Assembly Bill No. 425–Committee
on Commerce and Labor

CHAPTER.....

AN ACT relating to insurance; establishing certification provisions for certain enrollment facilitators by the Commissioner of Insurance; revising provisions relating to federal law and to conform with federal law; revising provisions relating to the general tax on insurance premiums; revising provisions relating to public inspection of information filed with the Commissioner; revising provisions relating to dental insurance; revising provisions relating to certain policies of health insurance and health care plans that provide coverage for the treatment of cancer through the use of chemotherapy; providing a penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Sections 1-26 of this bill establish certification provisions for exchange enrollment facilitators, who will be certified by the Commissioner of Insurance and appointed as navigators or assisters by the Silver State Health Insurance Exchange as part of the requirement that the Exchange implement a state-based health insurance exchange pursuant to the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152. (NRS 695I.210) **Section 119** of this bill repeals numerous sections of the Nevada Insurance Code (Title 57 of NRS) to conform to the federal acts, and **sections 27-118** of this bill generally make conforming changes based on the federal acts and on the repeal of those sections of NRS.

Section 31.5 of this bill revises a credit which may be used against an insurer's liability for the general tax on insurance premiums imposed pursuant to NRS 680B.027. **Sections 32.1 and 32.8** of this bill revise provisions relating to contracts for coverage for dental care which are sold to small employers. **Section 32.5** of this bill limits, for specified periods, public inspection of certain information filed with the Commissioner of Insurance.

Senate Bill No. 266 of this session establishes various provisions governing certain health care plans that provide coverage for the treatment of cancer through the use of chemotherapy. Sections 1, 3-5, 8 and 9 of Senate Bill No. 266 of this session prohibit those health care plans from requiring a copayment, deductible or coinsurance amount for orally administered chemotherapy in a combined amount that is more than $100 per prescription. **Sections 118.1 to 118.6** of this bill amend the corresponding provisions of Senate Bill No. 266 of this session to provide that the limit on the amount of the deductible that may be required does not apply if the plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the plan's annual deductible has not been satisfied.

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. Title 57 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 2 to 26, inclusive, of this act.

Sec. 2. ***As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 2.5 to 7, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 2.5. ***"Appointment" means a contract, agreement or other arrangement under which a person may act on behalf of the Exchange as an assister, navigator or any other designation authorized or required by the Federal Act.***

Sec. 3. ***"Assister" has the meaning ascribed to it by regulations adopted by the Board of Directors of the Exchange pursuant to NRS 695I.370.***

Sec. 4. ***"Exchange" means the Silver State Health Insurance Exchange established by NRS 695I.200.***

Sec. 5. ***"Exchange enrollment facilitator" means a person certified pursuant to this chapter who is engaged in the business of facilitating enrollment in qualified health plans offered by the Exchange.***

Sec. 6. ***"Navigator" means a person or entity that meets the requirements of 45 C.F.R. § 155.210 and any other requirements of the Exchange.***

Sec. 7. ***"Qualified health plan" has the meaning ascribed to it in NRS 695I.080.***

Sec. 8. ***1. The provisions of NRS 683A.341 and 683A.351 apply to exchange enrollment facilitators.***

2. For the purposes of subsection 1, unless the context requires that NRS 683A.341 or 683A.351 apply only to producers of insurance or insurers, any reference in those sections to "producer of insurance" or "insurer" must be replaced by a reference to "exchange enrollment facilitator."

Sec. 9. ***1. An applicant for an initial certificate as an exchange enrollment facilitator must:***

(a) Be a natural person of not less than 18 years of age;

(b) Apply on a form prescribed by the Commissioner;

(c) Pass a written examination established by the Commissioner by regulation;

(d) Successfully complete a course of instruction established by the Commissioner by regulation;

(e) Submit fingerprints as required pursuant to section 10 of this act; and

(f) Pay the nonrefundable:

(1) Application and certificate fee set forth in NRS 680B.010;

(2) Initial fee set forth in NRS 680C.110; and

(3) Additional fee of not more than $15 for the processing of the application established pursuant to section 25 of this act.

2. The additional fee for the processing of applications pursuant to subparagraph (3) of paragraph (f) of subsection 1 must be deposited in the Insurance Recovery Account created pursuant to NRS 679B.305.

Sec. 10. *1. The Commissioner shall prescribe the form for application for a certificate as an exchange enrollment facilitator. The form must require the applicant to declare, under penalty of refusal to issue, or suspension or revocation of, the certificate of the applicant, that the statements made in the application are true, correct and complete to the best of his or her knowledge and belief.*

2. Before approving an application, the Commissioner must find that the applicant:

(a) Meets the requirements of section 9 of this act.

(b) Has not committed any act that is a ground for refusal to issue, or suspension or revocation of a certificate pursuant to NRS 683A.451.

(c) Paid all applicable fees prescribed pursuant to section 9 of this act.

(d) Meets the requirements of subsections 3 and 5.

3. An applicant must, as part of his or her application and at the applicant's own expense:

(a) Arrange to have a complete set of his or her fingerprints taken by a law enforcement agency or other authorized entity acceptable to the Commissioner; and

(b) Submit to the Commissioner:

(1) A completed fingerprint card and written permission authorizing the Commissioner to submit the applicant's fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary; or

(2) Written verification, on a form prescribed by the Commissioner, stating that the fingerprints of the applicant were taken and directly forwarded electronically or by another means to the Central Repository and that the applicant has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary.

4. The Commissioner may:

(a) Unless the applicant's fingerprints are directly forwarded pursuant to subparagraph (2) of paragraph (b) of subsection 3, submit those fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Commissioner deems necessary;

(b) Request from each such agency any information regarding the applicant's background as the Commissioner deems necessary; and

(c) Adopt regulations concerning the procedures for obtaining the information described in paragraph (b).

5. The Commissioner may require from the applicant any document reasonably necessary to verify information contained in an application.

6. Except as otherwise provided in section 23 of this act, a certificate issued pursuant to this chapter is valid for 3 years after the date of issuance unless it is suspended, revoked or otherwise terminated.

Sec. 11. *1. A person taking the examination required pursuant to section 9 of this act must apply to the Commissioner to take the examination and pay a nonrefundable fee in an amount prescribed in the regulations adopted pursuant to section 25 of this act.*

2. A person who fails to appear for the examination as scheduled or fails to pass the examination must reapply for examination and pay the required fees in order to be scheduled for another examination.

Sec. 12. *1. A certificate may be renewed for an additional 3-year period by submitting to the Commissioner an application for renewal and:*

(a) If the application is made:

(1) On or before the expiration date of the certificate, all applicable renewal fees and an additional fee established by the

Commissioner of not more than $15 for deposit in the Insurance Recovery Account created pursuant to NRS 679B.305; or

(2) Except as otherwise provided in subsection 3:

(I) Not more than 30 days after the expiration date of the certificate, all applicable renewal fees plus any late fee required and an additional fee established by the Commissioner of not more than $15 for deposit in the Insurance Recovery Account created pursuant to NRS 679B.305; or

(II) More than 30 days but not more than 1 year after the expiration date of the certificate, all applicable renewal fees plus a penalty of twice all applicable renewal fees, except for any fee required pursuant to NRS 680C.110.

(b) Proof of the successful completion of appropriate courses of study required for renewal, as established by the Commissioner by regulation.

2. The fees specified in this section are not refundable.

3. An exchange enrollment facilitator who is unable to renew his or her certificate because of military service, extended medical disability or other extenuating circumstance may request a waiver of the time limit and of any fine or sanction otherwise required or imposed because of the failure to renew.

Sec. 13. *1. An applicant for the issuance or renewal of a certificate to act as an exchange enrollment facilitator shall submit to the Commissioner the statement prescribed by the Division of Welfare and Supportive Services of the Department of Health and Human Services pursuant to NRS 425.520. The statement must be completed and signed by the applicant.*

2. The Commissioner shall include the statement required pursuant to subsection 1 in:

(a) The application or any other forms that must be submitted for the issuance or renewal of the certificate; or

(b) A separate form prescribed by the Commissioner.

3. A certificate to act as an exchange enrollment facilitator may not be issued or renewed by the Commissioner if the applicant is a natural person who:

(a) Fails to submit the statement required pursuant to subsection 1; or

(b) Indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

4. If an applicant indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order, the Commissioner shall advise the applicant to contact the district attorney or other public agency enforcing the order to determine the actions that the applicant may take to satisfy the arrearage.

Sec. 14. *1. If the Commissioner receives a copy of a court order issued pursuant to NRS 425.540 that provides for the suspension of all professional, occupational and recreational licenses, certificates and permits issued to a person who is the holder of a certificate to act as an exchange enrollment facilitator, the Commissioner shall deem the certificate issued to that person to be suspended at the end of the 30th day after the date on which the court order was issued unless the Commissioner receives a letter issued to the holder of the certificate by the district attorney or other public agency pursuant to NRS 425.550 stating that the holder of the certificate has complied with the subpoena or warrant or has satisfied the arrearage pursuant to NRS 425.560.*

2. The Commissioner shall reinstate a certificate to act as an exchange enrollment facilitator that has been suspended by a district court pursuant to NRS 425.540 if the Commissioner receives a letter issued by the district attorney or other public agency pursuant to NRS 425.550 to the person whose certificate was suspended stating that the person whose certificate was suspended has complied with the subpoena or warrant or has satisfied the arrearage pursuant to NRS 425.560.

Sec. 15. *The application of a natural person who applies for the issuance or renewal of a certificate as an exchange enrollment facilitator must include the social security number of the applicant.*

Sec. 16. *1. A certificate issued pursuant to this chapter must state the certificate holder's name, address, personal identification number, the date of issuance and the date of expiration, and must contain any other information the Commissioner considers necessary. The certificate must be made available by the certificate holder for public inspection upon request.*

2. A certificate holder shall inform the Commissioner of all locations from which he or she conducts business and of each change of business or residence address, in writing or by other

means acceptable to the Commissioner, within 30 days after the date on which the change takes place. If a certificate holder changes his or her business or residence address without giving written notice and the Commissioner is unable to locate the certificate holder after diligent effort, the Commissioner may revoke the certificate without a hearing. The mailing of a letter by certified mail, return receipt requested, addressed to the certificate holder at his or her last mailing address appearing on the records of the Division, and the return of the letter undelivered, constitutes a diligent effort by the Commissioner.

Sec. 17. *1. If the Commissioner believes that a temporary certificate is necessary to carry on the business of facilitating selection of a qualified health plan, the Commissioner may issue a temporary certificate as an exchange enrollment facilitator for 180 days or less without requiring an examination to:*

(a) The surviving spouse, personal representative or guardian of an exchange enrollment facilitator who dies or becomes incompetent, to allow adequate time for the sale of the business, the recovery or return of the exchange enrollment facilitator, or the training and certification of new personnel to operate the business;

(b) A member or employee of a business organization appointed by the Exchange, upon the death or disability of the natural person designated in its application or certificate;

(c) The designee of an exchange enrollment facilitator entering active service in the Armed Forces of the United States; or

(d) A person in any other circumstance in which the Commissioner believes that the public interest will be best served by issuing the certificate.

2. The Commissioner may by order limit the authority of a person who holds a temporary certificate as the Commissioner believes necessary to protect persons insured and the public. The Commissioner may require the person who holds a temporary certificate to have a suitable sponsor who is an exchange enrollment facilitator and who assumes responsibility for all acts of the person who holds the temporary certificate, and may impose similar requirements to protect persons insured and the public. The Commissioner may order revocation of a temporary certificate if the interests of persons insured or the public are endangered. A temporary certificate expires when the owner or the personal representative or guardian of the owner disposes of the business.

Sec. 18. *An entity other than a natural person that is appointed by the Exchange must require that each natural person who is authorized to act for the entity be an exchange enrollment facilitator. Each exchange enrollment facilitator must be named in the partnership's or corporation's appointment.*

Sec. 19. *An exchange enrollment facilitator:*

1. May not concurrently hold a license as a producer of insurance, an insurance consultant or a surplus lines broker's license in any line.

2. Shall not:

(a) Sell, solicit or negotiate insurance;

(b) Receive any consideration, directly or indirectly, from any health insurance issuer or issuer of stop-loss insurance in connection with the enrollment of any individuals or employees in a qualified health plan or health insurance plan; or

(c) Employ, be employed by or be in partnership with, or receive any remuneration arising out of his or her activities as an exchange enrollment facilitator from, any licensed producer of insurance, insurance consultant or surplus lines broker or insurer.

Sec. 20. *An exchange enrollment facilitator is obligated under his or her certificate to:*

1. Serve with objectivity and complete loyalty the interests of his or her client; and

2. Render to his or her client information, counsel and service which, to the best of the exchange enrollment facilitator's knowledge, understanding and opinion, best serves the client's insurance needs and interests.

Sec. 21. *1. A nonresident who is an exchange enrollment facilitator shall appoint the Commissioner, in writing, as his or her registered agent upon whom may be served all legal process issued in connection with any action or proceeding brought or pending in this State against or involving the nonresident certificate holder and relating to transactions under his or her Nevada certificate. The appointment is irrevocable and remains in force so long as such an action or proceeding exists or may arise. Duplicate copies of process must be served upon the Commissioner, or other person in apparent charge of the Division during the Commissioner's absence, accompanied by payment of the fee for service of process. Promptly after any such service, the Commissioner shall forward a copy of the process by certified mail, return receipt requested, to the nonresident certificate holder at his or her business address of most recent record with the*

Division. Process so served and the copy so forwarded constitutes personal service upon the certificate holder for all purposes.

2. Each such nonresident certificate holder shall also file with the Commissioner a written agreement to appear before the Commissioner pursuant to notice of hearing, order to show cause or subpoena issued by the Commissioner and sent by certified mail to the certificate holder at his or her business address of most recent record with the Division, and that if the nonresident certificate holder fails to appear, the nonresident certificate holder thereby consents to any subsequent suspension, revocation or refusal to renew his or her certificate.

Sec. 22. *1. The Commissioner may place an exchange enrollment facilitator on probation, suspend his or her certificate for not more than 12 months, or revoke or refuse to renew his or her certificate, or may impose an administrative fine or take any combination of the foregoing actions, for one or more of the causes set forth in NRS 683A.451.*

2. The provisions of NRS 683A.461 also apply to an exchange enrollment facilitator.

Sec. 23. *1. Upon the suspension, limitation or revocation of the certificate of an exchange enrollment facilitator, the Commissioner shall immediately notify the certificate holder in person or by mail addressed to the certificate holder at his or her most recent address of record with the Division. Notice by mail is effective when mailed.*

2. Upon the suspension, limitation or revocation of the certificate of an exchange enrollment facilitator, the Commissioner shall immediately notify the Executive Director of the Exchange. Upon receipt of such notification, the Executive Director shall immediately terminate the certificate holder's appointment.

3. The Commissioner shall not again issue a certificate under this chapter to any natural person whose certificate has been revoked until at least 1 year after the revocation has become final, and thereafter not until the person again qualifies for a certificate under this chapter. A person whose certificate has been revoked twice is not eligible for any certificate under this title.

Sec. 24. *1. If an exchange enrollment facilitator fails to obtain an appointment by the Exchange within 30 days after the date on which the certificate was issued, the exchange enrollment facilitator's certificate expires and the exchange enrollment facilitator shall promptly deliver his or her certificate to the Commissioner.*

2. If the Exchange terminates an exchange enrollment facilitator's appointment, the exchange enrollment facilitator is prohibited from engaging in the business of an exchange enrollment facilitator under his or her certificate until such time as the exchange enrollment facilitator receives a new appointment by the Exchange. If the exchange enrollment facilitator does not obtain a new appointment by the Exchange within 30 days after the date the appointment was terminated, the exchange enrollment facilitator's certificate expires and the exchange enrollment facilitator shall promptly deliver his or her certificate to the Commissioner.

3. Except as otherwise provided in subsection 4, if the Exchange terminates the appointment of an entity other than a natural person:

(a) The appointments of exchange enrollment facilitators named on the entity's appointment also terminate; and

(b) The exchange enrollment facilitator is prohibited from engaging in the business of an exchange enrollment facilitator under his or her certificate until such time as the exchange enrollment facilitator receives a new appointment by the Exchange. If the exchange enrollment facilitator does not obtain a new appointment by the Exchange within 30 days after the date on which the appointment was terminated, the exchange enrollment facilitator's certificate expires and the exchange enrollment facilitator shall promptly deliver his or her certificate to the Commissioner.

4. The provisions of subsection 3 do not apply to any appointments the exchange enrollment facilitator may have individually or through an entity other than the terminated entity.

5. Upon the termination of an appointment for an entity or certificate holder, the Executive Director of the Exchange shall notify the Commissioner of the effective date of the termination and the grounds for termination.

Sec. 25. *1. The Commissioner shall adopt regulations:*

(a) For establishing and conducting an examination required by this chapter for the initial issuance and renewal of a certificate;

(b) For the establishment of a course of instruction as required by this chapter for the initial issuance and renewal of a certificate;

(c) Establishing the fee required by section 9 of this act for the processing of an application;

(d) Establishing the fee required by section 11 of this act for the administration of the examination; and

(e) For carrying out the provisions of this chapter.

2. The Commissioner may contract with a person to perform functions required by this chapter, including, without limitation:

(a) Administering examinations;

(b) Providing courses of instruction;

(c) Processing applications; and

(d) Collecting fees.

Sec. 26. ***1. No person may engage in the business of an exchange enrollment facilitator unless a certificate has been issued to the person by the Commissioner.***

2. A person who violates subsection 1 is subject to an administrative fine of not more than $1,000 for each act or violation.

Sec. 27. Chapter 679A of NRS is hereby amended by adding thereto the provisions set forth as sections 28, 28.5 and 29 of this act.

Sec. 28. ***"Federal Act" means the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, or regulations or guidance issued pursuant to, those acts.***

Sec. 28.5. ***"Grandfathered plan" means a health benefit plan that meets the requirements of 42 U.S.C. § 18011.***

Sec. 29. ***"Rating characteristic" means age, family composition, tobacco use or geographic rating area.***

Sec. 30. NRS 679A.020 is hereby amended to read as follows:

679A.020 As used in this Code, unless the context otherwise requires, the words and terms defined in NRS 679A.030 to 679A.130, inclusive, ***and sections 28, 28.5 and 29 of this act*** have the meanings ascribed to them in those sections.

Sec. 31. NRS 680B.010 is hereby amended to read as follows:

680B.010 The Commissioner shall collect in advance and receipt for, and persons so served must pay to the Commissioner, fees and miscellaneous charges as follows:

1. Insurer's certificate of authority:

(a) Filing initial application $2,450

(b) Issuance of certificate:

(1) For any one kind of insurance as defined in NRS 681A.010 to 681A.080, inclusive 283

(2) For two or more kinds of insurance as so defined 578

(3) For a reinsurer 2,450

(c) Each annual continuation of a certificate 2,450

(d) Reinstatement pursuant to NRS 680A.180, 50 percent of the annual continuation fee otherwise required.

