to file a written complaint and the procedure for filing such a complaint.



~~[3.]~~ 4. A written notice which is approved by the Commissioner shall be deemed to be in clear and comprehensible language that is understandable to an ordinary layperson.

5. *If an insurer denies a claim submitted by a provider of health care, the insurer shall notify the provider of health care in writing of the denial within:*

(a) Twenty-one days after the insurer receives all information necessary to make a determination concerning the claim, if the information is submitted electronically; or

(b) Thirty days after the insurer receives all information necessary to make a determination concerning the claim, if the information is not submitted electronically.

6. *The notice required pursuant to subsection 5 must include, without limitation:*

(a) All reasons for denying the claim;

(b) The criteria by which the insurer determines whether to approve or deny the claim and a description of the manner in which the insurer applied those criteria to the claim;

(c) Any other legal or factual basis for denying the claim; and

(d) A summary of any applicable process established pursuant to NRS 687B.820 for challenging the denial of the claim.

Sec. 8. NRS 689B.255 is hereby amended to read as follows:

689B.255 1. Except as otherwise provided in subsection 2 and NRS 439B.754, an insurer shall approve or deny a claim relating to a policy of group health insurance or blanket insurance within *21 days after the insurer receives the claim, if the claim is submitted electronically, or* 30 days after the insurer receives the claim ~~[.]~~, *if the claim is not submitted electronically.* If the claim is approved, the insurer shall *also* pay the claim within ~~[30 days after it is approved.]~~ *that period.* 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]~~ *10 percent [.] per annum.* The interest must be calculated from ~~[30 days after]~~ the date on which *payment of* the claim is ~~[approved]~~ *due pursuant to this subsection* 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 *working* days after it receives the claim. The insurer shall notify the ~~[provider of~~



~~health-care]~~ *claimant* of all the specific reasons for the delay in approving or denying the claim. The insurer shall approve or deny the claim within *21 days after receiving the additional information, if the additional information is submitted electronically, or* 30 days after receiving the additional information ~~[]~~, *if the additional information is not submitted electronically.* If the claim is approved, the insurer shall *also* pay the claim within ~~[30 days after it receives the additional information.]~~ *that period.* 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) *Deny a claim without a reasonable basis for the denial.*

(b) *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]~~ *the time periods specified by this section* 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 ~~[]~~ *or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,* 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 ~~[]~~ *or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,* the Commissioner may suspend or revoke the certificate of authority of the insurer.



9. On or before February 1 of each year, an insurer shall submit to the Commissioner a report concerning the compliance of the insurer with the requirements of this section during the immediately preceding calendar year. The report must include, without limitation:

(a) The number of claims for which the insurer failed to comply with the requirements of subsections 1 and 2 during the immediately preceding calendar year; and

(b) The total amount of interest paid by the insurer pursuant to subsections 1 and 2 during the immediately preceding calendar year.

Sec. 9. NRS 689C.335 is hereby amended to read as follows:

689C.335 1. Except as otherwise provided in subsection ~~[2]~~ 3 and NRS 439B.754, 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 *and, if the carrier:*

(a) Approves the claim, pay the claim within ~~[30]~~ :

(1) Twenty-one 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.]~~, if the claim is submitted electronically; or

(2) Thirty days after the carrier receives the claim, if the claim is not submitted electronically.

(b) Denies the claim, notify the claimant in writing of the denial within 21 days after the carrier receives the claim, if the claim is submitted electronically, or 30 days after the carrier receives the claim, if the claim is not submitted electronically. The notice must include, without limitation:

(1) All reasons for denying the claim, including, without limitation, the specific facts and provisions of the policy relied upon by the carrier as a basis to deny the claim;

(2) The criteria by which the carrier determines whether to approve or deny the claim and a description of the manner in which the carrier applied those criteria to the claim; and

(3) A summary of any applicable process established pursuant to NRS 687B.820 for challenging the denial of the claim.

