Assembly Bill No. 463–Assemblymember Backus

CHAPTER.....

AN ACT relating to insurance; requiring certain health insurers to respond to requests for prior authorization for medical or dental care within a certain amount of time; prohibiting certain insurers from requiring prior authorization for certain types of medical care; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law authorizes certain health insurers to require prior authorization before an insured may receive coverage for medical and dental care in certain circumstances. If an insurer requires prior authorization, existing law requires the insurer to: (1) file its procedure for obtaining prior authorization with the Commissioner of Insurance for approval; and (2) respond to a request for prior authorization within 20 days after receiving the request. (NRS 687B.225) **Sections 27 and 45** of this bill require private insurers and insurers providing coverage for recipients of Medicaid and the Children's Health Insurance Program, respectively, to respond to a request for prior authorization within 2 business days after receiving the request, unless certain nationally recognized operating rules governing prior authorization would allow the insurer to have additional time to respond to the particular request. In such a case, **sections 27 and 45** authorize an insurer to respond to the request within the period of time prescribed by the operating rules, unless doing so would result in the insurer responding to the request more than 7 calendar days after receiving the request.

Sections 19 and 48 of this bill prohibit insurers from requiring an insured to obtain prior authorization for: (1) certain preventive care services; (2) hospice care provided to pediatric patients; and (3) care provided to treat neonatal abstinence syndrome. **Section 19** additionally prohibits insurers, other than those covering recipients of Medicaid or the Children's Health Insurance Program, from requiring prior authorization for: (1) outpatient services for the treatment of substance use disorder; and (2) the prescription of test strips for measuring blood glucose in persons with diabetes. **Section 27** makes conforming changes to clarify that a private insurer may not require prior authorization where prohibited by **section 19**.

Sections 4-15 and 35-42 of this bill define certain terms relating to the process of obtaining and processing requests for prior authorization, and **sections 2 and 34** of this bill establish the applicability of those definitions. **Section 23** of this bill provides that if a private insurer violates any provision of **section 19 or 27** with respect to a particular request for prior authorization, that the request is deemed approved.

Section 28 of this bill requires a nonprofit hospital and medical or dental service corporation to comply with **sections 2-26** of this bill. **Section 29** of this bill requires the Director of the Department to administer the provisions of **sections 33-52** of this bill in the same manner as other provisions governing Medicaid. **Section 56** of this bill requires plans of self-insurance for private employers, respectively, to comply with the requirements of **sections 19 and 27** to the extent applicable. **Section 15.5** of this bill provides that a health maintenance organization or other managed care organization that provides services to recipients of Medicaid or the Children's Health Insurance Program or members of the Public Employees' Benefits Program, or a utilization review organization that conducts utilization reviews for such entities, is not subject to **sections 2-27**.

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:

Section 1. Chapter 687B of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 26, inclusive, of this act.

Sec. 2. ***As used in NRS 687B.225 and sections 2 to 26, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 16, inclusive, of this act have the meanings ascribed to them in those sections.***

Secs. 3-6. (Deleted by amendment.)

Sec. 7. ***"Health carrier" has the meaning ascribed to it in NRS 695G.024, and includes, without limitation, an organization for dental care. The term additionally includes a utilization review organization, as defined in NRS 695G.085, while acting in its capacity as a utilization review organization for a health carrier.***

Sec. 8. (Deleted by amendment.)

Sec. 9. ***"Insured" means a policyholder, subscriber, enrollee or other person covered by a health carrier.***

Sec. 10. (Deleted by amendment.)

Sec. 11. ***"Medically necessary" has the meaning ascribed to it in NRS 695G.055.***

Secs. 12 and 13. (Deleted by amendment.)

Sec. 14. ***"Prior authorization" means:***

1. Any process by which a health carrier determines, before medical care or dental care that is otherwise covered by the health carrier is provided to an insured, that the medical care or dental care is medically necessary or medically appropriate with respect to the particular insured; or

2. Any requirement that an insured or a provider of health care of the insured notify the health carrier before medical or dental care is provided to the insured.

Sec. 15. ***"Provider of health care" has the meaning ascribed to it in NRS 695G.070.***

Sec. 15.5. ***The provisions of NRS 687B.225 and sections 2 to 26, inclusive, of this act, do not apply to:***

1. A health maintenance organization or other managed care organization that enters into a contract with the Department of Health and Human Services or the Division of Health Care Financing and Policy of the Department pursuant to NRS 422.273 to provide health care services to recipients of Medicaid under the

State Plan for Medicaid or insurance under the Children's Health Insurance Program to the extent that the organization is providing such services.

2. A managed care organization that provides health care services to members of the Public Employees' Benefits Program or utilization review organization that conducts utilization reviews for a managed care organization that provides health care services to members of the Public Employees' Benefits Program while the utilization review organization is providing such services.