(e) Registration of additional title pursuant to NRS 680A.240 ..... $50

(f) Annual renewal of the registration of additional title pursuant to NRS 680A.240 25

2. Charter documents, other than those filed with an application for a certificate of authority. Filing amendments to articles of incorporation, charter, bylaws, power of attorney and other constituent documents of the insurer, each document $10

3. Annual statement or report. For filing annual statement or report $25

4. Service of process:

(a) Filing of power of attorney $5

(b) Acceptance of service of process 30

5. Licenses, appointments and renewals for producers of insurance:

(a) Application and license $125

(b) Appointment fee for each insurer 15

(c) Triennial renewal of each license 125

(d) Temporary license 10

(e) Modification of an existing license 50

6. Surplus lines brokers:

(a) Application and license $125

(b) Triennial renewal of each license 125

7. Managing general agents' licenses, appointments and renewals:

(a) Application and license $125

(b) Appointment fee for each insurer 15

(c) Triennial renewal of each license 125

8. Adjusters' licenses and renewals:

(a) Independent and public adjusters:

(1) Application and license $125

(2) Triennial renewal of each license 125

(b) Associate adjusters:

(1) Application and license 125

(2) Triennial renewal of each license 125

9. Licenses and renewals for appraisers of physical damage to motor vehicles:

(a) Application and license $125

(b) Triennial renewal of each license 125

10. Additional title and property insurers pursuant to NRS 680A.240:
(a) Original registration $50
(b) Annual renewal 25
11. Insurance vending machines:
(a) Application and license, for each machine $125
(b) Triennial renewal of each license 125
12. Permit for solicitation for securities:
(a) Application for permit $100
(b) Extension of permit 50
13. Securities salespersons for domestic insurers:
(a) Application and license $25
(b) Annual renewal of license 15
14. Rating organizations:
(a) Application and license $500
(b) Annual renewal 500
15. Certificates and renewals for administrators licensed pursuant to chapter 683A of NRS:
(a) Application and certificate of registration $125
(b) Triennial renewal 125
16. For copies of the insurance laws of Nevada, a fee which is not less than the cost of producing the copies.
17. Certified copies of certificates of authority and licenses issued pursuant to the Code $10
18. For copies and amendments of documents on file in the Division, a reasonable charge fixed by the Commissioner, including charges for duplicating or amending the forms and for certifying the copies and affixing the official seal.
19. Letter of clearance for a producer of insurance or other licensee if requested by someone other than the licensee $10
20. Certificate of status as a producer of insurance or other licensee if requested by someone other than the licensee $10
21. Licenses, appointments and renewals for bail agents:
(a) Application and license $125
(b) Appointment for each surety insurer 15
(c) Triennial renewal of each license 125
22. Licenses and renewals for bail enforcement agents:
(a) Application and license $125

(b) Triennial renewal of each license..... $125
23. Licenses, appointments and renewals for general agents for bail:
(a) Application and license $125
(b) Initial appointment by each insurer..... 15
(c) Triennial renewal of each license..... 125
24. Licenses and renewals for bail solicitors:
(a) Application and license $125
(b) Triennial renewal of each license..... 125
25. Licenses and renewals for title agents and escrow officers:
(a) Application and license $125
(b) Triennial renewal of each license..... 125
(c) Appointment fee for each title insurer..... 15
(d) Change in name or location of business or in association..... 10
26. Certificate of authority and renewal for a seller of prepaid funeral contracts..... $125
27. Licenses and renewals for agents for prepaid funeral contracts:
(a) Application and license $125
(b) Triennial renewal of each license..... 125
28. Licenses, appointments and renewals for agents for fraternal benefit societies:
(a) Application and license $125
(b) Appointment for each insurer 15
(c) Triennial renewal of each license..... 125
29. Reinsurance intermediary broker or manager:
(a) Application and license $125
(b) Triennial renewal of each license..... 125
30. Agents for and sellers of prepaid burial contracts:
(a) Application and certificate or license..... $125
(b) Triennial renewal 125
31. Risk retention groups:
(a) Initial registration $250
(b) Each annual continuation of a certificate of registration 250
32. Required filing of forms:
(a) For rates and policies $25
(b) For riders and endorsements 10
33. Viatical settlements:
(a) Provider of viatical settlements:

(1) Application and license $1,000
(2) Annual renewal 1,000
(b) Broker of viatical settlements:
(1) Application and license 500
(2) Annual renewal 500
(c) Registration of producer of insurance acting as a viatical settlement broker 250
34. Insurance consultants:
(a) Application and license $125
(b) Triennial renewal 125
35. Licensee's association with or appointment or sponsorship by an organization:
(a) Initial appointment, association or sponsorship, for each organization $50
(b) Renewal of each association or sponsorship 50
(c) Annual renewal of appointment 15
36. Purchasing groups:
(a) Initial registration and review of an application $100
(b) Each annual continuation of registration 100
37. ***Exchange enrollment facilitators:***
(a) Application and certificate $125
(b) Triennial renewal of each certificate 125
(c) Temporary certificate 10
(d) Modification of an existing certificate 50
38. In addition to any other fee or charge, all applicable fees required of any person, including, without limitation, persons listed in this section, pursuant to NRS 680C.110.

Sec. 31.5. NRS 680B.050 is hereby amended to read as follows:

680B.050 1. Except as otherwise provided in this section, a domestic or foreign insurer ***, including, without limitation, an insurer that is exempt from federal taxation pursuant to 26 U.S.C. § 501(c)(29),*** which owns and substantially occupies and uses any building in this state as its home office or as a regional home office is entitled to the following credits against the tax otherwise imposed by NRS 680B.027:

(a) An amount equal to 50 percent of the aggregate amount of the tax as determined under NRS 680B.025 to 680B.039, inclusive; and

(b) An amount equal to the full amount of ad valorem taxes paid by the insurer during the calendar year next preceding the filing of the report required by NRS 680B.030, upon the home office or regional home office together with the land, as reasonably required

for the convenient use of the office, upon which the home office or regional home office is situated.

➥ These credits must not reduce the amount of tax payable to less than 20 percent of the tax otherwise payable by the insurer under NRS 680B.027.

2. As used in this section, a "regional home office" means an office of the insurer performing for an area covering two or more states, with a minimum of 25 employees on its office staff, the supervision, underwriting, issuing and servicing of the insurance business of the insurer.

3. The insurer shall, on or before March 15 of each year, furnish proof to the satisfaction of the Executive Director of the Department of Taxation, on forms furnished by or acceptable to the Executive Director, as to its entitlement to the tax reduction provided for in this section. A determination of the Executive Director of the Department of Taxation pursuant to this section is not binding upon the Commissioner for the purposes of NRS 682A.240.

4. An insurer is not entitled to the credits provided in this section unless:

(a) The insurer owned the property upon which the reduction is based for the entire year for which the reduction is claimed; and

(b) The insurer occupied at least 70 percent of the usable space in the building to transact insurance or the insurer is a general or limited partner and occupies 100 percent of its ownership interest in the building.

5. If two or more insurers under common ownership or management and control jointly own in equal interest, and jointly occupy and use such a home office or regional home office in this state for the conduct and administration of their respective insurance businesses as provided in this section, each of the insurers is entitled to the credits provided for by this section if otherwise qualified therefor under this section.

6. For the purposes of subsection 1, any insurer that is exempt from federal taxation pursuant to 26 U.S.C. § 501(c)(29) and is restricted or prohibited from purchasing or owning real property pursuant to a contract with the Federal Government, including any entity thereof, shall be deemed to own any portion of any real property that the insurer occupies. The provisions of this subsection expire upon the expiration, cancellation, repayment or any other termination of the contract restricting or prohibiting such purchase or ownership.

Sec. 32. NRS 680C.110 is hereby amended to read as follows:

680C.110 1. In addition to any other fee or charge, the Commissioner shall collect in advance and receipt for, and persons so served must pay to the Commissioner, the fees required by this section.

2. A fee required by this section must be:

(a) If an initial fee, paid at the time of an initial application or issuance of a license, as applicable;

(b) If an annual fee, paid on or before March 1 of every year;

(c) If a triennial fee, paid on or before the time of continuation, renewal or other similar action in regard to a certificate, license, permit or other type of authorization, as applicable; and

(d) Deposited in the Fund for Insurance Administration and Enforcement created by NRS 680C.100.

3. The fees required pursuant to this section are not refundable.

4. The following fees must be paid by the following persons to the Commissioner:

(a) Associations of self-insured private employers, as defined in NRS 616A.050:

(1) Initial fee $1,300
(2) Annual fee $1,300

(b) Associations of self-insured public employers, as defined in NRS 616A.055:

(1) Initial fee $1,300
(2) Annual fee $1,300

(c) Independent review organizations, as provided for in NRS 616A.469 or 683A.3715, or both:

(1) Initial fee $60
(2) Annual fee $60

(d) Insurers not otherwise provided for in this subsection:

(1) Initial fee $1,300
(2) Annual fee $1,300

(e) Producers of insurance, as defined in NRS 679A.117:

(1) Initial fee $60
(2) Triennial fee $60

(f) Accredited reinsurers, as provided for in NRS 681A.160:

(1) Initial fee $1,300
(2) Annual fee $1,300

(g) Intermediaries, as defined in NRS 681A.330:

(1) Initial fee $60

(2) Triennial fee $60

(h) Reinsurers, as defined in NRS 681A.370:

(1) Initial fee $1,300

(2) Annual fee $1,300

(i) Administrators, as defined in NRS 683A.025:

(1) Initial fee $60

(2) Triennial fee $60

(j) Managing general agents, as defined in NRS 683A.060:

(1) Initial fee $60

(2) Triennial fee $60

(k) Agents who perform utilization reviews, as defined in NRS 683A.376:

(1) Initial fee $60

(2) Annual fee $60

(l) Insurance consultants, as defined in NRS 683C.010:

(1) Initial fee $60

(2) Triennial fee $60

(m) Independent adjusters, as defined in NRS 684A.030:

(1) Initial fee $60

(2) Triennial fee $60

(n) Public adjusters, as defined in NRS 684A.030:

(1) Initial fee $60

(2) Triennial fee $60

(o) Associate adjusters, as defined in NRS 684A.030:

(1) Initial fee $60

(2) Triennial fee $60

(p) Motor vehicle physical damage appraisers, as defined in NRS 684B.010:

(1) Initial fee $60

(2) Triennial fee $60

(q) Brokers, as defined in NRS 685A.031:

(1) Initial fee $60

(2) Triennial fee $60

(r) Eligible surplus line insurers, as provided for in NRS 685A.070:

(1) Initial fee $1,300

(2) Annual fee $1,300

(s) Companies, as defined in NRS 686A.330:

(1) Initial fee $1,300

(2) Annual fee $1,300

(t) Rate service organizations, as defined in NRS 686B.020:
(1) Initial fee $1,300
(2) Annual fee $1,300
(u) Brokers of viatical settlements, as defined in NRS 688C.030:
(1) Initial fee $60
(2) Annual fee $60
(v) Providers of viatical settlements, as defined in NRS 688C.080:
(1) Initial fee $60
(2) Annual fee $60
(w) Agents for prepaid burial contracts subject to the provisions of chapter 689 of NRS:
(1) Initial fee $60
(2) Triennial fee $60
(x) Agents for prepaid funeral contracts subject to the provisions of chapter 689 of NRS:
(1) Initial fee $60
(2) Triennial fee $60
(y) Sellers of prepaid burial contracts subject to the provisions of chapter 689 of NRS:
(1) Initial fee $60
(2) Triennial fee $60
(z) Sellers of prepaid funeral contracts subject to the provisions of chapter 689 of NRS:
(1) Initial fee $60
(2) Triennial fee $60
(aa) Providers, as defined in NRS 690C.070:
(1) Initial fee $1,300
(2) Annual fee $1,300
(bb) Escrow officers, as defined in NRS 692A.028:
(1) Initial fee $60
(2) Triennial fee $60
(cc) Title agents, as defined in NRS 692A.060:
(1) Initial fee $60
(2) Triennial fee $60
(dd) Captive insurers, as defined in NRS 694C.060:
(1) Initial fee $250
(2) Annual fee $250
(ee) Fraternal benefit societies, as defined in NRS 695A.010:
(1) Initial fee $1,300

(2) Annual fee $1,300

(ff) Insurance agents for societies, as provided for in NRS 695A.330:

(1) Initial fee $60

(2) Triennial fee $60

(gg) Corporations subject to the provisions of chapter 695B of NRS:

(1) Initial fee $1,300

(2) Annual fee $1,300

(hh) Health maintenance organizations, as defined in NRS 695C.030:

(1) Initial fee $1,300

(2) Annual fee $1,300

(ii) Organizations for dental care, as defined in NRS 695D.060:

(1) Initial fee $1,300

(2) Annual fee $1,300

(jj) Purchasing groups, as defined in NRS 695E.100:

(1) Initial fee $250

(2) Annual fee $250

(kk) Risk retention groups, as defined in NRS 695E.110:

(1) Initial fee $250

(2) Annual fee $250

(ll) Prepaid limited health service organizations, as defined in NRS 695F.050:

(1) Initial fee $1,300

(2) Annual fee $1,300

(mm) Medical discount plans, as defined in NRS 695H.050:

(1) Initial fee $1,300

(2) Annual fee $1,300

(nn) Club agents, as defined in NRS 696A.040:

(1) Initial fee $60

(2) Triennial fee $60

(oo) Motor clubs, as defined in NRS 696A.050:

(1) Initial fee $1,300

(2) Annual fee $1,300

(pp) Bail agents, as defined in NRS 697.040:

(1) Initial fee $60

(2) Triennial fee $60

(qq) Bail enforcement agents, as defined in NRS 697.055:
(1) Initial fee $60
(2) Triennial fee $60
(rr) Bail solicitors, as defined in NRS 697.060:
(1) Initial fee $60
(2) Triennial fee $60
(ss) General agents, as defined in NRS 697.070:
(1) Initial fee $60
(2) Triennial fee $60
(tt) Exchange enrollment facilitators, as defined in section 5 of this act:
(1) Initial fee $60
(2) Triennial fee $60

Sec. 32.1. NRS 686B.030 is hereby amended to read as follows:

686B.030 1. Except as otherwise provided in subsection 2 ~~[,]~~ ***and NRS 686B.125,*** NRS 686B.010 to 686B.1799, inclusive, apply to all kinds and lines of direct insurance written on risks or operations in this State by any insurer authorized to do business in this State, except:
(a) Ocean marine insurance;
(b) Contracts issued by fraternal benefit societies;
(c) Life insurance and credit life insurance;
(d) Variable and fixed annuities;
(e) Credit accident and health insurance;
(f) Property insurance for business and commercial risks;
(g) Casualty insurance for business and commercial risks other than insurance covering the liability of a practitioner licensed pursuant to chapters 630 to 640, inclusive, of NRS;
(h) Surety insurance;
(i) Health insurance offered through a group health plan maintained by a large employer; and
(j) Credit involuntary unemployment insurance.
2. The exclusions set forth in paragraphs (f) and (g) of subsection 1 extend only to issues related to the determination or approval of premium rates.

Sec. 32.2. NRS 686B.070 is hereby amended to read as follows:

686B.070 1. Every authorized insurer and every rate service organization licensed under NRS 686B.140 which has been designated by any insurer for the filing of rates under subsection 2 of NRS 686B.090 shall file with the Commissioner all:

(a) Rates and proposed increases thereto;
(b) Forms of policies to which the rates apply;
(c) Supplementary rate information; and
(d) Changes and amendments thereof,

➥ made by it for use in this state.

2. If an insurer makes a filing for a proposed increase in a rate for insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of the practitioner's professional duty toward a patient, the insurer shall not include in the filing any component that is directly or indirectly related to the following:

(a) Capital losses, diminished cash flow from any dividends, interest or other investment returns, or any other financial loss that is materially outside of the claims experience of the professional liability insurance industry, as determined by the Commissioner.

(b) Losses that are the result of any criminal or fraudulent activities of a director, officer or employee of the insurer.

➥ If the Commissioner determines that a filing includes any such component, the Commissioner shall, pursuant to NRS 686B.110, disapprove the proposed increase, in whole or in part, to the extent that the proposed increase relies upon such a component.

3. If an insurer makes a filing for a proposed increase in a rate for a health benefit plan, as that term is defined in section 33.4 of this act, the filing must include a unified rate review template, a written description justifying the rate increase and any rate filing documentation.

4. As used in this section, "rate filing documentation," "unified rate review template" and "written description justifying the rate increase" have the meanings ascribed in 45 C.F.R. § 154.215.

Sec. 32.5. NRS 686B.080 is hereby amended to read as follows:

686B.080 ~~[Each]~~

1. Except as otherwise provided in subsections 2 and 3, each filing and any supporting information filed under NRS 686B.010 to 686B.1799, inclusive, must, as soon as filed, be open to public inspection at any reasonable time. Copies may be obtained by any person on request and upon payment of a reasonable charge therefor.

2. All approved rates for health benefit plans available for purchase by individuals are considered proprietary and to constitute trade secrets, and are not subject to disclosure by the

Commissioner to persons outside the Division except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

3. The provisions of subsection 2 expire annually on the date 30 days before open enrollment.

4. For the purposes of this section, "open enrollment" has the meaning ascribed to it in 45 C.F.R. § 147.104(b)(1)(ii).

Sec. 32.8. NRS 686B.125 is hereby amended to read as follows:

686B.125 ~~[No]~~

1. Except as otherwise provided in this section, no insurer, organization or person licensed pursuant to this title may sell or offer to sell any contract providing coverage for dental care at a rate which is excessive for the benefits offered to the insured or member. For the purpose of this section, a ratio of losses to premiums collected which is less than 75 percent is presumed to show an excessive rate.

2. The provisions of subsection 1 do not apply to a contract providing coverage for dental care that is sold to a small employer pursuant to the provisions of chapter 689C of NRS.

3. As used in this section, "small employer" has the meaning ascribed to it in NRS 689C.095.

Sec. 33. Chapter 687B of NRS is hereby amended by adding thereto the provisions set forth as sections 33.4 to 33.8, inclusive, of this act.

Sec. 33.4. ***1. "Health benefit plan" means a policy, contract, certificate or agreement offered by a carrier to provide for, deliver payment for, arrange for the payment of, pay for or reimburse any of the costs of health care services. Except as otherwise provided in this section, the term includes catastrophic health insurance policies and a policy that pays on a cost-incurred basis.***

2. The term does not include:

(a) Coverage that is only for accident or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Coverage for medical payments under a policy of automobile insurance;

(f) Credit insurance;

(g) Coverage for on-site medical clinics;

(h) Other similar insurance coverage specified pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) Coverage under a short-term health insurance policy; and

(j) Coverage under a blanket student accident and health insurance policy.