2. Except as otherwise provided in this section, if the approved claim is not paid within ~~[that]~~ the period ~~[.]~~ specified in subsection 1, 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]~~ 10 percent ~~[.]~~ per annum. The interest



must be calculated from ~~[30 days after]~~ the date on which *payment of* the claim is ~~[approved]~~ *due pursuant to subsection 1* until the date on which the claim is paid.

~~[2.]~~ 3. 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 *working* days after it receives the claim. The carrier shall notify the ~~[provider of health care]~~ *claimant* of all the specific reasons for the delay in approving or denying the claim. The carrier shall approve or deny the claim *and, if the carrier:*

(a) *Approves the claim, pay the claim* within ~~[30]~~ :

(1) *Twenty-one days after receiving the additional information, if the information is submitted electronically; or*

(2) *Thirty 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 information is not submitted electronically.*

(b) *Denies the claim, provide notice of the denial in the manner prescribed in paragraph (b) of subsection 1 within 21 days after receiving the additional information, if the information is submitted electronically, or 30 days after receiving the additional information, if the information is not submitted electronically.*

4. If ~~[the approved]~~ a claim *approved pursuant to subsection 3* is not paid within ~~[that]~~ *the* period ~~[.]~~ *specified in that subsection*, the carrier shall pay interest on the claim in the manner prescribed in subsection ~~[1.]~~ 2.

~~[3.]~~ 5. A carrier shall not ~~[request]~~ :

(a) *Deny a claim without a reasonable basis for the denial.*

(b) *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.]~~ 6. A carrier shall not pay only part of a claim that has been approved and is fully payable.

~~[5.]~~ 7. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

~~[6.]~~ 8. 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.]~~ 9. 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}~~ *the time periods specified by this section* of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.

~~{8.}~~ **10.** If the Commissioner determines that a carrier is not in substantial compliance with the requirements set forth in this section ~~{ }~~ *or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim*, 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 ~~{ }~~ *or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim*, the Commissioner may suspend or revoke the certificate of authority of the carrier.

11. On or before February 1 of each year, a carrier shall submit to the Commissioner a report concerning the compliance of the carrier with the requirements of this section during the immediately preceding calendar year. The report must include, without limitation:

(a) The number of claims for which the carrier failed to comply with the requirements of subsections 1 and 3 during the immediately preceding calendar year; and

(b) The total amount of interest paid by the carrier pursuant to subsections 2 and 4 during the immediately preceding calendar year.

Sec. 10. NRS 695A.188 is hereby amended to read as follows:
695A.188 1. Except as otherwise provided in subsection ~~{2}~~ **3** and NRS 439B.754, a society shall approve or deny a claim relating to a certificate of health insurance *and, if the society:*

(a) Approves the claim, pay the claim within ~~{30}~~ :

(1) Twenty-one 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~~ , if the claim is submitted electronically; or

(2) Thirty days after the society receives the claim, if the claim is not submitted electronically.

(b) Denies the claim, notify the claimant in writing of the denial within 21 days after the society receives the claim, if the claim is submitted electronically, or 30 days after the society receives the claim, if the claim is not submitted electronically. The notice must include, without limitation:



(1) *All reasons for denying the claim, including, without limitation, the specific facts and provisions of the certificate relied upon by the society as a basis to deny the claim;*

(2) *The criteria by which the society determines whether to approve or deny the claim and a description of the manner in which the society applied those criteria to the claim; and*

(3) *A summary of any applicable process established pursuant to NRS 687B.820 for challenging the denial of the claim.*

2. *Except as otherwise provided in this section, if the approved claim is not paid within ~~[that] the~~ period ~~[.] specified by subsection 1,~~ 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.] 10 percent per annum.~~ The interest must be calculated from ~~[30 days after]~~ the date on which *payment of* the claim is ~~[approved]~~ *due pursuant to subsection 1* until the claim is paid.*

~~[2.]~~ 3. 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 *working* days after it receives the claim. The society shall notify the ~~[provider of health care]~~ *claimant* of all the specific reasons for the delay in approving or denying the claim. The society shall approve or deny the claim *and, if the society:*