3. A utilization review organization that conducts utilization reviews for an entity described in subsection 1, while the utilization review organization is providing such services.

Secs. 16-18. (Deleted by amendment.)

Sec. 19. ***1. A health carrier shall not require prior authorization for:***

(a) Outpatient services for the treatment of a substance use disorder.

(b) Evidence-based goods or services for preventive care that have in effect a grade of "A" or "B" identified by the United States Preventive Services Task Force.

(c) Preventive care for women described in 45 C.F.R. § 147.130(a)(1)(iv).

(d) Hospice care provided to pediatric patients in a facility for hospice care licensed pursuant to chapter 449 of NRS.

(e) Care provided to treat neonatal abstinence syndrome provided by a provider of health care who specializes in pain management for pediatric patients or palliative care provided to pediatric patients.

(f) The prescription of test strips for measuring blood glucose in persons with diabetes.

2. As used in this section:

(a) "Facility for hospice care" has the meaning ascribed to it in NRS 449.0033.

(b) "Hospice care" has the meaning ascribed to it in NRS 449.0115.

Secs. 20-22. (Deleted by amendment.)

Sec. 23. ***If a health carrier violates NRS 687B.225 or section 19 of this act with respect to a particular request for prior authorization, the request shall be deemed approved.***

Secs. 24-26. (Deleted by amendment.)

Sec. 27. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0412, 689A.0413, 689A.0418, 689A.0437,

689A.044, 689A.0445, 689A.0459, 689B.031, 689B.0312, 689B.0313, 689B.0315, 689B.0317, 689B.0319, 689B.0374, 689B.0378, 689C.1665, 689C.1671, 689C.1675, 689C.1676, 695A.1843, 695A.1856, 695A.1865, 695A.1874, 695B.1912, 695B.1913, 695B.1914, 695B.1919, 695B.19197, 695B.1924, 695B.1925, 695B.1942, 695C.1696, 695C.1699, 695C.1713, 695C.1735, 695C.1737, 695C.1743, 695C.1745, 695C.1751, 695G.170, 695G.1705, 695G.171, 695G.1714, 695G.1715, 695G.1719 and 695G.177, ***and section 19 of this act,*** any contract ~~[for group, blanket or individual health]~~ ***or policy of*** insurance ~~[or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care]~~ ***issued by a health carrier*** which provides for payment of a certain part of medical or dental care may require the insured ~~[or member]~~ to obtain prior authorization for that care from the ~~[insurer or organization. The insurer or organization]~~ ***health carrier. The health carrier*** shall:

(a) File its procedure for obtaining ~~[approval of care]~~ ***prior authorization*** pursuant to this section for approval by the Commissioner; and

(b) Unless a shorter time period is prescribed by a specific statute, including, without limitation, NRS 689A.0446, 689B.0361, 689C.1688, 695A.1859, 695B.19087, 695C.16932 and 695G.1703, ***and except as otherwise provided by subsection 2,*** respond to any request for ~~[approval]~~ ***prior authorization*** by the insured ~~[or member]~~ pursuant to this section within ~~[20]~~ ***:***

(1) Two business days after it receives the request ~~[.]~~ ***; or***

(2) If the Prior Authorization and Referrals Operating Rules prescribed by the Committee on Operating Rules for Information Exchange of the Council for Affordable Quality Healthcare, or its successor organization, would allow the health carrier more than 2 business days to respond to a particular request for prior authorization after receiving the request, the time period prescribed by the Rules.

2. ***Notwithstanding any time period prescribed by the Rules described in subparagraph (2) of paragraph (b) of subsection 1, a health carrier shall respond to a request for prior authorization within 7 calendar days after receiving the request.***

3. The Commissioner, in collaboration with the Department of Health and Human Services, shall review each revision to the Rules described in subparagraph (2) of paragraph (b) of subsection 1 to ensure their suitability for this State. If the Commissioner determines that a revision is not suitable for this State, the Commissioner shall give notice within 30 days after the

hearing that the revisions are not suitable for this State. If the Commissioner gives such notice, a health carrier shall respond to any request for prior authorization that is submitted to the health carrier after the date on which such notice is given within 2 business days after receiving the request.

4. The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

Sec. 28. NRS 695B.320 is hereby amended to read as follows:

695B.320 1. Nonprofit hospital and medical or dental service corporations are subject to the provisions of this chapter, and to the provisions of chapters 679A and 679B of NRS, subsections 2, 4, 17, 18 and 30 of NRS 680B.010, NRS 680B.025 to 680B.060, inclusive, chapter 681B of NRS, NRS 686A.010 to 686A.315, inclusive, 686B.010 to 686B.175, inclusive, 687B.010 to 687B.040, inclusive, 687B.070 to 687B.140, inclusive, 687B.150, 687B.160, 687B.180, 687B.200 to 687B.255, inclusive, ***and sections 2 to 26, inclusive, of this act,*** 687B.270, 687B.310 to 687B.380, inclusive, 687B.410, 687B.420, 687B.430, 687B.500 and chapters 692B, 692C, 693A and 696B of NRS, to the extent applicable and not in conflict with the express provisions of this chapter.