3. The term does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of a health benefit plan:

(a) Limited-scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care or community-based care, or any combination thereof; and

(c) Such other similar benefits as are specified in any federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

4. The term does not include the following benefits if the benefits are provided under a separate policy, certificate or contract, there is no coordination between the provisions of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid for a claim without regard to whether benefits are provided for such a claim under any group health plan maintained by the same plan sponsor:

(a) Coverage that is only for a specified disease or illness; and

(b) Hospital indemnity or other fixed indemnity insurance.

5. The term does not include any of the following, if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined in section 1882(g)(1) of the Social Security Act, 42 U.S.C. § 1395ss, as that section existed on July 16, 1997;

(b) Coverage supplemental to the coverage provided pursuant to the Civilian Health and Medical Program of Uniformed Services, CHAMPUS, 10 U.S.C. §§ 1071 et seq.; and

(c) Similar supplemental coverage provided under a group health plan.

Sec. 33.5. *1. All health benefit plans must be made available in the manner required by 45 C.F.R § 147.104.*

2. In addition to the requirements of subsection 1, any health benefit plan for individuals that is not purchased on the Silver State Health Insurance Exchange established by NRS 695I.210:

(a) Must be made available for purchase at any time during the calendar year;

(b) Is subject to a waiting period of not more than 90 days after the date on which the application for coverage was received;

(c) Is effective upon the first day of the month immediately succeeding the month in which the waiting period expires; and

(d) Is not retroactive to the date on which the application for coverage was received.

Sec. 33.6. *1. A carrier that offers coverage in the group or individual market must, before making any network plan available for sale in this State, demonstrate the capacity to deliver services adequately by applying to the Commissioner for the issuance of a network plan and submitting a description of the procedures and programs to be implemented to meet the requirements described in subsection 2.*

2. The Commissioner shall determine, within 90 days after receipt of the application required pursuant to subsection 1, if the carrier, with respect to the network plan:

(a) Has demonstrated the willingness and ability to ensure that health care services will be provided in a manner to ensure both availability and accessibility of adequate personnel and facilities in a manner that enhances availability, accessibility and continuity of service;

(b) Has organizational arrangements established in accordance with regulations promulgated by the Commissioner; and

(c) Has a procedure established in accordance with regulations promulgated by the Commissioner to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services and such other matters as may be reasonably required by the Commissioner.

3. The Commissioner may certify that the carrier and the network plan meet the requirements of subsection 2, or may determine that the carrier and the network plan do not meet such requirements. Upon a determination that the carrier and the network plan do not meet the requirements of subsection 2, the Commissioner shall specify in what respects the carrier and the network plan are deficient.

4. A carrier approved to issue a network plan pursuant to this section must file annually with the Commissioner a summary of information compiled pursuant to subsection 2 in a manner determined by the Commissioner.

5. The Commissioner shall, not less than once each year, or more often if deemed necessary by the Commissioner for the protection of the interests of the people of this State, make a determination concerning the availability and accessibility of the health care services of any network plan approved pursuant to this section.

6. The expense of any determination made by the Commissioner pursuant to this section must be assessed against the carrier and remitted to the Commissioner.

7. As used in this section, "network plan" has the meaning ascribed to it in NRS 689B.570.

Sec. 33.8. ***1. The premium rate charged by a health insurer for health benefit plans offered in the individual or small group market may vary with respect to the particular plan or coverage involved based solely on these characteristics:***

(a) Whether the plan or coverage applies to an individual or a family;

(b) Geographic rating area;

(c) Tobacco use, except that the rate shall not vary by a ratio of more than 1.5 to 1 for like individuals who vary in tobacco use; and

(d) Age, except that the rate must not vary by a ratio of more than 3 to 1 for like individuals of different age who are age 21 years or older and that the variation in rate must be actuarially justified for individuals who are under the age of 21 years, consistent with the uniform age rating curve established in the Federal Act. For the purpose of identifying the appropriate age adjustment under this paragraph and the age band defined in the Federal Act to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal must be used.

2. The provisions of subsection 1:

(a) Apply to a fraternal benefit society organized under chapter 695A of NRS; and

(b) Do not apply to grandfathered plans.

Sec. 34. NRS 689A.020 is hereby amended to read as follows:

689A.020 Nothing in this chapter applies to or affects:

1. Any policy of liability or workers' compensation insurance with or without supplementary expense coverage therein.

2. Any group or blanket policy.

3. Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to health insurance as to:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(b) Operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity if the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract.

4. Reinsurance, except as otherwise provided in NRS 689A.470 to 689A.740, inclusive, and 689C.610 to ~~[689C.980,]~~ ***689C.940,*** inclusive, relating to the program of reinsurance.

Sec. 35. NRS 689A.030 is hereby amended to read as follows:

689A.030 A policy of health insurance must not be delivered or issued for delivery to any person in this State unless it otherwise complies with this Code, and complies with the following:

1. The entire money and other considerations for the policy must be expressed therein.

2. The time when the insurance takes effect and terminates must be expressed therein.

3. It must purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two or more eligible members of that family, including the husband, wife, ***domestic partner as defined in NRS 122A.030,*** dependent children, from the time of birth, adoption or placement for the purpose of adoption as provided in NRS 689A.043, or any ~~[children under a specified age which must not exceed 19]~~ ***child on or before the last day of the month in which the child attains 26*** years ~~[except as provided in NRS 689A.045,]~~ ***of age,*** and any other person dependent upon the policyholder.

4. The style, arrangement and overall appearance of the policy must not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers must be plainly printed in light-faced type of a style in general use, the size of which must be uniform and not less than 10 points with a lowercase unspaced alphabet length not less than 120 points. "Text" includes all printed matter except the name and address of the insurer, the name or the title of the policy, the brief description, if any, and captions and subcaptions.

5. The exceptions and reductions of indemnity must be set forth in the policy and, other than those contained in NRS 689A.050 to 689A.290, inclusive, must be printed, at the insurer's option, with the benefit provision to which they apply or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions,"

except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of that exception or reduction must be included with the benefit provision to which it applies.

6. Each such form, including riders and endorsements, must be identified by a number in the lower left-hand corner of the first page thereof.

7. The policy must not contain any provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless that portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the Commissioner.

8. The policy must provide benefits for expense arising from care at home or health supportive services if that care or service was prescribed by a physician and would have been covered by the policy if performed in a medical facility or facility for the dependent as defined in chapter 449 of NRS.

9. The policy must provide, at the option of the applicant, benefits for expenses incurred for the treatment of abuse of alcohol or drugs, unless the policy provides coverage only for a specified disease or provides for the payment of a specific amount of money if the insured is hospitalized or receiving health care in his or her home.

10. The policy must provide benefits for expense arising from hospice care.

Sec. 36. NRS 689A.040 is hereby amended to read as follows:

689A.040 1. Except as otherwise provided in subsections 2 and 3, each such policy delivered or issued for delivery to any person in this State must contain the provisions specified in NRS 689A.050 to 689A.170, inclusive, in the words in which the provisions appear, except that the insurer may, at its option, substitute for one or more of the provisions corresponding provisions of different wording approved by the Commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Each such provision must be preceded individually by the applicable caption shown or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

2. ~~[Each policy delivered or issued for delivery in this State after November 1, 1973, must contain a provision, if applicable, setting forth the provisions of NRS 689A.045.~~

~~3.]~~ If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the Commissioner, may omit from the policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of a provision in such a manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

Sec. 37. (Deleted by amendment.)

Sec. 38. NRS 689A.044 is hereby amended to read as follows:

689A.044 1. A policy of health insurance must provide coverage for benefits payable for expenses incurred for administering the human papillomavirus vaccine ~~[to women and girls at such ages]~~ as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. A policy of health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.

3. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after July 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with subsection 1 is void.

4. For the purposes of this section, "human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

Sec. 39. NRS 689A.0455 is hereby amended to read as follows:

689A.0455 1. ~~[Notwithstanding any provisions of this Title to the contrary, a]~~ ***A*** policy of health insurance delivered or issued for delivery in this state pursuant to this chapter must provide coverage for the treatment of conditions relating to severe mental illness.

2. ~~[The coverage required by this section:~~

~~(a) Must provide:~~

~~(1) Benefits for at least 40 days of hospitalization as an inpatient per policy year and 40 visits for treatment as an outpatient per policy year, excluding visits for the management of medication; and~~

(2) That two visits for partial or respite care, or a combination thereof, may be substituted for each 1 day of hospitalization not used by the insured. In no event is the policy required to provide coverage for more than 40 days of hospitalization as an inpatient per policy year.

(b) Is not required to provide benefits for psychosocial rehabilitation or care received as a custodial inpatient.

3. Any deductibles and copayments required to be paid for the coverage required by this section must not be greater than 150 percent of the out-of-pocket expenses required to be paid for medical and surgical benefits provided pursuant to the policy of health insurance.

4. The provisions of this section do not apply to a policy of health insurance if, at the end of the policy year, the premiums charged for that policy, or a standard grouping of policies, increase by more than 2 percent as a result of providing the coverage required by this section and the insurer obtains an exemption from the Commissioner pursuant to subsection 5.

5. To obtain the exemption required by subsection 4, an insurer must submit to the Commissioner a written request therefor that is signed by an actuary and sets forth the reasons and actuarial assumptions upon which the request is based. To determine whether an exemption may be granted, the Commissioner shall subtract from the amount of premiums charged during the policy year the amount of premiums charged during the period immediately preceding the policy year and the amount of any increase in the premiums charged that is attributable to factors that are unrelated to providing the coverage required by this section. The Commissioner shall verify the information within 30 days after receiving the request. The request shall be deemed approved if the Commissioner does not deny the request within that time.

6. The provisions of this section do not:

(a) Limit the provision of specialized services covered by Medicaid for persons with conditions relating to mental health or substance abuse.

(b) Supersede any provision of federal law, any federal or state policy relating to Medicaid, or the terms and conditions imposed on any Medicaid waiver granted to this state with respect to the provisions of services to persons with conditions relating to mental health or substance abuse.

7. A policy of health insurance subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2000, has the legal effect of including the coverage

~~required by this section, and any provision of the policy or the renewal which is in conflict with this section is void, unless the policy is otherwise exempt from the provisions of this section pursuant to subsection 4.~~

~~8.]~~ As used in this section, "severe mental illness" means any of the following mental illnesses that are biologically based and for which diagnostic criteria are prescribed in the ***most recent edition of the*** Diagnostic and Statistical Manual of Mental Disorders, ~~[Fourth Edition,]~~ published by the American Psychiatric Association:

(a) Schizophrenia.
(b) Schizoaffective disorder.
(c) Bipolar disorder.
(d) Major depressive disorders.
(e) Panic disorder.
(f) Obsessive-compulsive disorder.

Sec. 39.5. NRS 689A.230 is hereby amended to read as follows:

689A.230 1. There may be a provision as follows:

> Coordination of Benefits: If, with respect to a person covered under this policy, benefits for allowable expense incurred during a claim determination period under this policy, together with benefits for allowable expense during such period under all other valid coverage (without giving effect to this provision or to any "coordination of benefits provision" applying to such other valid coverage), exceed the total of such person's allowable expense during such period, this insurer shall be liable only for such proportionate amount of the benefits for allowable expense under this policy during such period as (a) the total allowable expense during such period bears to (b) the total amount of benefits payable during such period for such expense under this policy and all other valid coverage (without giving effect to this provision or to any "coordination of benefits provision" applying to such other valid coverage) less in both (a) and (b) any amount of benefits for allowable expense payable under other valid coverage which does not contain a "coordination of benefits provision." In no event shall this provision operate to increase the amount of benefits for allowable expense payable under this policy with respect to a person covered under this policy above the amount which would have been paid in the absence of this provision. This insurer may pay benefits to any insurer providing other valid coverage in the event of overpayment

by such insurer. Any such payment shall discharge the liability of this insurer as fully as if the payment had been made directly to the insured or the assignee or beneficiary of the insured. If this insurer pays benefits to the insured or the assignee or beneficiary of the insured, in excess of the amount which would have been payable if the existence of other valid coverage had been disclosed, this insurer shall have a right of action against the insured or the assignee or beneficiary of the insured to recover the amount which would not have been paid had there been a disclosure of the existence of the other valid coverage. The amount of other valid coverage which is on a provision of service basis shall be computed as the amount the services rendered would have cost in the absence of such coverage.

For the purposes of this provision:

(1) "Allowable expense" means 100 percent of any necessary, reasonable and customary item of expense which is covered, in whole or in part, as a hospital, surgical, medical or major medical expense under this policy or under any other valid coverage.

(2) "Claim determination period" with respect to any covered person means the initial period of ..... (insert period of not less than 30 days) and each successive period of a like number of days, during which allowable expense covered under this policy is incurred on account of such person. The first such period begins on the date when the first such expense is incurred, and successive periods shall begin when such expense is incurred after expiration of a prior period.

or, in lieu thereof:

(2) "Claim determination period" with respect to any covered person means each ..... (insert calendar or policy period of not less than a month) during which allowable expense covered under this policy is incurred on account of such person.

(3) "Coordination of benefits provision" means this provision and any other provision which may reduce an insurer's liability because of the existence of benefits under other valid coverage.

2. The foregoing policy provisions may be inserted in all policies providing hospital, surgical, medical or major medical

benefits for which the application includes a question as to other coverages subject to this provision. If the policy provision stated in subsection 1 is included in a policy which also contains the policy provision stated in NRS 689A.240, there shall be added to the caption of the provision stated in subsection 1 of the phrase "expense-incurred benefits." The insurer may make this provision applicable to either or both:

(a) Other valid coverage with other insurers; and

(b) Other valid coverage with the same insurer.

➥ The insurer shall include in this provision a definition of "other valid coverage" approved as to form by the Commissioner. Such term may include hospital, surgical, medical or major medical benefits provided by individual or family-type coverage, government programs or workers' compensation. Such term shall not include any ~~[group insurance,]~~ automobile medical payments or third-party liability coverage. The insurer shall not include a subrogation clause in the policy. The insurer may require, as part of the proof of claim, the information necessary to administer this provision.

3. If by application of any of the foregoing provisions the insurer effects a material reduction of benefits otherwise payable under the policy, the insurer shall refund to the insured any premium unearned on the policy by reason of such reduction of coverage during the policy year current and that next preceding at the time the loss commenced, subject to the insurer's right to provide in the policy that no such reduction of benefits or refund will be made unless the unearned premium to be so refunded amounts to $5 or such larger sum as the insurer may so specify.

Sec. 40. NRS 689A.470 is hereby amended to read as follows:

689A.470 As used in NRS 689A.470 to 689A.740, inclusive, unless the context otherwise requires, the words and terms defined in NRS 689A.475 to ~~[689A.605,]~~ ***689A.600,*** inclusive, have the meanings ascribed to them in those sections.

Sec. 41. NRS 689A.520 is hereby amended to read as follows:

689A.520 ~~["Established geographic]~~ ***"Geographic*** service area" means a geographic area, as approved by the Commissioner **,** ~~[and based on the certificate of authority of the carrier to transact insurance in this state,]~~ within which the carrier is authorized to provide coverage.

Sec. 42. NRS 689A.525 is hereby amended to read as follows:

689A.525 "Geographic ***rating*** area" means an area established by the Commissioner for use in adjusting the rates for a health benefit plan.

Sec. 43. NRS 689A.630 is hereby amended to read as follows:

689A.630 1. Except as otherwise provided in this section, coverage under an individual health benefit plan must be renewed by the individual carrier that issued the plan, at the option of the individual, unless:

(a) The individual has failed to pay premiums or contributions in accordance with the terms of the health benefit plan or the individual carrier has not received timely premium payments.

(b) The individual has performed an act or a practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage.

(c) The individual carrier decides to discontinue offering and renewing all health benefit plans delivered or issued for delivery in this state. If the individual carrier decides to discontinue offering and renewing such plans, the individual carrier shall:

(1) Provide notice of its intention to the Commissioner and the chief regulatory officer for insurance in each state in which the individual carrier is licensed to transact insurance at least 60 days before the date on which notice of cancellation or nonrenewal is delivered or mailed to the persons covered by the insurance to be discontinued pursuant to subparagraph (2).

(2) Provide notice of its intention to all persons covered by the discontinued insurance and to the Commissioner and the chief regulatory officer for insurance in each state in which such a person is known to reside. The notice must be made at least 180 days before the nonrenewal of any health benefit plan by the individual carrier.

(3) Discontinue all health insurance issued or delivered for issuance for individuals in this state and not renew coverage under any health benefit plan issued to such individuals.

(d) The Commissioner finds that the continuation of the coverage in this state by the individual carrier would not be in the best interests of the policyholders or certificate holders of the individual carrier or would impair the ability of the individual carrier to meet its contractual obligations. If the Commissioner makes such a finding, the Commissioner shall assist the persons covered by the discontinued insurance in this state in finding replacement coverage.

2. An individual carrier may discontinue the issuance and renewal of a form of a product of a health benefit plan if the Commissioner finds that the form of the product offered by the individual carrier is obsolete and is being replaced with comparable coverage. A form of a product of a health benefit plan may be

discontinued by the individual carrier pursuant to this subsection only if:

(a) The individual carrier notifies the Commissioner and the chief regulatory officer for insurance in each state in which it is licensed of its decision pursuant to this subsection to discontinue the issuance and renewal of the form of the product at least 60 days before the individual carrier notifies the persons covered by the discontinued insurance pursuant to paragraph (b).

(b) The individual carrier notifies each person covered by the discontinued insurance, the Commissioner and the chief regulatory officer for insurance in each state in which a person covered by the discontinued insurance is known to reside of the decision of the individual carrier to discontinue offering the form of the product. The notice must be made to persons covered by the discontinued insurance at least 180 days before the date on which the individual carrier will discontinue offering the form of the product.

(c) The individual carrier offers to each person covered by the discontinued insurance the option to purchase any other health benefit plan currently offered by the individual carrier to individuals in this state.

(d) In exercising the option to discontinue the form of the product and in offering the option to purchase other coverage pursuant to paragraph (c), the individual carrier acts uniformly without regard to the claim experience of the persons covered by the discontinued insurance or any health status-related factor relating to those persons or beneficiaries covered by the discontinued form of the product or any persons or beneficiaries who may become eligible for such coverage.

3. An individual carrier may discontinue the issuance and renewal of a health benefit plan that is made available to individuals pursuant to this chapter only through a bona fide association if:

(a) The membership of the individual in the association was the basis for the provision of coverage;

(b) The membership of the individual in the association ceases; and

(c) The coverage is terminated pursuant to this subsection uniformly without regard to any health status-related factor relating to the covered individual.