(a) *Approves the claim, pay the claim* within ~~[30]~~ :

(1) *Twenty-one days after receiving the additional information, if the information is submitted electronically; or*

(2) *Thirty 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 information is not submitted electronically.~~*

(b) *Denies the claim, provide notice of the denial in the manner prescribed in paragraph (b) of subsection 1 within 21 days after receiving the additional information, if the information is submitted electronically, or 30 days after receiving the information, if the information is not submitted electronically.*

4. If ~~[the approved]~~ a claim *approved pursuant to subsection 3* is not paid within ~~[that] the~~ period ~~[.] specified in that subsection,~~ the society shall pay interest on the claim in the manner prescribed in subsection ~~[1.]~~ 2.

~~[3.]~~ 5. A society shall not ~~[request]~~ :

(a) *Deny a claim without a reasonable basis for the denial.*



(b) 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.]~~ 6. A society shall not pay only part of a claim that has been approved and is fully payable.

~~[5.]~~ 7. A court shall award costs and reasonable attorney's fees to the prevailing party in an action brought pursuant to this section.

8. *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 society.*

9. *The Commissioner may require a society to provide evidence which demonstrates that the society has substantially complied with the requirements set forth in this section, including, without limitation, payment within the time periods specified by this section of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.*

10. *If the Commissioner determines that a society is not in substantial compliance with the requirements set forth in this section or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim, the Commissioner may require the society to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that a society is not in substantial compliance with the requirements set forth in this section or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim, the Commissioner may suspend or revoke the certificate of authority of the society.*

11. *On or before February 1 of each year, a society shall submit to the Commissioner a report concerning the compliance of the society with the requirements of this section during the immediately preceding calendar year. The report must include, without limitation:*

(a) The number of claims for which the society failed to comply with the requirements of subsections 1 and 3 during the immediately preceding calendar year; and

(b) The total amount of interest paid by the society pursuant to subsections 2 and 4 during the immediately preceding calendar year.



Sec. 11. NRS 695B.2505 is hereby amended to read as follows:

695B.2505 1. Except as otherwise provided in subsection 2 and NRS 439B.754, 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 *21 days after the corporation receives the claim, if the claim is submitted electronically, or* 30 days after the corporation receives the claim ~~[.]~~, *if the claim is not submitted electronically.* If the claim is approved, the corporation shall *also* pay the claim within ~~[30 days after it is approved.]~~ *that period.* Except as otherwise provided in this section, if the approved claim is not paid within ~~[that]~~ *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]~~ *10* percent ~~[.]~~ *per annum.* The interest must be calculated from ~~[30 days after]~~ the date on which the *payment of the* claim is ~~[approved]~~ *due pursuant to this subsection* 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 *working* days after it receives the claim. The corporation shall notify the ~~[provider of dental, hospital or medical services]~~ *claimant* of all the specific reasons for the delay in approving or denying the claim. The corporation shall approve or deny the claim within *21 days after receiving the additional information, if the additional information is submitted electronically, or* 30 days after receiving the additional information ~~[.]~~, *if the information is not submitted electronically.* If the claim is approved, the corporation shall pay the claim within ~~[30 days after it receives the additional information.]~~ *that period.* 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) *Deny a claim without a reasonable basis for the denial.*

(b) *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}~~ *the time periods specified by this section* 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 ~~{ } or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,~~ 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 ~~{ } or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim,~~ the Commissioner may suspend or revoke the certificate of authority of the corporation.

9. On or before February 1 of each year, a corporation shall submit to the Commissioner a report concerning the compliance of the corporation with the requirements of this section during the immediately preceding calendar year. The report must include, without limitation:

(a) The number of claims for which the corporation failed to comply with the requirements of subsections 1 and 3 during the immediately preceding calendar year; and

(b) The total amount of interest paid by the corporation pursuant to subsections 1 and 2 during the immediately preceding calendar year.