2. For the purposes of this section and the provisions set forth in subsection 1, a nonprofit hospital and medical or dental service corporation is included in the meaning of the term "insurer."

Sec. 29. NRS 232.320 is hereby amended to read as follows:

232.320 1. The Director:

(a) Shall appoint, with the consent of the Governor, administrators of the divisions of the Department, who are respectively designated as follows:

(1) The Administrator of the Aging and Disability Services Division;

(2) The Administrator of the Division of Welfare and Supportive Services;

(3) The Administrator of the Division of Child and Family Services;

(4) The Administrator of the Division of Health Care Financing and Policy; and

(5) The Administrator of the Division of Public and Behavioral Health.

(b) Shall administer, through the divisions of the Department, the provisions of chapters 63, 424, 425, 427A, 432A to 442, inclusive, 446 to 450, inclusive, 458A and 656A of NRS, NRS 127.220 to 127.310, inclusive, 422.001 to 422.410, inclusive, ***and***

sections 33 to 54, inclusive, of this act, 422.580, 432.010 to 432.133, inclusive, 432B.6201 to 432B.626, inclusive, 444.002 to 444.430, inclusive, and 445A.010 to 445A.055, inclusive, and all other provisions of law relating to the functions of the divisions of the Department, but is not responsible for the clinical activities of the Division of Public and Behavioral Health or the professional line activities of the other divisions.

(c) Shall administer any state program for persons with developmental disabilities established pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. §§ 15001 et seq.

(d) Shall, after considering advice from agencies of local governments and nonprofit organizations which provide social services, adopt a master plan for the provision of human services in this State. The Director shall revise the plan biennially and deliver a copy of the plan to the Governor and the Legislature at the beginning of each regular session. The plan must:

(1) Identify and assess the plans and programs of the Department for the provision of human services, and any duplication of those services by federal, state and local agencies;

(2) Set forth priorities for the provision of those services;

(3) Provide for communication and the coordination of those services among nonprofit organizations, agencies of local government, the State and the Federal Government;

(4) Identify the sources of funding for services provided by the Department and the allocation of that funding;

(5) Set forth sufficient information to assist the Department in providing those services and in the planning and budgeting for the future provision of those services; and

(6) Contain any other information necessary for the Department to communicate effectively with the Federal Government concerning demographic trends, formulas for the distribution of federal money and any need for the modification of programs administered by the Department.

(e) May, by regulation, require nonprofit organizations and state and local governmental agencies to provide information regarding the programs of those organizations and agencies, excluding detailed information relating to their budgets and payrolls, which the Director deems necessary for the performance of the duties imposed upon him or her pursuant to this section.

(f) Has such other powers and duties as are provided by law.

2. Notwithstanding any other provision of law, the Director, or the Director's designee, is responsible for appointing and removing subordinate officers and employees of the Department.

Secs. 30 and 31. (Deleted by amendment.)

Sec. 32. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 33 to 54, inclusive, of this act.

Sec. 33. (Deleted by amendment.)

Sec. 34. ***As used in sections 34 to 54, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 35 to 43, inclusive, of this act have the meanings ascribed to them in those sections.***

Secs. 35-39. (Deleted by amendment.)

Sec. 39.5. ***"Medicaid managed care entity" means:***

1. A health maintenance organization or other managed care organization that enters into a contract with the Department or the Division pursuant to NRS 422.273 to provide health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program; or

2. A utilization review organization, as defined in NRS 695G.085, that conducts utilization reviews for the Department or a health maintenance organization or managed care organization described in subsection 1 with respect to Medicaid or the Children's Health Insurance Program, while acting in its capacity as a utilization review organization for the Department or the health maintenance organization or managed care organization.

Secs. 40 and 41. (Deleted by amendment.)

Sec. 42. ***"Recipient" means a natural person who receives benefits through Medicaid or the Children's Health Insurance Program, as applicable.***

Secs. 43 and 44. (Deleted by amendment.)

Sec. 45. ***1. Unless a shorter time period is prescribed by a specific statute, and except as otherwise provided in subsection 2, the Department or a Medicaid managed care entity, with respect to Medicaid and the Children's Health Insurance Program, shall respond to a request for prior authorization submitted by or on behalf of a recipient within:***

(a) Two business days after receiving the request; or

(b) If the Prior Authorization and Referrals Operating Rules prescribed by the Committee on Operating Rules for Information Exchange of the Council for Affordable Quality Healthcare, or its successor organization, would allow the Department or Medicaid managed care entity more than 2 business days to respond to a

particular request for prior authorization after receiving the request, the period of time prescribed by the Rules.