4. An individual carrier that elects not to renew a health benefit plan pursuant to paragraph (c) of subsection 1 shall not write new business for individuals pursuant to this chapter for 5 years after the date on which notice is provided to the Commissioner pursuant to subparagraph (2) of paragraph (c) of subsection 1.

5. If an individual carrier does business in only one ~~[established]~~ geographic service area of this state, the provisions of this section apply only to the operations of the individual carrier in that service area.

Sec. 44. NRS 689A.635 is hereby amended to read as follows:

689A.635 1. An individual carrier that offers coverage through a network plan is not required pursuant to NRS 689A.630 to offer coverage to or accept an application from ~~[an eligible]~~ ***a*** person if the ~~[eligible]~~ person does not reside or work in the ~~[established]~~ geographic service area or in a geographic ***rating*** area ***,*** ~~[for which the individual carrier is authorized to transact insurance,]~~ provided that the coverage is refused or terminated uniformly without regard to any health status-related factor of any eligible person.

2. As used in this section, "network plan" means a health benefit plan offered by a health carrier under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.

Sec. 45. NRS 689A.637 is hereby amended to read as follows:

689A.637 1. An individual carrier that offers a health benefit plan that includes a provision for a restricted network shall use its best efforts to contract with at least one health center in each ~~[established]~~ geographic service area to provide health care services to persons covered by the plan if the health center:

(a) Meets all conditions imposed by the carrier on similarly situated providers of health care with which the carrier contracts, including, without limitation:

(1) Certification for participation in the Medicaid or Medicare program; and

(2) Requirements relating to the appropriate credentials for providers of health care; and

(b) Agrees to reasonable reimbursement rates that are generally consistent with those offered by the carrier to similarly situated providers of health care with which the carrier contracts.

2. As used in this section, "health center" has the meaning ascribed to it in 42 U.S.C. § 254b.

Sec. 46. (Deleted by amendment.)

Sec. 47. NRS 689A.690 is hereby amended to read as follows:

689A.690 1. As part of its solicitation and sales materials for an individual health benefit plan, an individual carrier shall disclose, to the extent reasonable:

(a) The extent to which premium rates for an individual and the dependent of the individual are established or adjusted based upon rating characteristics;

(b) The right of the individual carrier to change premium rates and the factors, other than claims experience, that may affect changes in premium rates; ***and***

(c) Any provisions in the individual health benefit plan relating to the renewability of the plan**.** ~~[; and~~

~~(d) Any provisions in the individual health benefit plan relating to an exclusion for a preexisting condition.]~~

2. For the purposes of this section, an individual carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

~~[3. On or before March 1 of each year, an individual carrier shall file with the Commissioner an actuarial certification that the individual carrier is in compliance with NRS 689A.680 to 689A.700, inclusive, and that the rating methods of the individual carrier are actuarially sound. The certification must be in such a form and must contain such information as specified by the Commissioner. A copy of the certification must be retained by the individual carrier at its principal place of business.~~

~~4. As used in this section, "actuarial certification" means a written statement signed by a member of the American Academy of Actuaries or any other person acceptable to the Commissioner that an individual carrier is in compliance with the provisions of NRS 689A.680 to 689A.700, inclusive, based upon an examination conducted by the person which included a review of the appropriate records and the actuarial assumptions and methods used by the individual carrier in establishing premium rates for applicable health benefit plans.]~~

Sec. 47.5. NRS 689A.695 is hereby amended to read as follows:

689A.695 An individual carrier shall make the information and documents described in NRS ~~[689A.680 to]~~ ***689A.690, 689A.695 and*** 689A.700, ~~[inclusive,]~~ available to the Commissioner upon request. Except in cases of violations of the provisions of this chapter, the information, other than the premium rates charged by the individual carrier, is proprietary, constitutes a trade secret and is not subject to disclosure by the Commissioner to persons outside of

the Division except as agreed to by the individual carrier or as ordered by a court of competent jurisdiction.

Sec. 48. NRS 689A.700 is hereby amended to read as follows:

689A.700 The Commissioner may adopt regulations to carry out the provisions of NRS ~~[689A.680 to]~~ ***689A.690, 689A.695 and*** 689A.700, ~~[inclusive,]~~ and to ensure that the practices used by individual carriers relating to the establishment of rates are consistent with the purposes of NRS 689A.470 to 689A.740, inclusive ***.*** ~~[, including, but not limited to, determining the manner in which geographic rating areas are designated by all individual carriers.]~~

Sec. 49. NRS 689A.710 is hereby amended to read as follows:

689A.710 1. Except as otherwise provided in this section, an individual carrier or a producer shall not, directly or indirectly:

(a) Encourage or direct an ~~[eligible person]~~ ***individual or family*** to refrain from filing an application for coverage with an individual carrier because of the health status, claims experience, industry, occupation or geographic location of the ~~[eligible person.]~~ ***individual or family.***

(b) Encourage or direct an ~~[eligible person]~~ ***individual or family*** to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the ~~[eligible person.]~~ ***individual or family.***

2. The provisions of subsection 1 do not apply to information provided to an ~~[eligible person]~~ ***individual or family*** by an individual carrier or a producer relating to the ~~[established]~~ geographic service area or a provision for a restricted network of the individual carrier.

3. Except as otherwise provided in this subsection, an individual carrier shall not, directly or indirectly, enter into any contract, agreement or arrangement with a producer if the contract, agreement or arrangement provides for or results in a variation to the compensation paid to a producer for the sale of a health benefit plan because of the health status, claims experience, industry, occupation or geographic location of the individual at the time that the health benefit plan is issued to or renewed by the individual. ~~[The provisions of this subsection do not apply to any arrangement for compensation that provides payment to a producer on the basis of a percentage of premiums, except that the percentage may not vary because of the health status, claims experience, industry, occupation or geographic area of the individual.]~~

4. An individual carrier shall not terminate, fail to renew, or limit its contract or agreement of representation with a producer for

any reason related to the health status, claims experience, industry, occupation or geographic location of an individual at the time that the health benefit plan is issued to or renewed by the individual placed by the producer with the individual carrier.

5. A denial by an individual carrier of an application for coverage from an ~~[eligible person]~~ ***individual or family*** must be in writing and must state the reason for the denial.

6. The Commissioner may adopt regulations that set forth additional standards to provide for the fair marketing and broad availability of health benefit plans to ~~[eligible persons]~~ ***individuals or families*** in this state.

7. A violation of any provision of this section by an individual carrier may constitute an unfair trade practice for the purposes of chapter 686A of NRS.

8. The provisions of this section apply to a third-party administrator if the third-party administrator enters into a contract, agreement or other arrangement with an individual carrier to provide administrative, marketing or other services related to the offering of a health benefit plan to ~~[eligible persons]~~ ***individuals or families*** in this state.

9. Nothing in this section interferes with the right and responsibility of a ~~[broker]~~ ***producer*** to advise and represent the best interests of an ~~[eligible person]~~ ***individual or family*** who is seeking health insurance coverage from an individual carrier.

Sec. 50. NRS 689A.725 is hereby amended to read as follows:

689A.725 For the purposes of NRS 689A.470 to 689A.740, inclusive, a plan for coverage of a bona fide association must:

1. Conform with ~~[NRS 689A.680 to]~~ ***689A.690, 689A.695 and*** 689A.700, ~~[inclusive,]~~ concerning rates.

2. Provide for the renewability of coverage for members of the bona fide association, and their dependents, if such coverage meets the criteria set forth in NRS 689A.630.

~~[3. Provide for the availability of coverage for members of the bona fide association, and their dependents, if such coverage conforms with NRS 689A.640, except that the bona fide association is not required to offer basic and standard health benefit plan coverage to its members or their dependents.~~

~~4. Conform with subsection 1 of NRS 689A.660, relating to preexisting conditions.]~~

Sec. 51. (Deleted by amendment.)

Sec. 52. NRS 689B.0313 is hereby amended to read as follows:

689B.0313 1. A policy of group health insurance must provide coverage for benefits payable for expenses incurred for administering the human papillomavirus vaccine ~~[to women and girls at such ages]~~ as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. A policy of group health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.

3. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after July 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with subsection 1 is void.

4. For the purposes of this section, "human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

Sec. 53. NRS 689B.033 is hereby amended to read as follows:

689B.033 1. All group health insurance policies providing coverage on an expense-incurred basis and all employee welfare plans providing medical, surgical or hospital care or benefits established or maintained for employees or their families or dependents, or for both, must as to the family members' coverage provide that the health benefits applicable for children are payable with respect to:

(a) A newly born child of the insured from the moment of birth;

(b) An adopted child from the date the adoption becomes effective, if the child was not placed in the home before adoption; and

(c) A child placed with the insured for the purpose of adoption from the moment of placement as certified by the public or private agency making the placement. The coverage of such a child ceases if the adoption proceedings are terminated as certified by the public or private agency making the placement.

➥ The policies must provide the coverage specified in subsection 3 and must not exclude premature births.

2. The policy or contract may require that notification of:

(a) The birth of a newly born child;
(b) The effective date of adoption of a child; or
(c) The date of placement of a child for adoption,

➥ and payments of the required premium or fees, if any, must be furnished to the insurer or welfare plan within 31 days after the date of birth, adoption or placement for adoption in order to have the coverage continue beyond the 31-day period.

3. The coverage for newly born and adopted children and children placed for adoption consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center under major medical policies, and with respect to basic policies to the extent such costs are charged by the treatment center.

~~[4. An insurer shall not restrict the coverage of a dependent child adopted or placed for adoption solely because of a preexisting condition the child has at the time the child would otherwise become eligible for coverage pursuant to the group health policy. Any provision relating to an exclusion for a preexisting condition must comply with NRS 689B.500.]~~

Sec. 54. NRS 689B.061 is hereby amended to read as follows:

689B.061 A policy of group health insurance which offers a difference of payment between preferred providers of health care and providers of health care who are not preferred:

1. ~~[May not require a deductible of more than $600 difference per admission to a facility for inpatient treatment which is not a preferred provider of health care.~~

~~2. May not require a deductible of more than $500 difference per treatment, other than inpatient treatment at a hospital, by a provider which is not preferred.~~

~~3.]~~ May not require an insured, another insurer who issues policies of group health insurance, a nonprofit medical service corporation or a health maintenance organization to pay any amount in excess of the deductible or coinsurance due from the insured based on the rates agreed upon with a provider.

~~[4. May not provide for a difference in percentage rates of payment for coinsurance of more than 30 percentage points between the payment for coinsurance required to be paid by the insured to a preferred provider of health care and the payment for coinsurance required to be paid by the insured to a provider of health care who is not preferred.~~

~~5.~~ ***2.*** Must require that the deductible and payment for coinsurance paid by the insured to a preferred provider of health care be applied to the negotiated reduced rates of that provider.

~~6.~~ ***3.*** Must include for providers of health care who are not preferred a provision establishing the point at which an insured's payment for coinsurance is no longer required to be paid if such a provision is included for preferred providers of health care. Such provisions must be based on a calendar year. The point at which an insured's payment for coinsurance is no longer required to be paid for providers of health care who are not preferred must not be greater than twice the amount for preferred providers of health care, regardless of the method of payment.

~~7.~~ ***4.*** Must provide that if there is a particular service which a preferred provider of health care does not provide and the provider of health care who is treating the insured requests the service and the insurer determines that the use of the service is necessary for the health of the insured, the service shall be deemed to be provided by the preferred provider of health care.

~~8.~~ ***5.*** Must require the insurer to process a claim of a provider of health care who is not preferred not later than 30 working days after the date on which proof of the claim is received.

Sec. 54.5. NRS 689B.063 is hereby amended to read as follows:

689B.063 1. When a policy of group insurance is primary, its benefits are determined before those of another policy and the benefits of another policy are not considered. When a policy of group insurance is secondary, its benefits are determined after those of another policy. Secondary benefits may not be reduced because of benefits under the primary policy. When there are more than two policies, a policy may be primary as to one and may be secondary as to another.

2. The benefits payable under a policy of group health insurance may not be reduced because of any benefits payable under ~~an individual health insurance policy,~~ health insurance on a franchise plan or first-party coverage under an automobile insurance policy.

3. As used in this section, "a policy of group insurance" includes Medicare.

Sec. 55. NRS 689B.340 is hereby amended to read as follows:

689B.340 As used in NRS 689B.340 to ~~689B.590,~~ ***689B.580,*** inclusive, unless the context otherwise requires, the words and terms defined in NRS 689B.350 to 689B.460, inclusive, have the meanings ascribed to them in those sections.

Secs. 56 and 57. (Deleted by amendment.)

Sec. 58. NRS 689B.480 is hereby amended to read as follows:

689B.480 1. In determining the applicable creditable coverage of a person for the purposes of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, a period of creditable coverage must not be included if, after the expiration of that period but before the enrollment date, there was a 63-day period during all of which the person was not covered under any creditable coverage. To establish a period of creditable coverage, a person must present any certificates of coverage provided to the person in accordance with NRS 689B.490 and such other evidence of coverage as required by regulations adopted by the Commissioner. For the purposes of this subsection, any waiting period for coverage or an affiliation period must not be considered in determining the applicable period of creditable coverage.

2. In determining the period of creditable coverage of a person **,** ~~[for the purposes of NRS 689B.500,]~~ a carrier shall include each applicable period of creditable coverage without regard to the specific benefits covered during that period, except that the carrier may elect to include applicable periods of creditable coverage based on coverage of specific benefits as specified in the regulations of the United States Department of Health and Human Services, if such an election is made on a uniform basis for all participants and beneficiaries of the health benefit plan or coverage. Pursuant to such an election, the carrier shall include each applicable period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within that class or category, as specified by those regulations.

3. Regardless of whether coverage is actually provided, if a carrier elects in accordance with subsection 2 to determine creditable coverage based on specified benefits, a statement that such an election has been made and a description of the effect of the election must be:

(a) Included prominently in any disclosure statement concerning the health benefit plan; and

(b) Provided to each person at the time of enrollment in the health benefit plan.

4. The provisions of this section apply only to grandfathered plans.

Sec. 59. NRS 689B.500 is hereby amended to read as follows:

689B.500 ~~[1. Except as otherwise provided in this section, a]~~ ***A*** carrier that issues a group health plan or coverage under blanket

accident and health insurance or group health insurance shall not deny, exclude or limit a benefit for a preexisting condition . [for:

(a) More than 12 months after the effective date of coverage if the employee or other insured enrolls through open enrollment or after the first day of the waiting period for that enrollment, whichever is earlier; or

(b) More than 18 months after the effective date of coverage for a late enrollee.

➥ A carrier may not define a preexisting condition more restrictively than that term is defined in NRS 689B.450.

2. The period of any exclusion for a preexisting condition imposed by a group health plan or coverage under blanket accident and health insurance or group health insurance on a person to be insured in accordance with the provisions of this chapter must be reduced by the aggregate period of creditable coverage of that person, if the creditable coverage was continuous to a date not more than 63 days before the effective date of the coverage. The period of continuous coverage must not include:

(a) Any waiting period for the effective date of the new coverage applied by the employer or the carrier; or

(b) Any affiliation period not to exceed 60 days for a new enrollee and 90 days for a late enrollee required before becoming eligible to enroll in the group health plan.

3. A health maintenance organization authorized to transact insurance pursuant to chapter 695C of NRS that does not restrict coverage for a preexisting condition may require an affiliation period before coverage becomes effective under a plan of insurance if the affiliation period applies uniformly to all employees or other persons insured and without regard to any health status-related factors. During the affiliation period, the carrier shall not collect any premiums for coverage of the employee or other insured.

4. An insurer that restricts coverage for preexisting conditions shall not impose an affiliation period.

5. A carrier shall not impose any exclusion for a preexisting condition:

(a) Relating to pregnancy.

(b) In the case of a person who, as of the last day of the 30-day period beginning on the date of the birth of the person, is covered under creditable coverage.

(c) In the case of a child who is adopted or placed for adoption before attaining the age of 18 years and who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, whichever is earlier, is covered under creditable

~~coverage. The provisions of this paragraph do not apply to coverage before the date of adoption or placement for adoption.~~

~~(d) In the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage, and the medical advice, diagnosis, care or treatment was a benefit under the plan, if the creditable coverage was continuous to a date not more than 63 days before the effective date of the new coverage.~~

~~➥ The provisions of paragraphs (b) and (c) do not apply to a person after the end of the first 63-day period during all of which the person was not covered under any creditable coverage.~~

~~6. As used in this section, "late enrollee" means an eligible employee, or a dependent of the eligible employee, who requests enrollment in a group health plan following the initial period of enrollment, if that initial period of enrollment is at least 30 days, during which the person is entitled to enroll under the terms of the health benefit plan. The term does not include an eligible employee or a dependent of the eligible employee if:~~

~~(a) The employee or dependent:~~

~~(1) Was covered under creditable coverage at the time of the initial enrollment;~~

~~(2) Lost coverage under creditable coverage as a result of cessation of contributions by his or her employer, termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination of creditable coverage, or death of, or divorce or legal separation from, a covered spouse; and~~

~~(3) Requests enrollment not later than 30 days after the date on which the creditable coverage of the employee or dependent was terminated or on which the change in conditions that gave rise to the termination of the coverage occurred.~~

~~(b) The employee enrolls during the open enrollment period, as provided in the contract or as otherwise specifically provided by specific statute.~~

~~(c) The employer of the employee offers several health benefit plans and the employee elected a different plan during an open enrollment period.~~

~~(d) A court has ordered coverage to be provided to the spouse or a minor or dependent child of an employee under a health benefit plan of the employee and a request for enrollment is made within 30 days after the issuance of the court order.~~

~~(e) The employee changes status from not being an eligible employee to being an eligible employee and requests enrollment,~~

~~subject to any waiting period, within 30 days after the change in status.~~

~~(f) The person has continued coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, and that coverage has been exhausted.]~~

Sec. 60. NRS 689B.560 is hereby amended to read as follows:

689B.560 1. Except as otherwise provided in this section, coverage under a policy of group health insurance must be renewed by the carrier at the option of the plan sponsor, unless:

(a) The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the group health insurance or the carrier has not received timely premium payments;

(b) The plan sponsor has performed an act or a practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage;

(c) The plan sponsor has failed to comply with any material provision of the group health insurance relating to employer contributions and group participation; or

(d) The carrier decides to discontinue offering coverage under group health insurance. If the carrier decides to discontinue offering and renewing such insurance, the carrier shall:

(1) Provide notice of its intention to the Commissioner and the chief regulatory officer for insurance in each state in which the carrier is licensed to transact insurance at least 60 days before the date on which notice of cancellation or nonrenewal is delivered or mailed to the persons covered by the discontinued insurance pursuant to subparagraph (2).