Sec. 12. NRS 695B.400 is hereby amended to read as follows:

695B.400 1. Following approval by the Commissioner, each insurer that issues a contract for hospital or medical services in this State shall provide written notice to an insured, in clear and comprehensible language that is understandable to an ordinary



layperson, explaining the right of the insured to file a written complaint. Such notice must be provided to an insured:

(a) At the time the insured receives a certificate of coverage or evidence of coverage;

(b) Any time that the insurer denies coverage of a health care service or limits coverage of a health care service to an insured; and

(c) Any other time deemed necessary by the Commissioner.

2. Any time that an insurer denies coverage of a health care service to a beneficiary or subscriber, including, without limitation, denying a claim relating to a contract for dental, hospital or medical services pursuant to NRS 695B.2505, it shall notify the beneficiary or subscriber in writing within :

(a) Twenty-one days after the insurer receives all information necessary to make a determination concerning the claim, if the information is submitted electronically;

(b) Thirty days after the insurer receives all information necessary to make a determination concerning the claim, if the information is not submitted electronically; or

(c) If no claim is received, 10 working days after ~~the~~ the insurer denies coverage of the health care service of:

~~[(a) The reason]~~

(1) All reasons for denying coverage of the service ~~the~~ , including, without limitation, the specific facts and provisions of the contract relied upon by the insurer as a basis to deny coverage for the service;

~~[(b)]~~ (2) The criteria by which the insurer determines whether to authorize or deny coverage of the health care service ~~the~~ and the manner in which the insurer applied those criteria to the health care service;

(3) A summary of any applicable process established pursuant to NRS 687B.820 for challenging the denial of the claim; and

~~[(c)]~~ (4) The right of the beneficiary or subscriber to file a written complaint and the procedure for filing such a complaint.

3. A written notice which is approved by the Commissioner shall be deemed to be in clear and comprehensible language that is understandable to an ordinary layperson.

Sec. 12.5. 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.1751, 695C.1755, 695C.1759, 695C.176 to 695C.200, inclusive, 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.16932 to 695C.1699, inclusive, 695C.1701, 695C.1708, 695C.1728, 695C.1731, 695C.17333, 695C.17345, 695C.17347, 695C.1736 to 695C.1745, inclusive, 695C.1757 and 695C.204 apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

6. The provisions of NRS 695C.17095 *and* **695C.187** do not apply to a health maintenance organization that provides health care services to members of the Public Employees' Benefits Program. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

7. The provisions of NRS 695C.1735 do not apply to a health maintenance organization that provides health care services to:

(a) The officers and employees, and the dependents of officers and employees, of the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of this State; or

(b) Members of the Public Employees' Benefits Program.



↪ This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 13. NRS 695C.187 is hereby amended to read as follows:

695C.187 1. A health maintenance organization shall not:

(a) Enter into any contract or agreement, or make any other arrangements, with a provider for the provision of health care; or

(b) Employ a provider pursuant to a contract, an agreement or any other arrangement to provide health care,

↪ unless the contract, agreement or other arrangement specifically provides that the health maintenance organization and provider agree to the schedule for the payment of claims set forth in ~~[NRS 695C.185.]~~ *section 16 of this act.*

2. Any contract, agreement or other arrangement between a health maintenance organization and a provider that is entered into or renewed on or after ~~[October]~~ *January* 1, ~~[2001,]~~ *2026*, that does not specifically include a provision concerning the schedule for the payment of claims as required by subsection 1 shall be deemed to conform with the requirements of subsection 1 by operation of law.

Sec. 14. NRS 695D.215 is hereby amended to read as follows:

695D.215 1. Except as otherwise provided in subsection ~~[2,]~~ *3*, an organization for dental care shall approve or deny a claim relating to a plan for dental care *and, if the organization for dental care:*

(a) Approves the claim, pay the claim within [30] :

(1) Twenty-one days after the organization for dental care receives the claim ~~[. If the claim is approved, the organization for dental care shall pay the claim within 30 days after it is approved. If], if the claim is submitted electronically; or~~

(2) Thirty days after the organization for dental care receives the claim, if the claim is not submitted electronically.