2. Notwithstanding any period of time prescribed by the Rules described in paragraph (b) of subsection 1, the Department or a Medicaid managed care entity shall respond to a request for prior authorization within 7 calendar days after receiving the request.

3. The Department, in collaboration with the Commissioner of Insurance, shall review each revision to the Rules described in paragraph (b) of subsection 1 to ensure their suitability for Medicaid coverage in this State. If the Department determines that a revision is not suitable for Medicaid coverage in this State, the Department shall give notice within 30 days after the hearing that the revisions are not suitable for Medicaid coverage in this State. If the Department gives such notice, the Department or a Medicaid managed care entity shall respond to any request for prior authorization that is submitted to the Department or Medicaid managed care entity, as applicable, after the date on which such notice is given within 2 business days after receiving the request.

Secs. 46 and 47. (Deleted by amendment.)

Sec. 48. ***1. The Department or a Medicaid managed care entity, with respect to Medicaid and the Children's Health Insurance Program, shall not require prior authorization for:***

(a) Evidence-based goods or services for preventive care that have in effect a grade of "A" or "B" identified by the United States Preventive Services Task Force.

(b) Preventive care for women described in 45 C.F.R. § 147.130(a)(iv).

(c) Hospice care provided to pediatric patients in a facility for hospice care licensed pursuant to chapter 449 of NRS.

(d) Care provided to treat neonatal abstinence syndrome provided by a provider of health care who specializes in pain management for pediatric patients or palliative care provided to pediatric patients.

2. As used in this section:

(a) "Facility for hospice care" has the meaning ascribed to it in NRS 449.0033.

(b) "Hospice care" has the meaning ascribed to it in NRS 449.0115.

(c) "Provider of health care" means a person who participates in the State Plan for Medicaid or the Children's Health Insurance Program as a provider of goods or services.

Secs. 49-51. (Deleted by amendment.)

Sec. 52. ***Nothing in sections 44 to 51, inclusive, of this act shall be construed to require the Department or a Medicaid managed care entity to provide coverage:***

1. For medical or dental care that, regardless of whether such care is medically necessary, would not be a covered benefit under the terms and conditions of Medicaid or the Children's Health Insurance Program, as applicable; or

2. To a person who is not a recipient or is not otherwise eligible to receive coverage under Medicaid or the Children's Health Insurance Program, as applicable, on the date on which medical or dental care is provided to the person.

Secs. 53-55. (Deleted by amendment.)

Sec. 56. NRS 608.1555 is hereby amended to read as follows:

608.1555 Any employer who provides benefits for health care to his or her employees shall provide the same benefits and pay providers of health care in the same manner as a policy of insurance pursuant to chapters 689A and 689B of NRS, including, without limitation, as required by ***paragraph (b) of subsection 1 of NRS 687B.225, subsections 2, 3 and 4 of NRS 687B.225,*** NRS 687B.409, 687B.723 and 687B.725 ~~[.]~~ ***and sections 2 to 26, inclusive, of this act.***

Sec. 57. 1. The amendatory provisions of this act do not apply to a request for prior authorization submitted:

(a) Under a contract or policy of health insurance issued before January 1, 2026, but apply to any request for prior authorization submitted under any renewal of such a contract or policy.

(b) To the Department of Health and Human Services or a Medicaid managed care entity before January 1, 2026, for medical or dental care provided to a recipient of Medicaid.

2. A health carrier must, in order to continue requiring prior authorization in contracts or policies of health insurance issued or renewed after January 1, 2026:

(a) Develop a procedure for obtaining prior authorization that complies with NRS 687B.225, as amended by section 27 of this act, and sections 2 to 26, inclusive, of this act; and

(b) Obtain the approval of the Commissioner of Insurance pursuant to NRS 687B.225, as amended by section 27 of this act, for the procedure developed pursuant to paragraph (a).

3. As used in this section:

(a) "Health carrier" has the meaning ascribed to it in section 7 of this act.

(b) "Medicaid managed care entity" has the meaning ascribed to it in section 39.5 of this act.

Secs. 58 and 59. (Deleted by amendment.)

Sec. 60. 1. This section and section 57 of this act become effective upon passage and approval.

2. Sections 1 to 56, inclusive, 58 and 59 of this act become effective:

(a) Upon passage and approval for the purposes of adopting any regulations, performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act and approving procedures for obtaining prior authorization pursuant to NRS 687B.225, as amended by section 27 of this act, and section 57 of this act; and

(b) On January 1, 2026, for all other purposes.

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