(2) Provide notice of its intention to all persons covered by the discontinued insurance and to the Commissioner and the chief regulatory officer for insurance in each state in which such a person is known to reside. The notice must be made at least 180 days before the discontinuance of any group health plan by the carrier.

(3) Discontinue all health insurance issued or delivered for issuance for persons in this state and not renew coverage under any group health insurance issued to such persons.

2. A carrier may discontinue the issuance and renewal of a form of a product of group health insurance if the Commissioner finds that the form of the product offered by the carrier is obsolete and is being replaced with comparable coverage. A form of a product may be discontinued by the carrier pursuant to this subsection only if:

(a) The carrier notifies the Commissioner and the chief regulatory officer in each state in which it is licensed of its decision

pursuant to this subsection to discontinue the issuance and renewal of the form of the product at least 60 days before the individual carrier notifies the persons covered by the discontinued insurance pursuant to paragraph (b).

(b) The carrier notifies each person covered by the discontinued insurance and the Commissioner and the chief regulatory officer in each state in which such a person is known to reside of the decision of the carrier to discontinue offering the form of the product. The notice must be made at least 180 days before the date on which the carrier will discontinue offering the form of the product.

(c) The carrier offers to each person covered by the discontinued insurance the option to purchase any other health benefit plan currently offered by the carrier to large groups in this state.

(d) In exercising the option to discontinue the form of the product and in offering the option to purchase other coverage pursuant to paragraph (c), the carrier acts uniformly without regard to the claim experience of the persons covered by the discontinued insurance or any health status-related factor relating to those persons or beneficiaries covered by the discontinued form of the product or any person or beneficiary who may become eligible for such coverage.

3. A carrier may discontinue the issuance and renewal of any type of group health insurance offered by the carrier in this state that is made available pursuant to this chapter only to a member of a bona fide association if:

(a) The membership of the person in the bona fide association was the basis for the provision of coverage under the group health insurance;

(b) The membership of the person in the bona fide association ceases; and

(c) Coverage is terminated pursuant to this subsection for all such former members uniformly without regard to any health status-related factor relating to the former member.

4. A carrier that elects not to renew group health insurance pursuant to paragraph (d) of subsection 1 shall not write new business pursuant to this chapter for 5 years after the date on which notice is provided to the Commissioner pursuant to subparagraph (2) of paragraph (d) of subsection 1.

5. If the carrier does business in only one ~~[established]~~ geographic service area of this state, the provisions of this section apply only to the operations of the carrier in that service area.

6. As used in this section, "bona fide association" has the meaning ascribed to it in NRS 689A.485.

Sec. 61. NRS 689B.570 is hereby amended to read as follows:

689B.570 1. A carrier that offers coverage through a network plan is not required to offer coverage to or accept an application from an employer that does not employ or no longer employs any enrollees who reside or work in the ~~[established]~~ geographic service area of the carrier ***,*** ~~[or the geographic rating area for which the carrier is authorized to transact insurance,]~~ provided that such coverage is refused or terminated uniformly without regard to any health status-related factor for any employee of the employer.

2. As used in this section, "network plan" means a health benefit plan offered by a health carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.

Sec. 62. (Deleted by amendment.)

Sec. 63. NRS 689B.580 is hereby amended to read as follows:

689B.580 1. A plan sponsor of a governmental plan that is a group health plan to which the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, otherwise apply may elect to exclude the governmental plan from compliance with those sections. Such an election:

(a) Must be made in such a form and in such a manner as the Commissioner prescribes by regulation.

(b) Is effective for a single specified year of the plan or, if the plan is provided pursuant to a collective bargaining agreement, for the term of that agreement.

(c) May be extended by subsequent elections.

(d) Excludes the governmental plan from those provisions in this chapter that apply only to group health plans.

2. If a plan sponsor of a governmental plan makes an election pursuant to this section, the plan sponsor shall:

(a) Annually and at the time of enrollment, notify the enrollees in the plan of the election and the consequences of the election; and

(b) Provide certification and disclosure of creditable coverage under the plan with respect to those enrollees pursuant to NRS 689B.490.

3. As used in this section, "governmental plan" has the meaning ascribed to in section 3(32) of the Employee Retirement Income Security Act of 1974, as that section existed on July 16, 1997.

Sec. 64. NRS 689C.055 is hereby amended to read as follows:

689C.055 "Dependent" means a spouse ***, a domestic partner as defined in NRS 122A.030,*** or ~~[:~~

~~1. An unmarried]~~ ***a*** child ~~[under 19]~~ ***on or before the last day of the month in which the child attains 26*** years of age ***.*** ~~[;~~

~~2. An unmarried child who is a full-time student under 24 years of age and who is financially dependent upon the parent; or~~

~~3. An unmarried child of any age who is medically certified as disabled and dependent upon the parent,~~

~~➥ who the parent claimed as his or her dependent on the form for income tax returns which the parent filed with the Internal Revenue Service for the previous fiscal year.]~~

Sec. 65. NRS 689C.067 is hereby amended to read as follows:

689C.067 ~~[~~"Established geographic~~]~~ ***"Geographic*** service area" means a geographic area, as approved by the Commissioner ***,*** ~~[and based on the certificate of authority of the carrier to transact insurance in this state,]~~ within which the carrier is authorized to provide coverage.

Sec. 66. NRS 689C.071 is hereby amended to read as follows:

689C.071 "Geographic ***rating*** area" means an area established by the Commissioner for use in adjusting the rates for a health benefit plan.

Sec. 66.5. NRS 689C.095 is hereby amended to read as follows:

689C.095 ~~[1.]~~ "Small employer" ~~[means, with respect to a calendar year and a plan year, an employer who employed on business days during the preceding calendar year an average of at least 2 employees, but not more than 50 employees, who have a normal workweek of 30 hours or more, and who employs at least 2 employees on the first day of the plan year. For the purposes of determining the number of eligible employees, organizations which are affiliated or which are eligible to file a combined tax return for the purposes of taxation constitute one employer.~~

~~2. For the purposes of this section, organizations are "affiliated" if one directly, or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, the other, as determined pursuant to the provisions of NRS 692C.050.]~~ ***has the meaning ascribed to it in 42 U.S.C. § 18024(b)(2).***

Sec. 67. NRS 689C.125 is hereby amended to read as follows:

689C.125 1. A carrier serving small employers shall apply rating factors ~~[, including characteristics,]~~ consistently with respect to all small employers ***.*** ~~[in a class of business.]~~ Rating factors must

produce premiums for identical groups that differ only by the amounts attributable to the design of the plans and the terms of the coverage and do not reflect differences based on the nature of the groups that will select particular health benefit plans. As used in this subsection, "premium" means all money paid by a small employer and eligible employees to a carrier as a condition of receiving coverage from a carrier, including any fees or other contributions associated with the health benefit plan.

2. A carrier serving small employers shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period, if the terms of coverage provided in the plans are the same.

Sec. 68. (Deleted by amendment.)

Sec. 69. NRS 689C.155 is hereby amended to read as follows:

689C.155 The Commissioner may adopt regulations to carry out the provisions of NRS ~~[689C.107]~~ ***689C.109*** to ~~[689C.145,]~~ ***689C.142,*** inclusive, 689C.156 to 689C.159, inclusive, 689C.165, 689C.183, 689C.187, 689C.191 ***, 689C.192*** to 689C.198, inclusive, 689C.203, 689C.207, 689C.265, ~~[689C.283, 689C.287,]~~ 689C.325, ~~[689C.342 to 689C.348, inclusive,]~~ 689C.355 and 689C.610 to ~~[689C.980,]~~ ***689C.940,*** inclusive, and to ensure that rating practices used by carriers serving small employers are consistent with those sections, including regulations that:

1. Ensure that differences in rates charged for health benefit plans by such carriers are reasonable and reflect only differences in the designs of the plans, the terms of the coverage, the amount contributed by the employers to the cost of coverage and differences based on the rating factors established by the carrier.

2. Prescribe the manner in which ~~[characteristics]~~ ***rating factors*** may be used by such carriers.

Sec. 70. NRS 689C.156 is hereby amended to read as follows:

689C.156 1. As a condition of transacting business in this State with small employers, a carrier shall actively market to a small employer each health benefit plan which is actively marketed in this State by the carrier to any small employer in this State. ~~[The health insurance plans marketed pursuant to this section by the carrier must include, without limitation, a basic health benefit plan and a standard health benefit plan.]~~ A carrier shall be deemed to be actively marketing a health benefit plan when it makes available any of its plans to a small employer that is not currently receiving coverage under a health benefit plan issued by that carrier.

2. A carrier shall issue to a small employer any health benefit plan marketed in accordance with this section if the eligible small

employer applies for the plan and agrees to make the required premium payments and satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with NRS 689C.015 to 689C.355, inclusive, and 689C.610 to ~~[689C.980,]~~ ***689C.940,*** inclusive, except that a carrier is not required to issue a health benefit plan to a self-employed person who is covered by, or is eligible for coverage under, a health benefit plan offered by another employer.

3. If a health benefit plan marketed pursuant to this section provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care, the carrier shall provide a system for resolving any complaints of an employee concerning those health care services that complies with the provisions of NRS 695G.200 to 695G.310, inclusive.

Sec. 71. NRS 689C.159 is hereby amended to read as follows:

689C.159 The provisions of NRS 689C.156 ~~[, 689C.157]~~ and 689C.190 do not apply to health benefit plans offered by a carrier if the carrier makes the health benefit plan available in the small employer market only through a bona fide association.

Sec. 72. NRS 689C.160 is hereby amended to read as follows:

689C.160 The requirements used by a carrier serving small employers to determine whether to provide coverage to a small employer, including, without limitation, ~~[standards for medical underwriting,]~~ requirements for minimum participation of eligible employees and minimum employer's contributions, must be applied uniformly among all small employers with the same number of eligible employees applying for coverage or receiving coverage from the carrier.

Sec. 73. NRS 689C.169 is hereby amended to read as follows:

689C.169 1. ~~[Notwithstanding any provisions of this title to the contrary, a]~~ ***A*** policy of group health insurance delivered or issued for delivery in this State pursuant to this chapter must provide coverage for the treatment of conditions relating to severe mental illness.

2. ~~[The coverage required by this section:~~

~~(a) Must provide:~~

~~(1) Benefits for at least 40 days of hospitalization as an inpatient per policy year and 40 visits for treatment as an outpatient per policy year, excluding visits for the management of medication; and~~

~~(2) That two visits for partial or respite care, or a combination thereof, may be substituted for each 1 day of hospitalization not used by the insured. In no event is the policy~~

~~required to provide coverage for more than 40 days of hospitalization as an inpatient per policy year.~~

~~(b) Is not required to provide benefits for psychosocial rehabilitation or care received as a custodial inpatient.~~

~~3. Any deductibles and copayments required to be paid for the coverage required by this section must not be greater than 150 percent of the out-of-pocket expenses required to be paid for medical and surgical benefits provided pursuant to the policy of group health insurance.~~

~~4. The provisions of this section do not apply to a policy of group health insurance if, at the end of the policy year, the premiums charged for that policy, or a standard grouping of policies, increase by more than 2 percent as a result of providing the coverage required by this section and the insurer obtains an exemption from the Commissioner pursuant to subsection 5.~~

~~5. To obtain the exemption required by subsection 4, an insurer must submit to the Commissioner a written request therefor that is signed by an actuary and sets forth the reasons and actuarial assumptions upon which the request is based. To determine whether an exemption may be granted, the Commissioner shall subtract from the amount of premiums charged during the policy year the amount of premiums charged during the period immediately preceding the policy year and the amount of any increase in the premiums charged that is attributable to factors that are unrelated to providing the coverage required by this section. The Commissioner shall verify the information within 30 days after receiving the request. The request shall be deemed approved if the Commissioner does not deny the request within that time.~~

~~6. The provisions of this section do not:~~

~~(a) Limit the provision of specialized services covered by Medicaid for persons with conditions relating to mental health or substance abuse.~~

~~(b) Supersede any provision of federal law, any federal or state policy relating to Medicaid, or the terms and conditions imposed on any Medicaid waiver granted to this State with respect to the provisions of services to persons with conditions relating to mental health or substance abuse.~~

~~7. A policy of group health insurance subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 3, 2009, has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void, unless the~~

~~policy is otherwise exempt from the provisions of this section pursuant to subsection 4.~~

~~8.]~~ As used in this section, "severe mental illness" means any of the following mental illnesses that are biologically based and for which diagnostic criteria are prescribed in the ***latest edition of the*** Diagnostic and Statistical Manual of Mental Disorders, ~~[Fourth Edition,]~~ published by the American Psychiatric Association:

(a) Schizophrenia.
(b) Schizoaffective disorder.
(c) Bipolar disorder.
(d) Major depressive disorders.
(e) Panic disorder.
(f) Obsessive-compulsive disorder.

Sec. 74. NRS 689C.190 is hereby amended to read as follows:

689C.190 ~~[1. Except as otherwise provided in this section, a]~~ ***A*** carrier serving small employers that issues a health benefit plan shall not deny, exclude or limit a benefit for a preexisting condition**.** ~~[:~~

~~(a) For more than 12 months after the effective date of coverage if the employee enrolls through open enrollment or after the first day of the waiting period for such enrollment, whichever is earlier; or~~

~~(b) For more than 18 months after the effective date of coverage for a late enrollee. A carrier may not define a preexisting condition in its health benefit plan more restrictively than that term is defined in NRS 689C.082.~~

~~2. The period of any exclusion for a preexisting condition imposed by a health benefit plan on a person to be insured in accordance with the provisions of this chapter must be reduced by the aggregate period of creditable coverage of that person, if the creditable coverage was continuous to a date not more than 63 days before the effective date of the new coverage. The period of continuous coverage must not include:~~

~~(a) Any waiting period for the effective date of the new coverage applied by the employer or the carrier; or~~

~~(b) Any affiliation period, not to exceed 60 days for a new enrollee and 90 days for a late enrollee, required before becoming eligible to enroll in the health benefit plan.~~

~~3. A health maintenance organization authorized to transact insurance pursuant to chapter 695C of NRS that does not restrict coverage for a preexisting condition may require an affiliation period before coverage becomes effective under a plan of insurance if the affiliation period applies uniformly to all employees and without regard to any health status-related factors. During the~~

affiliation period, the carrier shall not collect any premiums for coverage of the employee.

4. A carrier that restricts coverage for preexisting conditions shall not impose an affiliation period.

5. A carrier shall not impose any exclusion for a preexisting condition:

(a) Relating to pregnancy.

(b) In the case of a person who, as of the last day of the 30-day period beginning on the date of the person's birth, is covered under creditable coverage.

(c) In the case of a child who is adopted or placed for adoption before attaining the age of 18 years and who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, whichever is earlier, is covered under creditable coverage. The provisions of this paragraph do not apply to coverage before the date of adoption or placement for adoption.

(d) In the case of a condition for which medical advice, diagnosis, care or treatment was recommended or received for the first time while the covered person held creditable coverage, and the medical advice, diagnosis, care or treatment was a covered benefit under the plan, if the creditable coverage was continuous to a date not more than 90 days before the effective date of the new coverage.

➥ The provisions of paragraphs (b) and (c) do not apply to a person after the end of the first 63-day period during all of which the person was not covered under any creditable coverage.

6. As used in this section, "late enrollee" means an eligible employee, or a dependent of the eligible employee, who requests enrollment in a health benefit plan of a small employer following the initial period of enrollment, if the initial period of enrollment is at least 30 days, during which the person is entitled to enroll under the terms of the health benefit plan. The term does not include an eligible employee or a dependent of the eligible employee if:

(a) The employee or dependent:

(1) Was covered under creditable coverage at the time of the initial enrollment;

(2) Lost coverage under creditable coverage as a result of cessation of employer contribution, termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination of creditable coverage, or the death of, or divorce or legal separation from, a covered spouse; and

(3) Requests enrollment not later than 30 days after the date on which his or her creditable coverage was terminated or on which

~~the change in conditions that gave rise to the termination of the coverage occurred.~~

~~(b) The person enrolls during the open enrollment period, as provided in the contract or as otherwise provided by specific statute.~~

~~(c) The person is employed by an employer which offers multiple health benefit plans and the person elected a different plan during an open enrollment period.~~

~~(d) A court has ordered coverage to be provided to the spouse or a minor or dependent child of an employee under a health benefit plan of the employee and a request for enrollment is made within 30 days after the issuance of the court order.~~

~~(e) The person changes status from not being an eligible employee to being an eligible employee and requests enrollment, subject to any waiting period, within 30 days after the change in status.~~

~~(f) The person has continued coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 and such coverage has been exhausted.]~~

Sec. 75. NRS 689C.191 is hereby amended to read as follows:

689C.191 1. In determining the applicable creditable coverage of a person **,** ~~[for the purposes of NRS 689C.190,]~~ a period of creditable coverage must not be included if, after the expiration of that period but before the enrollment date, there was a 63-day period during all of which the person was not covered under any creditable coverage. To establish a period of creditable coverage, an eligible employee must present any certificates of coverage provided to the eligible employee in accordance with NRS 689C.192 and such other evidence of coverage as required by regulations adopted by the Commissioner. For the purposes of this subsection, any waiting period for coverage or an affiliation period must not be considered in determining the applicable period of creditable coverage.

2. In determining the period of creditable coverage of a person **,** ~~[for the purposes of NRS 689C.190,]~~ a carrier shall include each applicable period of creditable coverage without regard to the specific benefits covered during that period, except that the carrier may elect to include applicable periods of creditable coverage based on coverage of specific benefits as specified by the United States Department of Health and Human Services by regulation, if such an election is made on a uniform basis for all participants and beneficiaries of the health benefit plan or coverage. Pursuant to such an election, the carrier shall include each applicable period of creditable coverage with respect to any class or category of benefits

if any level of benefits is covered within that class or category, as specified by those regulations.

3. Regardless of whether coverage is actually provided, if a carrier elects in accordance with subsection 2 to determine creditable coverage based on specified benefits, a statement that such an election has been made and a description of the effect of the election must be:

(a) Included prominently in any disclosure statement concerning the health benefit plan; and

(b) Provided to each eligible employee at the time of enrollment in the health benefit plan.

4. The provisions of this section apply only to grandfathered plans.

Sec. 76. NRS 689C.193 is hereby amended to read as follows:

689C.193 1. A carrier shall not place any restriction on a small employer or an eligible employee or a dependent of the eligible employee as a condition of being a participant in or a beneficiary of a health benefit plan that is inconsistent with NRS 689C.015 to 689C.355, inclusive.

2. A carrier that offers health insurance coverage to small employers pursuant to this chapter shall not establish rules of eligibility, including, but not limited to, rules which define applicable waiting periods, for the initial or continued enrollment under a health benefit plan offered by the carrier that are based on the following factors relating to the eligible employee or a dependent of the eligible employee:

(a) Health status.