(b) Denies the claim, notify the claimant in writing of the denial within 21 days after the organization for dental care receives the claim, if the claim was submitted electronically, or 30 days after the organization for dental care receives the claim, if the claim was not submitted electronically. The notice must include, without limitation:

(1) All reasons for denying the claim, including, without limitation, the specific facts and provisions of the plan relied upon by the organization for dental care as a basis to deny the claim;

(2) The criteria by which the organization for dental care determines whether to approve or deny the claim and a description



of the manner in which the organization for dental care applied those criteria to the claim; and

(3) A summary of any applicable process established pursuant to NRS 687B.820 for challenging the denial of the claim.

2. Except as otherwise provided in this section, if the approved claim is not paid within ~~that~~ the period ~~specified by subsection 1,~~ the organization for dental care shall pay interest on the claim at the rate of ~~interest established pursuant to NRS 99.040,~~ 10 percent per annum. The interest must be calculated from the date the payment of the claim is due pursuant to subsection 1 until the claim is paid.

~~2.~~ 3. If the organization for dental care 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 working days after it receives the claim. The organization for dental care shall notify the ~~provider of dental care~~ claimant of the reason for the delay in approving or denying the claim. The organization for dental care shall approve or deny the claim and, if the organization for dental care:

(a) Approves the claim, pay the claim within ~~30~~ :

(1) Twenty-one days after receiving the additional information, if the information is submitted electronically; or

(2) Thirty days after receiving the additional information ~~. If the claim is approved, the organization for dental care shall pay the claim within 30 days after it receives the additional information.~~, if the information is not submitted electronically.

(b) Denies the claim, provide notice of the denial in the manner prescribed in paragraph (b) of subsection 1 within 21 days after receiving the additional information, if the information is submitted electronically, or 30 days after receiving the additional information, if the information is not received electronically.

4. If ~~the approved~~ a claim approved pursuant to subsection 3 is not paid within ~~that~~ the period ~~specified in that subsection,~~ the organization for dental care shall pay interest on the claim in the manner prescribed in subsection ~~1.~~ 2.

5. An organization for dental care shall not:

(a) Deny a claim without a reasonable basis for the denial.

(b) Request a claimant to resubmit information that the claimant has already provided to the organization for dental care, unless the organization for dental care 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.



6. *An organization for dental care shall not pay only part of a claim that has been approved and is fully payable.*

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

8. *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 organization for dental care.*

9. *The Commissioner may require an organization for dental care to provide evidence which demonstrates that the organization for dental care has substantially complied with the requirements set forth in this section, including, without limitation, payment within the time periods specified by this section of at least 95 percent of approved claims or at least 90 percent of the total dollar amount for approved claims.*

10. *If the Commissioner determines that an organization for dental care is not in substantial compliance with the requirements set forth in this section or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim, the Commissioner may require the organization for dental care to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that an organization for dental care is not in substantial compliance with the requirements set forth in this section or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim, the Commissioner may suspend or revoke the certificate of authority of the organization for dental care.*

11. *On or before February 1 of each year, an organization for dental care shall submit to the Commissioner a report concerning the compliance of the organization for dental care with the requirements of this section during the immediately preceding calendar year. The report must include, without limitation:*

(a) *The number of claims for which the organization for dental care failed to comply with the requirements of subsections 1 and 3 during the immediately preceding calendar year; and*

(b) *The total amount of interest paid by the organization for dental care pursuant to subsections 2 and 4 during the immediately preceding calendar year.*



Sec. 15. Chapter 695F of NRS is hereby amended by adding thereto a new section to read as follows:

1. If a prepaid limited health service organization denies a claim, the prepaid limited health service organization shall notify the claimant in writing of the denial within:

(a) Twenty-one days after the prepaid limited health service organization receives all information necessary to make a determination concerning the claim, if the information is submitted electronically; or

(b) Thirty days after the prepaid limited health organization receives all information necessary to make a determination concerning the claim, if the information is not submitted electronically.

2. The notice required pursuant to subsection 1 must include, without limitation:

(a) All reasons for denying the claim, including, without limitation, the specific facts and provisions of the evidence of coverage relied upon by the prepaid limited health organization as a basis to deny the claim;

(b) The criteria by which the prepaid limited health service organization determines whether to approve or deny the claim and a description of the manner in which the prepaid limited health service organization applied those criteria to the claim; and

(c) A summary of any applicable process established pursuant to NRS 687B.820 for challenging the denial of the claim.

Sec. 16. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 2 and NRS 439B.754, a managed care organization shall approve or deny a claim within 21 days after the managed care organization receives the claim, if the claim is submitted electronically, or 30 days after the managed care organization receives the claim, if the claim is not submitted electronically. If the claim is approved, the managed care organization shall also pay the claim within that period. Except as otherwise provided in this section, if the approved claim is not paid within that period, the managed care organization shall pay interest on the claim at a rate of 10 percent per annum. The interest must be calculated from the date on which payment of the claim is due pursuant to this subsection until the date on which the claim is paid.

2. If the managed care 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 working days after it receives the claim. The managed care organization shall notify the claimant of all the specific reasons for the delay in approving or denying the claim. The managed care organization shall approve or deny the claim within 21 days after receiving the additional information, if the additional information is submitted electronically, or 30 days after receiving the additional information, if the additional information is not submitted electronically. If the claim is approved, the managed care organization shall also pay the claim within that period. If the approved claim is not paid within that period, the managed care organization shall pay interest on the claim in the manner prescribed in subsection 1.

3. A managed care organization shall not:

(a) Deny a claim without a reasonable basis for the denial.

(b) Request a claimant to resubmit information that the claimant has already provided to the managed care organization, unless the managed care 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 managed care 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 managed care organization.

7. The Commissioner may require a managed care organization to provide evidence which demonstrates that the managed care organization has substantially complied with the requirements set forth in this section, including, without limitation, payment within the time periods specified by this section 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 managed care organization is not in substantial compliance with the requirements set forth in this section or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim, the Commissioner may require the managed care organization to pay an administrative fine in an amount to be determined by the Commissioner. Upon a second or subsequent determination that a managed care organization is not



in substantial compliance with the requirements set forth in this section or has failed to approve or deny a claim or pay an approved claim within 60 working days after receiving the claim, the Commissioner may suspend or revoke the certificate of authority of the managed care organization.

9. On or before February 1 of each year, a managed care organization shall submit to the Commissioner a report concerning the compliance of the managed care organization with the requirements of this section during the immediately preceding calendar year. The report must include, without limitation:

(a) The number of claims for which the managed care organization failed to comply with the requirements of subsections 1 and 2 during the immediately preceding calendar year; and

(b) The total amount of interest paid by the managed care organization pursuant to subsections 1 and 2 during the immediately preceding calendar year.

Sec. 17. (Deleted by amendment.)

Sec. 17.5. 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.127, 695G.1639, 695G.164, 695G.1645, 695G.167 and 695G.200 to 695G.230, inclusive, *and section 16 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.

4. The provisions of NRS 695C.1735 , ~~and~~ 695G.1639 *and 695G.230 and section 16 of this act* do not apply to a managed care



organization that provides health care services to members of the Public Employees' Benefits Program.

5. Subsections 3 and 4 do not exempt a managed care organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 18. NRS 695G.230 is hereby amended to read as follows:

695G.230 1. After approval by the Commissioner, each health carrier shall provide a written notice to an insured, in clear and comprehensible language that is understandable to an ordinary layperson, explaining the right of the insured to file a written complaint and to obtain an expedited review pursuant to NRS 695G.210. Such a notice must be provided to an insured:

(a) At the time the insured receives his or her certificate of coverage or evidence of coverage;

(b) Any time that the health carrier denies coverage of a health care service or limits coverage of a health care service to an insured; and

(c) Any other time deemed necessary by the Commissioner.