(b) Medical condition, including physical and mental illnesses, or both.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions which arise out of acts of domestic violence.

(h) Disability.

3. Except as otherwise provided in NRS 689C.190, the provisions of subsection 1 do not ~~[:~~

~~(a) Require]~~ ***require*** a carrier to provide particular benefits other than those that would otherwise be provided under the terms of the health benefit plan or coverage**.** ~~[; or~~

~~(b) Prevent a carrier from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated persons.]~~

4. As a condition of enrollment or continued enrollment under a health benefit plan, a carrier shall not require any person to pay a premium or contribution that is greater than the premium or contribution for a similarly situated person covered by similar coverage on the basis of any factor described in subsection 2 in relation to the person or a dependent of the person.

5. Nothing in this section:

(a) Restricts the amount that a small employer may be charged for coverage by a carrier;

(b) Prevents a carrier from establishing premium discounts or rebates or from modifying otherwise applicable copayments or deductibles in return for adherence by the insured person to programs of health promotion and disease prevention; or

(c) Precludes a carrier from establishing rules relating to employer contribution or group participation when offering health insurance coverage to small employers in this State.

6. As used in this section:

(a) "Contribution" means the minimum employer contribution toward the premium for enrollment of participants and beneficiaries in a health benefit plan.

(b) "Group participation" means the minimum number of participants or beneficiaries that must be enrolled in a health benefit plan in relation to a specified percentage or number of eligible persons or employees of the employer.

Sec. 77. NRS 689C.200 is hereby amended to read as follows:

689C.200 A carrier serving small employers is not required to accept applications from or offer coverage to:

1. A small employer if the employer is not physically located in the carrier's ~~[established]~~ geographic ***service*** area; or

2. An employee if the employee does not work or reside within the carrier's ~~[established]~~ geographic ***service*** area.

Sec. 78. NRS 689C.250 is hereby amended to read as follows:

689C.250 ~~[A carrier serving small employers shall make the information and documents described in NRS 689C.210 to 689C.240, inclusive, available to the Commissioner upon request.]~~

1. Except in cases of violations of NRS 689C.015 to 689C.355, inclusive, the ~~[information is]~~ ***unified rate review template and rate filing documentation used by carriers servicing small employers are considered*** proprietary, ~~[constitutes]~~ ***constitute*** a trade secret, and ~~[is]~~ ***are*** not subject to disclosure by the Commissioner to

persons outside of the Division except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

2. As used in this section, "rate filing documentation" and "unified rate review template" ascribed to in 45 C.F.R § 154.215.

Sec. 79. NRS 689C.310 is hereby amended to read as follows:

689C.310 1. Except as otherwise provided in subsections 2 and 3, a carrier shall renew a health benefit plan at the option of the small employer who purchased the plan.

2. A carrier may refuse to issue or to renew a health benefit plan if:

(a) The carrier discontinues transacting insurance in this state or in the geographic ***service*** area of this state where the employer is located;

(b) The employer fails to pay the premiums or contributions required by the terms of the plan;

(c) The employer misrepresents any information regarding the employees covered under the plan or other information regarding eligibility for coverage under the plan;

(d) The plan sponsor has engaged in an act or practice that constitutes fraud to obtain or maintain coverage under the plan;

(e) The employer is not in compliance with the minimum requirements for participation or employer contribution as set forth in the plan; or

(f) The employer fails to comply with any of the provisions of this chapter.

3. A carrier may require a small employer to exclude a particular employee or a dependent of the particular employee from coverage under a health benefit plan as a condition to renewal of the plan if the employee or dependent of the employee commits fraud upon the carrier or misrepresents a material fact which affects his or her coverage under the plan.

4. A carrier shall discontinue the issuance and renewal of coverage to a small employer if the Commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders or certificate holders of the carrier in this state or would impair the ability of the carrier to meet its contractual obligations. If the Commissioner makes such a finding, the Commissioner shall assist the affected small employers in finding replacement coverage.

5. A carrier may discontinue the issuance and renewal of a form of a product of a health benefit plan offered to small employers pursuant to this chapter if the Commissioner finds that the form of the product offered by the carrier is obsolete and is being replaced

with comparable coverage. A form of a product of a health benefit plan may be discontinued by a carrier pursuant to this subsection only if:

(a) The carrier notifies the Commissioner and the chief regulatory officer for insurance in each state in which it is licensed of its decision pursuant to this subsection to discontinue the issuance and renewal of the form of the product at least 60 days before the carrier notifies the affected small employers pursuant to paragraph (b).

(b) The carrier notifies each affected small employer and the Commissioner and the chief regulatory officer for insurance in each state in which any affected small employer is located or eligible employee resides of the decision of the carrier to discontinue offering the form of the product. The notice must be made at least 180 days before the date on which the carrier will discontinue offering the form of the product.

(c) The carrier offers to each affected small employer the option to purchase any other health benefit plan currently offered by the carrier to small employers in this state.

(d) In exercising the option to discontinue the particular form of the product and in offering the option to purchase other coverage pursuant to paragraph (c), the carrier acts uniformly without regard to the claims experience of the affected small employers or any health status-related factor relating to any participant or beneficiary covered by the discontinued product or any new participant or beneficiary who may become eligible for such coverage.

6. A carrier may discontinue the issuance and renewal of a health benefit plan offered to a small employer or an eligible employee pursuant to this chapter only through a bona fide association if:

(a) The membership of the small employer or eligible employee in the association was the basis for the provision of coverage;

(b) The membership of the small employer or eligible employee in the association ceases; and

(c) The coverage is terminated pursuant to this subsection uniformly without regard to any health status-related factor relating to the small employer or eligible employee or dependent of the eligible employee.

7. If a carrier does business in only one ~~[established]~~ geographic service area of this state, the provisions of this section apply only to the operations of the carrier in that service area.

Sec. 80. NRS 689C.320 is hereby amended to read as follows:

689C.320 1. A carrier that discontinues transacting insurance in this State or in a particular geographic ***service*** area of this State shall:

(a) Notify the Commissioner and the chief regulatory officer for insurance in each state in which the carrier is licensed to transact insurance at least 60 days before a notice of cancellation or nonrenewal is delivered or mailed to the affected small employers pursuant to paragraph (b).

(b) Notify the Commissioner and each small employer affected not less than 180 days before the expiration of any policy or contract of insurance under any health benefit plan issued to a small employer pursuant to this chapter.

2. A carrier that cancels any health benefit plan because it has discontinued transacting insurance in this State or in a particular geographic ***service*** area of this State:

(a) Shall discontinue the issuance and delivery for issuance of all health benefit plans pursuant to this chapter in this State and not renew coverage under any health benefit plan issued to a small employer; and

(b) May not issue any health benefit plans pursuant to this chapter in this State or in the particular geographic area for 5 years after it gives notice to the Commissioner pursuant to paragraph (b) of subsection 1.

Sec. 81. NRS 689C.325 is hereby amended to read as follows:

689C.325 A carrier that offers coverage through a network plan is not required to offer coverage to or accept any applications for coverage from the eligible employees of a small employer pursuant to NRS 689C.310 and 689C.320 if:

1. The eligible employees do not reside or work in the ~~[established]~~ geographic service area of the network plan.

2. For a small employer whose eligible employees reside or work in the ~~[established]~~ geographic service area of the network plan, the carrier demonstrates to the satisfaction of the Commissioner that the carrier does not have the capacity to deliver adequate service to additional small employers and eligible employees because of the existing obligations of the carrier. If a carrier is authorized by the Commissioner not to offer coverage pursuant to this subsection, the carrier shall not thereafter offer coverage to additional small employers and eligible employees within that ~~[established]~~ geographic service area until the carrier demonstrates to the satisfaction of the Commissioner that it has

regained the capacity to deliver adequate service to additional small employers and eligible employees within that service area.

Sec. 82. (Deleted by amendment.)

Sec. 83. NRS 689C.350 is hereby amended to read as follows:

689C.350 A health benefit plan which offers a difference of payment between preferred providers of health care and providers of health care who are not preferred:

1. ~~[May not require a deductible of more than $600 difference per admission to a facility for inpatient treatment which is not a preferred provider of health care.~~

~~2. May not require a deductible of more than $500 difference per treatment, other than inpatient treatment at a hospital, by a provider which is not preferred.~~

~~3. May not provide for a difference in percentage rates of payment for coinsurance of more than 30 percentage points between the payment for coinsurance required to be paid by the insured to a preferred provider of health care and the payment for coinsurance required to be paid by the insured to a provider of health care who is not preferred.~~

~~4.]~~ Must require that the deductible and payment for coinsurance paid by the insured to a preferred provider of health care be applied to the negotiated reduced rates of that provider.

~~[5.]~~ ***2.*** Must include for providers of health care who are not preferred a provision establishing the point at which an insured's payment for coinsurance is no longer required to be paid if such a provision is included for preferred providers of health care. Such provisions must be based on a ~~[calendar]~~ ***plan*** year. The point at which an insured's payment for coinsurance is no longer required to be paid for providers of health care who are not preferred must not be greater than twice the amount for preferred providers of health care, regardless of the method of payment.

~~[6.]~~ ***3.*** Must provide that if there is a particular service which a preferred provider of health care does not provide and the provider of health care who is treating the insured requests the service and the insurer determines that the use of the service is necessary for the health of the insured, the service shall be deemed to be provided by the preferred provider of health care.

~~[7. Must require the insurer to process a claim of a provider of health care who is not preferred not later than 30 working days after the date on which proof of the claim is received.]~~

Sec. 84. NRS 689C.355 is hereby amended to read as follows:

689C.355 1. Except as otherwise provided in this section, a carrier or a producer shall not, directly or indirectly:

(a) Encourage or direct a small employer to refrain from filing an application for coverage with the carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

(b) Encourage or direct a small employer to seek coverage from another carrier because of the health status, claims experience, industry, occupation or geographic location of the small employer.

2. The provisions of subsection 1 do not apply to information provided to a small employer by a carrier or a producer relating to the ~~[established]~~ geographic service area or a provision for a restricted network of the carrier.

3. Except as otherwise provided in this subsection, a carrier shall not, directly or indirectly, enter into any contract, agreement or arrangement with a producer if the contract, agreement or arrangement provides for or results in a variation to the compensation that is paid to a producer for the sale of a health benefit plan because of the health status, claims experience, industry, occupation or geographic location of the small employer at the time that the health benefit plan is issued to or renewed by the small employer. ~~[The provisions of this subsection do not apply to any arrangement for compensation that provides payment to a producer on the basis of percentage of premium, except that the percentage may not vary because of the health status, claims experience, industry, occupation or geographic area of the small employer.]~~

4. A carrier shall not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status, claims experience, occupation or geographic location of a small employer at the time that the health benefit plan is issued to or renewed by the small employer placed by the producer with the carrier.

5. A carrier or producer shall not induce or otherwise encourage a small employer to separate or otherwise exclude an employee or a dependent of the employee from health coverage or benefits provided in connection with the employment of the employee.

6. A violation of any provision of this section by a carrier may constitute an unfair trade practice for the purposes of chapter 686A of NRS.

7. The provisions of this section apply to a third-party administrator if the third-party administrator enters into a contract, agreement or other arrangement with a carrier to provide

administrative, marketing or other services related to the offering of a health benefit plan to small employers in this state.

8. Nothing in this section interferes with the right and responsibility of a ~~[broker]~~ ***producer*** to advise and represent the best interests of a small employer who is seeking health insurance coverage from a small employer carrier.

Sec. 85. NRS 689C.390 is hereby amended to read as follows:

689C.390 "Dependent" means a spouse, ~~[an unmarried]~~ ***a domestic partner as defined in NRS 122A.030, or a*** child ~~[who has not attained 19]~~ ***on or before the last day of the month in which the child attains 26*** years of age ***.*** ~~[, an unmarried child who is a full-time student who has not attained 24 years of age and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent.]~~

Sec. 86. NRS 689C.610 is hereby amended to read as follows:

689C.610 As used in NRS 689C.610 to ~~[689C.980,]~~ ***689C.940,*** inclusive, unless the context otherwise requires, the words and terms defined in NRS ~~[689C.620 to 689C.730, inclusive,]~~ ***689C.630, 689C.660 and 689C.670*** have the meanings ascribed to them in those sections.

Sec. 87. (Deleted by amendment.)

Sec. 88. NRS 695A.152 is hereby amended to read as follows:

695A.152 1. To the extent reasonably applicable, a fraternal benefit society shall comply with the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance offered by the society to its members. If there is a conflict between the provisions of this chapter and the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS, the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS control.

2. For the purposes of subsection 1, unless the context requires that a provision apply only to a group health plan or a carrier that provides coverage under a group health plan, any reference in those sections to "group health plan" or "carrier" must be replaced by "fraternal benefit society."

Sec. 89. NRS 695A.159 is hereby amended to read as follows:

695A.159 1. If a person:

(a) Adopts a dependent child; or

(b) Assumes and retains a legal obligation for the total or partial support of a dependent child in anticipation of adopting the child,

➥ while the person is eligible for group coverage under a certificate for health benefits, the society issuing that certificate shall not restrict the coverage, in accordance with NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance, of the child solely because of a preexisting condition the child has at the time he or she would otherwise become eligible for coverage pursuant to that policy.

2. For the purposes of this section, "child" means a person who is under 18 years of age at the time of his or her adoption or the assumption of a legal obligation for his or her support in anticipation of his or her adoption.

Sec. 90. NRS 695B.187 is hereby amended to read as follows:

695B.187 Except as otherwise provided by the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance:

1. A group contract for hospital, medical or dental services issued by a nonprofit hospital, medical or dental service corporation to replace any discontinued policy or coverage for group health insurance must:

(a) Provide coverage for all persons who were covered under the previous policy or coverage on the date it was discontinued; and

(b) Except as otherwise provided in subsection 2, provide benefits which are at least as extensive as the benefits provided by the previous policy or coverage, except that the benefits may be reduced or excluded to the extent that such a reduction or exclusion was permissible under the terms of the previous policy or coverage,

➥ if that contract is issued within 60 days after the date on which the previous policy or coverage was discontinued.

2. If an employer obtains a replacement contract pursuant to subsection 1 to cover the employees of the employer, any benefits provided by the previous policy or coverage may be reduced if notice of the reduction is given to the employees of the employer pursuant to NRS 608.1577.

3. Any corporation which issues a replacement contract pursuant to subsection 1 may submit a written request to the insurer which provided the previous policy or coverage for a statement of benefits which were provided under that policy or coverage. Upon receiving such a request, the insurer shall give a written statement to the corporation which indicates what benefits were provided and what exclusions or reductions were in effect under the previous policy or coverage.

4. The provisions of this section apply to a self-insured employer who provides health benefits to the employees of the self-insured employer and replaces those benefits with a group contract for hospital, medical or dental services issued by a nonprofit hospital, medical or dental service corporation.

Sec. 91. NRS 695B.189 is hereby amended to read as follows:

695B.189 A group contract issued by a corporation under the provisions of this chapter must contain a provision which permits the continuation of coverage pursuant to the provisions of NRS ~~[689B.245 to 689B.249, inclusive, and]~~ 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance.

Sec. 92. NRS 695B.192 is hereby amended to read as follows:

695B.192 1. No hospital, medical or dental service contract issued by a corporation pursuant to the provisions of this chapter may contain any exclusion, reduction or other limitation of coverage relating to complications of pregnancy, unless the provision applies generally to all benefits payable under the contract and complies with the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance.

2. As used in this section, the term "complications of pregnancy" includes any condition which requires hospital confinement for medical treatment and:

(a) If the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or

(b) If the pregnancy is terminated, results in nonelective cesarean section, ectopic pregnancy or spontaneous termination.

3. A contract subject to the provisions of this chapter which is issued or delivered on or after July 1, 1977, has the legal effect of including the coverage required by this section, and any provision of the contract which is in conflict with this section is void.

Sec. 93. NRS 695B.251 is hereby amended to read as follows:

695B.251 1. Except as otherwise provided in the provisions of this section, NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance, all group subscriber contracts delivered or issued for delivery in this state providing for hospital, surgical or major medical coverage, or any combination of these coverages, on a service basis or an expense-incurred basis, or both, must contain a provision that the employee or member is entitled to have issued to

him or her a subscriber contract of health coverage when the employee or member is no longer covered by the group subscriber contract.

2. The requirement in subsection 1 does not apply to contracts providing benefits only for specific diseases or accidental injuries.

3. If an employee or member was a recipient of benefits under the coverage provided pursuant to NRS 695B.1944, the employee or member is not entitled to have issued to him or her by a replacement insurer a subscriber contract of health coverage unless the employee or member has reported for his or her normal employment for a period of 90 consecutive days after last being eligible to receive any benefits under the coverage provided pursuant to NRS 695B.1944.

Sec. 94. NRS 695B.259 is hereby amended to read as follows:

695B.259 The medical service corporation may continue coverage identical to that provided under the group contract instead of issuing a converted contract. Coverage may be offered by amending the group certificate or by issuing an individual contract and ~~[, except as otherwise provided in NRS 689B.245 to 689B.249, inclusive,]~~ must otherwise comply with every requirement of NRS 695B.251 to 695B.259, inclusive.

Sec. 95. NRS 695B.318 is hereby amended to read as follows:

695B.318 1. Nonprofit hospital, medical or dental service corporations are subject to the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance offered by such organizations. If there is a conflict between the provisions of this chapter and the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS, the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS control.

2. For the purposes of subsection 1, unless the context requires that a provision apply only to a group health plan or a carrier that provides coverage under a group health plan, any reference in those sections to:

(a) "Carrier" must be replaced by "corporation."

(b) "Group health plan" must be replaced by "group contract for hospital, medical or dental services."

Sec. 95.5. NRS 695B.320 is hereby amended to read as follows:

695B.320 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, NRS 686A.010 to 686A.315, 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, 687B.270, 687B.310 to 687B.380, inclusive, 687B.410, 687B.420, 687B.430, ***and section 33.8 of this act,*** and chapters 692C and 696B of NRS, to the extent applicable and not in conflict with the express provisions of this chapter.

Sec. 96. 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 to 695C.173, inclusive, 695C.1733 to 695C.200, inclusive, ~~[695C.250]~~ and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694, 695C.1695 and 695C.1731 apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 96.5. NRS 695C.055 is hereby amended to read as follows:

695C.055 1. The provisions of NRS 449.465, 679A.200, 679B.700, subsections 2, 4, 18, 19 and 32 of NRS 680B.010, NRS 680B.020 to 680B.060, inclusive, ***and section 33.8 of this act,*** and chapters 686A and 695G of NRS apply to a health maintenance organization.

2. For the purposes of subsection 1, unless the context requires that a provision apply only to insurers, any reference in those sections to "insurer" must be replaced by "health maintenance organization."