2. If a health carrier denies coverage of a health care service to an insured, including, without limitation, a ~~health-maintenance~~ *managed care* organization that denies a claim related to a health care plan pursuant to ~~[NRS-695C-185.]~~ *section 16 of this act*, it shall notify the insured *and, if applicable, the provider of health care who submitted the claim,* in writing within :

(a) *Twenty-one days after the health carrier receives all information necessary to make a determination concerning the claim, if the information is submitted electronically;*

(b) *Thirty days after the health carrier receives all information necessary to make a determination concerning the claim, if the information is not submitted electronically; or*

(c) *If no claim is received, within 10 working days after ~~it~~ the health carrier denies coverage of the health care service . ~~of~~*

3. *The notice required pursuant to subsection 2 must include, without limitation:*

(a) ~~[The reason]~~ *All reasons* for denying coverage of the service ~~[;]~~, *including, without limitation, the specific facts and provisions of the plan relied upon by the health carrier as a basis to deny coverage of the service;*

(b) The criteria by which the health carrier or insurer determines whether to authorize or deny coverage of the health care service ~~[;]~~ *and a description of the manner in which the health carrier applied those criteria to the health care service;*



(c) *A summary of any applicable process established pursuant to NRS 687B.820 for challenging the denial of the claim;*

(d) The right of the insured to:

(1) File a written complaint and the procedure for filing such a complaint;

(2) Appeal an adverse determination pursuant to NRS 695G.241 to 695G.310, inclusive;

(3) Receive an expedited external review of an adverse determination if the health carrier receives proof from the insured's provider of health care that failure to proceed in an expedited manner may jeopardize the life or health of the insured, including notification of the procedure for requesting the expedited external review; and

(4) Receive assistance from any person, including an attorney, for an external review of an adverse determination; and

~~[(d)]~~ (e) The telephone number of the Office for Consumer Health Assistance.

~~[(3)]~~ 4. A written notice which is approved by the Commissioner *pursuant to subsection 1* shall be deemed to be in clear and comprehensible language that is understandable to an ordinary layperson.

5. *If a health carrier denies a claim submitted by a provider of health care, the health carrier shall notify the provider of health care in writing of the denial within:*

(a) *Twenty-one days after the health carrier receives all information necessary to make a determination concerning the claim, if the information is submitted electronically; or*

(b) *Thirty days after the health carrier receives all information necessary to make a determination concerning the claim, if the information is not submitted electronically.*

6. *The notice required pursuant to subsection 5 must include, without limitation:*

(a) *All reasons for denying the claim, including, without limitation, the specific facts and provisions of the plan relied upon by the health carrier as a basis to deny coverage of the service;*

(b) *The criteria by which the health carrier determines whether to approve or deny the claim and a description of the manner in which the health carrier applied those criteria to the claim; and*

(c) *A summary of any applicable process established pursuant to NRS 687B.820 for challenging the denial of the claim.*



Sec. 18.5. 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 439.581 to 439.597, inclusive, 686A.135, 687B.352, 687B.409, 687B.692, 687B.723, 687B.725, 687B.805, 689B.0353, ~~689B.255,~~ 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.1675, 695G.170 to 695G.1712, inclusive, 695G.1714 to 695G.174, inclusive, 695G.176, 695G.177, 695G.200 ~~to 695G.230, inclusive~~ , **695G.210, 695G.220**, 695G.241 to 695G.310, inclusive, 695G.405 and 695G.415, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Secs. 19-22. (Deleted by amendment.)

Sec. 23. 1. The amendatory provisions of this act do not supersede the provisions of any contract entered into or policy issued before January 1, 2026, but apply to any renewal of such a contract or policy.

2. The amendatory provisions of this act do not apply to any claim under a policy of health insurance or other program that provides health coverage submitted before January 1, 2026, but, except as otherwise provided in subsection 1, apply to such claims submitted on or after that date.

Sec. 24. (Deleted by amendment.)

Sec. 25. NRS 695C.128 are 695C.185 are hereby repealed.

Sec. 26. This act becomes effective on January 1, 2026.