Sec. 97. NRS 695C.057 is hereby amended to read as follows:

695C.057 1. A health maintenance organization is subject to the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance offered by such organizations. If there is a conflict between the provisions of this chapter and the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS, the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS control.

2. For the purposes of subsection 1, unless the context requires that a provision apply only to a group health plan or a carrier that provides coverage under a group health plan, any reference in those sections to "group health plan" or "carrier" must be replaced by "health maintenance organization."

Sec. 98. NRS 695C.080 is hereby amended to read as follows:

695C.080 1. ~~[Upon receipt of an application for issuance of a certificate of authority, the Commissioner shall forthwith transmit copies of such application and accompanying documents to the State Board of Health.~~

~~2.]~~ The ~~[State Board of Health]~~ ***Commissioner*** shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished:

(a) Has demonstrated the willingness and ability to ensure that such health care services will be provided in a manner to ensure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability, accessibility and continuity of service;

(b) Has organizational arrangements, established in accordance with regulations promulgated by the ***Commissioner and in consultation with the*** State Board of Health; and

(c) Has a procedure established in accordance with regulations of the ~~[State Board of Health]~~ ***Commissioner*** to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services and such other matters as may be reasonably required by the ~~[State Board of Health.~~

~~3.]~~ ***Commissioner.***

2. Within 90 days of receipt of the application for issuance of a certificate of authority, the ~~[State Board of Health shall certify to~~

~~the~~ Commissioner ***shall certify*** whether the proposed health maintenance organization meets the requirements of subsection ~~[2.]~~ ***1.*** If the ~~[State Board of Health]~~ ***Commissioner*** certifies that the health maintenance organization does not meet such requirements, it shall specify in what respects it is deficient.

Sec. 99. NRS 695C.090 is hereby amended to read as follows:

695C.090 The Commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to NRS 695C.060 within 90 days ~~[of receipt of the]~~ ***after*** certification ***.*** ~~[from the State Board of Health.]~~ Issuance of a certificate of authority must be granted upon payment of the fees prescribed in NRS 695C.230 if the Commissioner is satisfied that the following conditions are met:

1. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations.

2. The ~~[State Board of Health]~~ ***Commissioner*** certifies, in accordance with NRS 695C.080, that the health maintenance organization's proposed plan of operation meets the requirements of subsection ~~[2]~~ ***1*** of NRS 695C.080.

3. The health care plan furnishes comprehensive health care services.

4. The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the Commissioner may consider:

(a) The financial soundness of the health care plan's arrangements for health care services and the schedule of charges used in connection therewith;

(b) The adequacy of working capital;

(c) Any agreement with an insurer, a government, or any other organization for insuring the payment of the cost of health care services;

(d) Any agreement with providers for the provision of health care services; and

(e) Any surety bond or deposit of cash or securities submitted in accordance with NRS 695C.270 as a guarantee that the obligations will be duly performed.

5. The enrollees will be afforded an opportunity to participate in matters of program content pursuant to NRS 695C.110.

6. Nothing in the proposed method of operation, as shown by the information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, or by independent investigation is contrary to the public interest.

Sec. 100. NRS 695C.140 is hereby amended to read as follows:

695C.140 1. A health maintenance organization shall, unless otherwise provided for in this chapter, file notice with the Commissioner ~~[and the State Board of Health]~~ before any material modification of the operations described in the information required by NRS 695C.070. If the Commissioner does not disapprove within 90 days after filing of the notice, the modification is deemed approved.

2. The Commissioner may adopt regulations to carry out the provisions of this section.

Sec. 101. NRS 695C.1693 is hereby amended to read as follows:

695C.1693 1. Except as otherwise provided in NRS 695C.050, a health care plan issued by a health maintenance organization must provide coverage for medical treatment which an enrollee receives as part of a clinical trial or study if:

(a) The medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;

(b) The clinical trial or study is approved by:

(1) An agency of the National Institutes of Health as set forth in 42 U.S.C. § 281(b);

(2) A cooperative group;

(3) The Food and Drug Administration as an application for a new investigational drug;

(4) The United States Department of Veterans Affairs; or

(5) The United States Department of Defense;

(c) In the case of:

(1) A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer; or

(2) A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner;

(d) There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;

(e) There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;

(f) The clinical trial or study is conducted in this State; and

(g) The enrollee has signed, before participating in the clinical trial or study, a statement of consent indicating that the enrollee has been informed of, without limitation:

(1) The procedure to be undertaken;

(2) Alternative methods of treatment; and

(3) The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

2. Except as otherwise provided in subsection 3, the coverage for medical treatment required by this section is limited to:

(a) Coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the enrollee.

(b) The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered under the health care plan.

(c) The cost of any routine health care services that would otherwise be covered under the health care plan for an enrollee in a Phase I clinical trial or study.

(d) The initial consultation to determine whether the enrollee is eligible to participate in the clinical trial or study.

(e) Health care services required for the clinically appropriate monitoring of the enrollee during a Phase II, Phase III or Phase IV clinical trial or study.

(f) Health care services which are required for the clinically appropriate monitoring of the enrollee during a Phase I clinical trial or study and which are not directly related to the clinical trial or study.

➥ Except as otherwise provided in NRS 695C.1691, the services provided pursuant to paragraphs (b), (c), (e) and (f) must be covered only if the services are provided by a provider with whom the health maintenance organization has contracted for such services. If the health maintenance organization has not contracted for the provision of such services, the health maintenance organization shall pay the

provider the rate of reimbursement that is paid to other providers with whom the health maintenance organization has contracted for similar services and the provider shall accept that rate of reimbursement as payment in full.

3. Particular medical treatment described in subsection 2 and provided to an enrollee is not required to be covered pursuant to this section if that particular medical treatment is provided by the sponsor of the clinical trial or study free of charge to the enrollee.

4. The coverage for medical treatment required by this section does not include:

(a) Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.

(b) Coverage for a drug or device described in paragraph (a) of subsection 2 which is paid for by the manufacturer, distributor or provider of the drug or device.

(c) Health care services that are specifically excluded from coverage under the enrollee's health care plan, regardless of whether such services are provided under the clinical trial or study.

(d) Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study.

(e) Extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that a participant may incur.

(f) Any expenses incurred by a person who accompanies the enrollee during the clinical trial or study.

(g) Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the enrollee.

(h) Any costs for the management of research relating to the clinical trial or study.

5. A health maintenance organization that delivers or issues for delivery a health care plan specified in subsection 1 may require copies of the approval or certification issued pursuant to paragraph (b) of subsection 1, the statement of consent signed by the enrollee, protocols for the clinical trial or study and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment pursuant to this section.

6. A health maintenance organization that delivers or issues for delivery a health care plan specified in subsection 1 shall ~~[:~~

~~(a) Include in the disclosure required pursuant to NRS 695C.193 notice to each enrollee of the availability of the benefits required by this section.~~

~~(b) Provide~~] ***provide*** the coverage required by this section subject to the same deductible, copayment, coinsurance and other such conditions for coverage that are required under the plan.

7. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2006, has the legal effect of including the coverage required by this section, and any provision of the plan that conflicts with this section is void.

8. A health maintenance organization that delivers or issues for delivery a health care plan specified in subsection 1 is immune from liability for:

(a) Any injury to an enrollee caused by:

(1) Any medical treatment provided to the enrollee in connection with his or her participation in a clinical trial or study described in this section; or

(2) An act or omission by a provider of health care who provides medical treatment or supervises the provision of medical treatment to the enrollee in connection with his or her participation in a clinical trial or study described in this section.

(b) Any adverse or unanticipated outcome arising out of an enrollee's participation in a clinical trial or study described in this section.

9. As used in this section:

(a) "Cooperative group" means a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health. The term includes:

(1) The Clinical Trials Cooperative Group Program; and

(2) The Community Clinical Oncology Program.

(b) "Facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer" means a facility or an affiliate of a facility that:

(1) Has in place a Phase I program which permits only selective participation in the program and which uses clear-cut criteria to determine eligibility for participation in the program;

(2) Operates a protocol review and monitoring system which conforms to the standards set forth in the Policies and Guidelines Relating to the Cancer-Center Support Grant published by the Cancer Centers Branch of the National Cancer Institute;

(3) Employs at least two researchers and at least one of those researchers receives funding from a federal grant;

(4) Employs at least three clinical investigators who have experience working in Phase I clinical trials or studies conducted at a facility designated as a comprehensive cancer center by the National Cancer Institute;

(5) Possesses specialized resources for use in Phase I clinical trials or studies, including, without limitation, equipment that facilitates research and analysis in proteomics, genomics and pharmacokinetics;

(6) Is capable of gathering, maintaining and reporting electronic data; and

(7) Is capable of responding to audits instituted by federal and state agencies.

(c) "Provider of health care" means:

(1) A hospital; or

(2) A person licensed pursuant to chapter 630, 631 or 633 of NRS.

Sec. 102. NRS 695C.1705 is hereby amended to read as follows:

695C.1705 Except as otherwise provided in the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS relating to the portability and accountability of health insurance:

1. A group health care plan issued by a health maintenance organization to replace any discontinued policy or coverage for group health insurance must:

(a) Provide coverage for all persons who were covered under the previous policy or coverage on the date it was discontinued; and

(b) Except as otherwise provided in subsection 2, provide benefits which are at least as extensive as the benefits provided by the previous policy or coverage, except that benefits may be reduced or excluded to the extent that such a reduction or exclusion was permissible under the terms of the previous policy or coverage,

➥ if that plan is issued within 60 days after the date on which the previous policy or coverage was discontinued.

2. If an employer obtains a replacement plan pursuant to subsection 1 to cover the employees of the employer, any benefits provided by the previous policy or coverage may be reduced if notice of the reduction is given to the employees pursuant to NRS 608.1577.

3. Any health maintenance organization which issues a replacement plan pursuant to subsection 1 may submit a written

request to the insurer which provided the previous policy or coverage for a statement of benefits which were provided under that policy or coverage. Upon receiving such a request, the insurer shall give a written statement to the organization indicating what benefits were provided and what exclusions or reductions were in effect under the previous policy or coverage.

4. If an employee or enrollee was a recipient of benefits under the coverage provided pursuant to NRS 695C.1709, the employee or enrollee is not entitled to have issued to him or her by a health maintenance organization a replacement plan unless the employee or enrollee has reported for his or her normal employment for a period of 90 consecutive days after last being eligible to receive any benefits under the coverage provided pursuant to NRS 695C.1709.

5. The provisions of this section apply to a self-insured employer who provides health benefits to the employees of the self-insured employer and replaces those benefits with a group health care plan issued by a health maintenance organization.

Sec. 103. NRS 695C.172 is hereby amended to read as follows:

695C.172 1. No health maintenance organization may issue evidence of coverage under a health care plan to any enrollee in this state if it contains any exclusion, reduction or other limitation of coverage relating to complications of pregnancy unless the provision applies generally to all benefits payable under the policy and complies with the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS relating to the portability and accountability of health insurance.

2. As used in this section, the term "complications of pregnancy" includes any condition which requires hospital confinement for medical treatment and:

(a) If the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or

(b) If the pregnancy is terminated, results in nonelective cesarean section, ectopic pregnancy or spontaneous termination.

3. Evidence of coverage under a health care plan subject to the provisions of this chapter which is issued on or after July 1, 1977, has the legal effect of including the coverage required by this section, and any provision which is in conflict with this section is void.

Sec. 104. NRS 695C.1727 is hereby amended to read as follows:

695C.1727 1. No evidence of coverage that provides coverage for hospital, medical or surgical expenses may be delivered or issued for delivery in this state unless the evidence of coverage includes coverage for the management and treatment of diabetes, including, without limitation, coverage for the self-management of diabetes.

2. An insurer who delivers or issues for delivery an evidence of coverage specified in subsection 1 ~~[:~~

~~(a) Shall include in the disclosure required pursuant to NRS 695C.193 notice to each enrollee under the evidence of coverage of the availability of the benefits required by this section.~~

~~(b) Shall]~~ ***shall*** provide the coverage required by this section subject to the same deductible, copayment, coinsurance and other such conditions for the evidence of coverage that are required under the evidence of coverage.

3. Evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 1998, has the legal effect of including the coverage required by this section, and any provision of the evidence of coverage that conflicts with this section is void.

4. As used in this section:

(a) "Coverage for the management and treatment of diabetes" includes coverage for medication, equipment, supplies and appliances that are medically necessary for the treatment of diabetes.

(b) "Coverage for the self-management of diabetes" includes:

(1) The training and education provided to the enrollee after the enrollee is initially diagnosed with diabetes which is medically necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes;

(2) Training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the enrollee and which requires modification of the enrollee's program of self-management of diabetes; and

(3) Training and education which is medically necessary because of the development of new techniques and treatment for diabetes.

(c) "Diabetes" includes type I, type II and gestational diabetes.

Sec. 105. NRS 695C.1745 is hereby amended to read as follows:

695C.1745 1. A health care plan of a health maintenance organization must provide coverage for benefits payable for expenses incurred for administering the human papillomavirus vaccine ~~[to women and girls at such ages]~~ as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. A health care plan of a health maintenance organization must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.

3. Any evidence of coverage subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after July 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with subsection 1 is void.

4. For the purposes of this section, "human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

Sec. 106. NRS 695C.200 is hereby amended to read as follows:

695C.200 The Commissioner shall within a reasonable period approve any form if the requirements of NRS 695C.170 are met . ~~[and any schedule of charges if the requirements of NRS 695C.180 are met.]~~ It is unlawful to issue such form or to use such schedule of charges until approved. If the Commissioner disapproves such filing, the Commissioner shall notify the filer. In the notice, the Commissioner shall specify the reasons for disapproval. A hearing will be granted within 90 days after a request in writing by the person filing.

Sec. 107. NRS 695C.210 is hereby amended to read as follows:

695C.210 1. Every health maintenance organization shall file with the Commissioner on or before March 1 of each year a report showing its financial condition on the last day of the preceding calendar year. The report must be verified by at least two principal officers of the organization. ~~[The organization shall file a copy of the report with the State Board of Health.]~~

2. The report must be on forms prescribed by the Commissioner and must include:

(a) A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding calendar year;

(b) Any material changes in the information submitted pursuant to NRS 695C.070;

(c) The number of persons enrolled during the year, the number of enrollees as of the end of the year, the number of enrollments terminated during the year and, if requested by the Commissioner, a compilation of the reasons for such terminations;

(d) The number and amount of malpractice claims initiated against the health maintenance organization and any of the providers used by it during the year broken down into claims with and without form of legal process, and the disposition, if any, of each such claim, if requested by the Commissioner;

(e) A summary of information compiled pursuant to paragraph (c) of subsection ~~[2]~~ ***1*** of NRS 695C.080 in such form as required by the ~~[State Board of Health;]~~ ***Commissioner;*** and

(f) Such other information relating to the performance of the health maintenance organization as is necessary to enable the Commissioner to carry out his or her duties pursuant to this chapter.

3. Every health maintenance organization shall file with the Commissioner annually an audited financial statement of the organization prepared by an independent certified public accountant. The statement must cover the preceding 12-month period and must be filed with the Commissioner within 120 days after the end of the organization's fiscal year. Upon written request, the Commissioner may grant a 30-day extension.

4. If an organization fails to file timely the report or financial statement required by this section, it shall pay an administrative penalty of $100 per day until the report or statement is filed, except that the total penalty must not exceed $3,000. The Attorney General shall recover the penalty in the name of the State of Nevada.

5. The Commissioner may grant a reasonable extension of time for filing the report or financial statement required by this section, if the request for an extension is submitted in writing and shows good cause.

Sec. 108. NRS 695C.310 is hereby amended to read as follows:

695C.310 1. The Commissioner shall make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements or other

arrangements pursuant to its health care plan as often as the Commissioner deems it necessary for the protection of the interests of the people of this State. An examination must be made not less frequently than once every 3 years.

2. The ~~[State Board of Health]~~ ***Commissioner*** shall make an examination concerning the quality of health care services of any health maintenance organization and providers with whom such organization has contracts, agreements or other arrangements pursuant to its health care plan as often as it deems necessary for the protection of the interests of the people of this State. An examination must be made not less frequently than once every 3 years.

3. Every health maintenance organization and provider shall submit its books and records relating to the health care plan to an examination made pursuant to subsection 1 or 2 and in every way facilitate the examination. Medical records of natural persons and records of physicians providing service pursuant to a contract to the health maintenance organization are not subject to such examination, although the records are subject to subpoena upon a showing of good cause. For the purpose of examinations, the Commissioner ~~[and the State Board of Health]~~ may administer oaths to, and examine the officers and agents of the health maintenance organization and the principals of such providers concerning their business.

4. The expenses of examinations pursuant to this section must be assessed against the organization being examined and remitted to the Commissioner **.** ~~[or the State Board of Health, whichever is appropriate.]~~

5. In lieu of such examination, the Commissioner may accept the report of an examination made by the insurance commissioner or the state board of health of another state.

Sec. 109. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if the Commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments

to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The ~~[State Board of Health certifies to the]~~ Commissioner ***certifies*** that the health maintenance organization:

(1) Does not meet the requirements of subsection ~~[2]~~ ***1*** of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional

groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 110. NRS 695C.340 is hereby amended to read as follows:

695C.340 1. When the Commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, the Commissioner shall notify the health maintenance organization ~~[and the State Board of Health]~~ in writing specifically stating the grounds for denial, suspension or revocation and fixing a time at least 30 days thereafter for a hearing on the matter.

2. ~~[The State Board of Health or its delegated representative shall be in attendance at the hearing and shall participate in the proceedings. The recommendation and findings of the State Board of Health with respect to matters relating to the quality of health maintenance services provided in connection with any decision regarding denial, suspension or revocation of a certificate of authority are conclusive and binding upon the Commissioner.]~~ After the hearing, or upon the failure of the health maintenance organization to appear at the hearing, the Commissioner shall take action as is deemed advisable on written findings which must be mailed to the health maintenance organization . ~~[with a copy thereof to the State Board of Health.]~~ The action of the Commissioner ~~[and the recommendation and findings of the State Board of Health]~~ are subject to review by the First Judicial District Court of the State of Nevada in and for Carson City. The court may, in disposing of the issue before it, modify, affirm or reverse the order of the Commissioner in whole or in part.

Sec. 111. NRS 695C.350 is hereby amended to read as follows:

695C.350 1. The Commissioner may, in lieu of suspension or revocation of a certificate of authority under NRS 695C.330, levy an administrative penalty in an amount not more than $2,500 for each act or violation, if reasonable notice in writing is given of the intent to levy the penalty.

2. Any person who violates the provisions of this chapter is guilty of a misdemeanor.

3. If the Commissioner ~~[or the State Board of Health]~~ for any reason ~~[have]~~ ***has*** cause to believe that any violation of this chapter has occurred or is threatened, the Commissioner ~~[or the State Board of Health]~~ may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives to attempt to determine the facts relating to the suspected violation, and, if it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

4. The proceedings conducted pursuant to the provisions of subsection 3 must not be governed by any formal procedural requirements, and may be conducted in such manner as the Commissioner ~~[or the State Board of Health]~~ may deem appropriate under the circumstances.

5. The Commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this chapter.

6. Within 30 days after service of the order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this chapter have occurred. The hearing must be conducted pursuant to the provisions of chapter 233B of NRS and judicial review must be available as provided therein.

7. In the case of any violation of the provisions of this chapter, if the Commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection 5, the Commissioner may institute a proceeding to obtain injunctive relief, or seek other appropriate relief in the district court of the judicial district of the county in which the violator resides.

Sec. 112. NRS 695F.090 is hereby amended to read as follows:

695F.090 Prepaid limited health service organizations are subject to the provisions of this chapter and to the following provisions, to the extent reasonably applicable:

1. NRS 687B.310 to 687B.420, inclusive, concerning cancellation and nonrenewal of policies.

2. NRS 687B.122 to 687B.128, inclusive, concerning readability of policies.

3. The requirements of NRS 679B.152.

4. The fees imposed pursuant to NRS 449.465.

5. NRS 686A.010 to 686A.310, inclusive, concerning trade practices and frauds.

6. The assessment imposed pursuant to NRS 679B.700.

7. Chapter 683A of NRS.

8. To the extent applicable, the provisions of NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance.

9. NRS 689A.035, 689A.410, 689A.413 and 689A.415.

10. NRS 680B.025 to 680B.039, inclusive, concerning premium tax, premium tax rate, annual report and estimated quarterly tax payments. For the purposes of this subsection, unless the context otherwise requires that a section apply only to insurers, any reference in those sections to "insurer" must be replaced by a reference to "prepaid limited health service organization."

11. Chapter 692C of NRS, concerning holding companies.

12. NRS 689A.637, concerning health centers.

Sec. 113. NRS 695G.130 is hereby amended to read as follows:

695G.130 1. In addition to any other report which is required to be filed with the Commissioner **,** ~~[or the State Board of Health,]~~ each managed care organization shall file with the Commissioner **,** ~~[and the State Board of Health,]~~ on or before March 1 of each year, a report regarding its methods for reviewing the quality of health care services provided to its insureds.

2. Each managed care organization shall include in its report the criteria, data, benchmarks or studies used to:

(a) Assess the nature, scope, quality and accessibility of health care services provided to insureds; or

(b) Determine any reduction or modification of the provision of health care services to insureds.

3. Except as already required to be filed with the Commissioner **,** ~~[or the State Board of Health,]~~ if the managed care

organization is not owned and operated by a public entity and has more than 100 insureds, the report filed pursuant to subsection 1 must include:

(a) A copy of all of its quarterly and annual financial reports;

(b) A statement of any financial interest it has in any other business which is related to health care that is greater than 5 percent of that business or $5,000, whichever is less; and

(c) A description of each complaint filed with or against it that resulted in arbitration, a lawsuit or other legal proceeding, unless disclosure is prohibited by law or a court order.

4. A report filed pursuant to this section must be made available for public inspection within a reasonable time after it is received by the Commissioner.

Sec. 114. NRS 695G.171 is hereby amended to read as follows:

695G.171 1. A health care plan issued by a managed care organization must provide coverage for benefits payable for expenses incurred for administering the human papillomavirus vaccine ~~[to women and girls at such ages]~~ as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. A health care plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.

3. An evidence of coverage for a health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after July 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal thereof which is in conflict with subsection 1 is void.

4. For the purposes of this section, "human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

Sec. 115. NRS 695G.173 is hereby amended to read as follows:

695G.173 1. A health care plan issued by a managed care organization must provide coverage for medical treatment which a person insured under the plan receives as part of a clinical trial or study if:

(a) The medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;

(b) The clinical trial or study is approved by:

(1) An agency of the National Institutes of Health as set forth in 42 U.S.C. § 281(b);

(2) A cooperative group;

(3) The Food and Drug Administration as an application for a new investigational drug;

(4) The United States Department of Veterans Affairs; or

(5) The United States Department of Defense;

(c) In the case of:

(1) A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer; or

(2) A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner;

(d) There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;

(e) There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;

(f) The clinical trial or study is conducted in this State; and

(g) The insured has signed, before participating in the clinical trial or study, a statement of consent indicating that the insured has been informed of, without limitation:

(1) The procedure to be undertaken;

(2) Alternative methods of treatment; and

(3) The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

2. Except as otherwise provided in subsection 3, the coverage for medical treatment required by this section is limited to:

(a) Coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the insured.

(b) The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered under the health care plan.

(c) The cost of any routine health care services that would otherwise be covered under the health care plan for an insured in a Phase I clinical trial or study.

(d) The initial consultation to determine whether the insured is eligible to participate in the clinical trial or study.

(e) Health care services required for the clinically appropriate monitoring of the insured during a Phase II, Phase III or Phase IV clinical trial or study.

(f) Health care services which are required for the clinically appropriate monitoring of the insured during a Phase I clinical trial or study and which are not directly related to the clinical trial or study.

➥ Except as otherwise provided in NRS 695G.164, the services provided pursuant to paragraphs (b), (c), (e) and (f) must be covered only if the services are provided by a provider with whom the managed care organization has contracted for such services. If the managed care organization has not contracted for the provision of such services, the managed care organization shall pay the provider the rate of reimbursement that is paid to other providers with whom the managed care organization has contracted for similar services and the provider shall accept that rate of reimbursement as payment in full.

3. Particular medical treatment described in subsection 2 and provided to a person insured under the plan is not required to be covered pursuant to this section if that particular medical treatment is provided by the sponsor of the clinical trial or study free of charge to the person insured under the plan.

4. The coverage for medical treatment required by this section does not include:

(a) Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.

(b) Coverage for a drug or device described in paragraph (a) of subsection 2 which is paid for by the manufacturer, distributor or provider of the drug or device.

(c) Health care services that are specifically excluded from coverage under the insured's health care plan, regardless of whether such services are provided under the clinical trial or study.

(d) Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study.

(e) Extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that a participant may incur.

(f) Any expenses incurred by a person who accompanies the insured during the clinical trial or study.

(g) Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the insured.

(h) Any costs for the management of research relating to the clinical trial or study.

5. A managed care organization that delivers or issues for delivery a health care plan specified in subsection 1 may require copies of the approval or certification issued pursuant to paragraph (b) of subsection 1, the statement of consent signed by the insured, protocols for the clinical trial or study and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment pursuant to this section.

6. A managed care organization that delivers or issues for delivery a health care plan specified in subsection 1 shall ~~[~~:

~~(a) Include in the disclosure required pursuant to NRS 695C.193 notice to each person insured under the plan of the availability of the benefits required by this section.~~

~~(b) Provide~~] ***provide*** the coverage required by this section subject to the same deductible, copayment, coinsurance and other such conditions for coverage that are required under the plan.

7. A health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2006, has the legal effect of including the coverage required by this section, and any provision of the plan that conflicts with this section is void.

8. A managed care organization that delivers or issues for delivery a health care plan specified in subsection 1 is immune from liability for:

(a) Any injury to an insured caused by:

(1) Any medical treatment provided to the insured in connection with his or her participation in a clinical trial or study described in this section; or

(2) An act or omission by a provider of health care who provides medical treatment or supervises the provision of medical treatment to the insured in connection with his or her participation in a clinical trial or study described in this section.

(b) Any adverse or unanticipated outcome arising out of an insured's participation in a clinical trial or study described in this section.

9. As used in this section:

(a) "Cooperative group" means a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health. The term includes:

(1) The Clinical Trials Cooperative Group Program; and

(2) The Community Clinical Oncology Program.

(b) "Facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer" means a facility or an affiliate of a facility that:

(1) Has in place a Phase I program which permits only selective participation in the program and which uses clear-cut criteria to determine eligibility for participation in the program;

(2) Operates a protocol review and monitoring system which conforms to the standards set forth in the Policies and Guidelines Relating to the Cancer-Center Support Grant published by the Cancer Centers Branch of the National Cancer Institute;

(3) Employs at least two researchers and at least one of those researchers receives funding from a federal grant;

(4) Employs at least three clinical investigators who have experience working in Phase I clinical trials or studies conducted at a facility designated as a comprehensive cancer center by the National Cancer Institute;

(5) Possesses specialized resources for use in Phase I clinical trials or studies, including, without limitation, equipment that facilitates research and analysis in proteomics, genomics and pharmacokinetics;

(6) Is capable of gathering, maintaining and reporting electronic data; and

(7) Is capable of responding to audits instituted by federal and state agencies.

(c) "Provider of health care" means:

(1) A hospital; or

(2) A person licensed pursuant to chapter 630, 631 or 633 of NRS.

Sec. 116. NRS 695G.200 is hereby amended to read as follows:

695G.200 1. Each managed care organization shall establish a system for resolving complaints of an insured concerning:

(a) Payment or reimbursement for covered health care services;

(b) Availability, delivery or quality of covered health care services, including, without limitation, an adverse determination made pursuant to utilization review; or

(c) The terms and conditions of a health care plan.

➥ The system must be approved by the Commissioner in consultation with the State Board of Health.

2. If an insured makes an oral complaint, a managed care organization shall inform the insured that if the insured is not satisfied with the resolution of the complaint, the insured must file the complaint in writing to receive further review of the complaint.

3. Each managed care organization shall:

(a) Upon request, assign an employee of the managed care organization to assist an insured or other person in filing a complaint or appealing a decision of the review board;

(b) Authorize an insured who appeals a decision of the review board to appear before the review board to present testimony at a hearing concerning the appeal; and

(c) Authorize an insured to introduce any documentation into evidence at a hearing of a review board and require an insured to provide the documentation required by the health care plan of the insured to the review board not later than 5 business days before a hearing of the review board.

4. The Commissioner ~~[or the State Board of Health]~~ may examine the system for resolving complaints established pursuant to this section at such times as either deems necessary or appropriate.

Sec. 117. NRS 695G.220 is hereby amended to read as follows:

695G.220 1. Each managed care organization shall submit to the Commissioner ~~[and the State Board of Health]~~ an annual report regarding its system for resolving complaints established pursuant to NRS 695G.200 on a form prescribed by the Commissioner in consultation with the State Board of Health which includes, without limitation:

(a) A description of the procedures used for resolving complaints of an insured;

(b) The total number of complaints and appeals handled through the system for resolving complaints since the last report and a compilation of the causes underlying the complaints filed;

(c) The current status of each complaint and appeal filed; and

(d) The average amount of time that was needed to resolve a complaint and an appeal, if any.

2. Each managed care organization shall maintain records of complaints filed with it which concern something other than health care services and shall submit to the Commissioner a report summarizing such complaints at such times and in such format as the Commissioner may require.

Sec. 117.5. NRS 287.010 is hereby amended to read as follows:

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

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

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

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of

administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 687B.408, 689B.030 to 689B.050, inclusive, ***and*** 689B.287 ~~[and 689B.575]~~ apply to coverage provided pursuant to this paragraph.

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

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

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

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

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

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

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

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

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

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

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

Sec. 118. NRS 287.045 is hereby amended to read as follows:

287.045 1. Except as otherwise provided in this section, every state officer or employee is eligible to participate in the Program on the first day of the month following the completion of 90 days of full-time employment.

2. Professional employees of the Nevada System of Higher Education who have annual employment contracts are eligible to participate in the Program on:

(a) The effective dates of their respective employment contracts, if those dates are on the first day of a month; or

(b) The first day of the month following the effective dates of their respective employment contracts, if those dates are not on the first day of a month.

3. Every officer or employee who is employed by a participating local governmental agency on a permanent and full-time basis on the date on which the participating local governmental agency enters into an agreement to participate in the Program pursuant to paragraph (a) of subsection 1 of NRS 287.025, and every officer or employee who commences employment with that participating local governmental agency after that date, is eligible to participate in the Program on the first day of the month following the completion of 90 days of full-time employment, unless that officer or employee is excluded pursuant to sub-subparagraph (III) of subparagraph (2) of paragraph (h) of subsection 2 of NRS 287.043.

4. Every member of the Senate and Assembly is eligible to participate in the Program on the first day of the month following the 90th day after the member's initial term of office begins.

5. Notwithstanding the provisions of subsections 1, 3 and 4, if the Board does not, pursuant to NRS 689B.580, elect to exclude the Program from compliance with NRS 689B.340 to ~~[689B.590,]~~ ***689B.580,*** inclusive, and if the coverage under the Program is provided by a health maintenance organization authorized to transact insurance in this State pursuant to chapter 695C of NRS, any affiliation period imposed by the Program may not exceed the statutory limit for an affiliation period set forth in NRS 689B.500.

Sec. 118.1. Section 1 of Senate Bill No. 266 of this session is hereby amended to read as follows:

Section 1. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer that offers or issues a policy of health insurance which provides coverage for the treatment of cancer through the use of chemotherapy shall not:

(a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than $100 per prescription. The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in section 33.4 of Assembly Bill No. 425 of this session, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

(b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

(c) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. A policy subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the policy or renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring an insurer to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

Sec. 118.2. Section 3 of Senate Bill No. 266 of this session is hereby amended to read as follows:

Sec. 3. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer that offers or issues a policy of group health insurance which provides coverage for the treatment of cancer through the use of chemotherapy shall not:

(a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than $100 per prescription. The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in section 33.4 of Assembly Bill No. 425 of this session, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

(b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

(c) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. A policy subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the policy or renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring an insurer to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

Sec. 118.3. Section 4 of Senate Bill No. 266 of this session is hereby amended to read as follows:

Sec. 4. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer that offers or issues a contract for hospital or medical service which provides coverage for the treatment of cancer through the use of chemotherapy shall not:

(a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than $100 per prescription. The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in section 33.4 of Assembly Bill No. 425 of this session, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

(b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

(c) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. A contract subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the contract or renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring an insurer to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

Sec. 118.4. Section 5 of Senate Bill No. 266 of this session is hereby amended to read as follows:

Sec. 5. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health maintenance organization that offers or issues a health care plan which provides coverage for the treatment of cancer through the use of chemotherapy shall not:

(a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than $100 per prescription. The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in section 33.4 of Assembly Bill No. 425 of this session, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

(b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

(c) Decrease the monetary limits applicable to such chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. Evidence of coverage subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring a health maintenance organization to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

Sec. 118.5. Section 8 of Senate Bill No. 266 of this session is hereby amended to read as follows:

Sec. 8. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. A managed care organization that offers or issues a health care plan which provides coverage for the treatment of cancer through the use of chemotherapy shall not:

(a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than $100 per prescription. The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in section 33.4 of Assembly Bill No. 425 of this session, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

(b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

(c) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. An evidence of coverage for a health care plan subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring a managed care organization to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

Sec. 118.6. Section 9 of Senate Bill No. 266 of this session is hereby amended to read as follows:

Sec. 9. Chapter 287 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental entity of the State of Nevada that provides health insurance through a plan of self-insurance which provides coverage for the treatment of cancer through the use of chemotherapy shall not:

(a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than $100 per prescription. The limitation on the amount of the deductible that may be required pursuant to this paragraph does not apply to a health benefit plan, as defined in section 33.4 of Assembly Bill No. 425 of this session, if the health benefit plan is a high deductible health plan, as defined in 26 U.S.C. § 223, and the amount of the annual deductible has not been satisfied.

(b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously.

(c) Decrease the monetary limits applicable to such chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section.

2. A plan of self-insurance subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the plan or the renewal which is in conflict with this section is void.

3. Nothing in this section shall be construed as requiring the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental entity of the State of Nevada that provides health insurance through a plan of

self-insurance to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug.

Sec. 119. NRS 689A.045, 689A.370, 689A.480, 689A.500, 689A.515, 689A.545, 689A.560, 689A.565, 689A.575, 689A.595, 689A.605, 689A.610, 689A.620, 689A.640, 689A.645, 689A.650, 689A.655, 689A.660, 689A.665, 689A.670, 689A.675, 689A.680, 689A.685, 689A.730, 689B.120, 689B.130, 689B.140, 689B.150, 689B.170, 689B.180, 689B.200, 689B.210, 689B.245, 689B.246, 689B.247, 689B.248, 689B.249, 689B.283, 689B.410, 689B.420, 689B.470, 689B.575, 689B.590, 689C.021, 689C.035, 689C.051, 689C.076, 689C.084, 689C.089, 689C.099, 689C.107, 689C.145, 689C.157, 689C.210, 689C.230, 689C.240, 689C.260, 689C.283, 689C.287, 689C.290, 689C.300, 689C.327, 689C.340, 689C.342, 689C.344, 689C.346, 689C.348, 689C.620, 689C.640, 689C.650, 689C.680, 689C.690, 689C.700, 689C.710, 689C.720, 689C.730, 689C.740, 689C.750, 689C.760, 689C.770, 689C.780, 689C.790, 689C.800, 689C.810, 689C.820, 689C.830, 689C.840, 689C.850, 689C.860, 689C.870, 689C.880, 689C.890, 689C.900, 689C.910, 689C.920, 689C.930, 689C.950, 689C.955, 689C.960, 689C.970, 689C.980, 695C.1707, 695C.180, 695C.193, 695C.195, 695C.250 and 695I.050 are hereby repealed.

Sec. 119.5. The provisions of sections 27 to 30, inclusive, 32.2, 33 to 66, inclusive, and 67 to 118.6, inclusive, of this act apply to policies which are issued on or after October 1, 2013, and which become effective on or after January 1, 2014.

Sec. 120. 1. This section and sections 1 to 26, inclusive, 31 to 32.1, inclusive, 32.5, 32.8 and 118.1 to 118.6, inclusive, of this act become effective upon passage and approval.

2. Sections 27 to 30, inclusive, 32.2, 33 to 66, inclusive, 67 to 118, inclusive, 119 and 119.5 of this act become effective:

(a) Upon passage and approval for the purpose of adopting regulations; and

(b) On January 1, 2014, for all other purposes.

3. Section 66.5 of this act becomes effective on January 1, 2016.

4. Sections 13, 14 and 15 of this act expire by limitation on the date on which the provisions of 42 U.S.C. § 666 requiring each state to establish procedures under which the state has authority to withhold or suspend, or to restrict the use of professional, occupational and recreational licenses of persons who:

(a) Have failed to comply with a subpoena or warrant relating to a proceeding to determine the paternity of a child or to establish or enforce an obligation for the support of a child; or

(b) Are in arrears in the payment for the support of one or more children,

➥ are repealed by the Congress of the United States.