ASSEMBLY BILL NO. 83–COMMITTEE ON COMMERCE AND LABOR

(ON BEHALF OF THE DEPARTMENT OF BUSINESS AND INDUSTRY)

PREFILED NOVEMBER 17, 2016

Referred to Committee on Commerce and Labor

SUMMARY—Makes various changes relating to insurance. (BDR 57-159)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: Yes.

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

AN ACT relating to insurance; providing for administrative supervision of insurers and other entities by the Commissioner of Insurance; providing for the regulation of network plans; revising provisions relating to medical malpractice insurance, the general regulation of insurers, reinsurance, motor vehicle insurance, industrial insurance, health insurance in general, health benefit plans in general, funeral and burial services, individual health insurance, group and blanket health insurance, health insurance for small employers, service contracts, credit personal property insurance, nonprofit corporations for hospital, medical and dental service, health maintenance organizations, plans for dental care, prepaid limited health service organizations and managed care organizations; revising provisions relating to the confidentiality of certain documents and other information; revising various references to insurance agents and brokers; repealing various provisions governing summaries of coverage, loss prevention, disclosures of certain information, continuation of coverage and insurance requirements for prepaid limited health service organizations; providing a penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law authorizes the Commissioner of Insurance to regulate insurance in this State. (NRS 679B.120) This bill adds to, revises and repeals various provisions of existing law, primarily in title 57 of NRS, relating to the regulation of insurance in this State.

Sections 2-13 of this bill authorize the Commissioner to place an insurer under administrative supervision and set forth the requirements for such supervision. **Section 6** authorizes the Commissioner to place an insurer under administrative supervision under specified circumstances, including, without limitation, when the insurer is in a hazardous financial condition, when the insurer appears to have exceeded its powers or if an insurer agrees to be placed under such supervision. **Section 6** further provides for the duration of the administrative supervision and the release of the insurer from administrative supervision. **Section 7** designates the Commissioner or an appointee thereof as the administrative supervisor of an insurer under administrative supervision, authorizes the Commissioner to limit the actions of such an insurer and lists various types of actions which the Commissioner may prohibit the insurer from taking without obtaining advance approval from the Commissioner or appointee. **Sections 3 and 4** define, for the purposes of **sections 2-13**, the terms "Commissioner" and "insurer." Both terms are currently defined for the purposes of existing law, but **sections 3 and 4** provide more expansive definitions for the purposes of **sections 2-13**. (NRS 679A.060, 679A.100) **Section 5** expressly makes **sections 2-13** apply to insurers and other persons, including, without limitation, a person purporting to be an insurer, organizing to be an insurer or holding himself or herself out as organizing to be an insurer. **Section 8** governs the use and confidentiality of information relating to the administrative supervision of an insurer. **Section 9** establishes provisions governing the contesting or reviewing of decisions made by the Commissioner or an appointee thereof pursuant to **sections 2-13**. **Section 10** ensures that the Commissioner may institute delinquency proceedings against an insurer without regard to whether the insurer is or was under administrative supervision. **Section 11** authorizes the Commissioner, a designee of the Commissioner and an attorney or other persons to meet, for specified purposes, outside the presence of other persons. **Section 12** authorizes the Commissioner to adopt regulations and to employ various persons to carry out the administrative supervision of an insurer. **Section 12** further authorizes the Commissioner to require the insurer under administrative supervision to pay the compensation and expenses of the persons the Commissioner appoints and employs for the purposes of the administrative supervision. **Section 13** provides that the Commissioner and his or her employees and agents are not liable for actions taken pursuant to **sections 2-13**.

Section 14 of this bill revises the information the Commissioner is required to collect regarding closed claims for medical malpractice. (NRS 679B.144) **Sections 117 and 118** remove the requirement to report certain information regarding closed claims for medical malpractice. (NRS 690B.250, 690B.260) **Section 119** of this bill revises requirements concerning professional liability insurance for essential medical specialties. (NRS 690B.350) **Section 120** of this bill revises requirements concerning information to be gathered and reports to be provided by the Commissioner concerning medical malpractice insurance. (NRS 690B.360)

Sections 15, 21, 26, 27, 29-32, 164 and 165 of this bill replace various references to insurance agents, brokers and solicitors, which are undefined terms, with the term "producer of insurance," which is defined as "a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance." (NRS 679A.117)

Section 16 of this bill requires an insurer to which the Commissioner has issued a certificate of authority to notify the Commissioner of material changes to the information provided by the insurer to the Commissioner in the insurer's

application for a certificate of authority. **Section 18** of this bill authorizes a life insurer or multiple lines insurer to issue life or health insurance policies under its own name and under additional titles. (NRS 680A.240)

Existing law requires an authorized insurer annually to file with the Commissioner a full and true statement of the insurer's financial condition, transactions and affairs as of the previous December 31 and makes confidential certain information submitted to the Division of Insurance of the Department of Business and Industry. (NRS 680A.270) **Section 19** of this bill expands the confidentiality provision to include all work papers, documents and materials prepared for the purpose of submitting the statement or by or on behalf of the Division. **Section 19** also authorizes the insurer to file, as an exhibit separate from the annual statement, specified disclosures of compensation paid to or on behalf of an insurer's officers, directors or employees and makes such information confidential.

Section 20 of this bill expands the applicability of the monetary penalty required to be imposed for a delay by an insurer in properly filing an annual statement. (NRS 680A.280) **Section 24** of this bill narrows the definition of the term "managing general agent" to include the management of an underwriting office. (NRS 683A.060) **Section 25** of this bill removes the willfulness requirement from one of the grounds for which the Commissioner may suspend or revoke the certificate of registration of an administrator and replaces it with a knowingly requirement. (NRS 683A.0892) **Section 33** of this bill revises the duties of an insurer with regard to the use of information in a consumer credit report. (NRS 686A.680)

Section 22 of this bill authorizes the Commissioner to adopt regulations governing certain arrangements for reinsurance, including, without limitation, the amounts and forms of security which must be held pursuant to those arrangements.

Section 28 of this bill provides for the automatic suspension of the license of a motor vehicle physical damage appraiser if the appraiser does not file a replacement bond for a required surety bond in the event of the cancellation of the required surety bond. (NRS 684B.030) **Section 86** of this bill revises provisions governing the cancellation, nonrenewal or increase in premiums for renewal of a policy of motor vehicle insurance as the result of the filing of certain claims. (NRS 687B.385)

Section 35 of this bill defines the term "large-deductible agreement" as certain agreements in which the policyholder must bear the risk of loss of a specified amount of $25,000 or more per claim or occurrence covered under the policy of industrial insurance. **Section 38** of this bill requires full collateralization of the outstanding obligations owed under a large-deductible agreement and limits the size of the policyholder's obligations under the large-deductible agreement. **Section 39** of this bill generally prohibits an insurer from issuing or renewing a policy of industrial insurance which includes a large-deductible agreement if the insurer is in a hazardous financial condition. **Section 37** of this bill limits the applicability of **sections 38 and 39** to policies of industrial insurance with large-deductible agreements which are issued by insurers with both ratings below specified levels and surpluses below specified amounts. **Section 37** further specifies that **sections 38 and 39** only apply to policies of industrial insurance issued or renewed on or after January 1, 2018, and which are not issued to a governmental entity. **Section 166** of this bill revises the definition of the term "tangible net worth" in relation to industrial insurance, specifically self-insured employers and associations of self-insured employers. (NRS 616A.330)

Existing law provides for the Commissioner to consider each proposed increase or decrease in the rates of various kinds and lines of insurance. (NRS 686B.070) **Section 36** of this bill creates new procedures for the Commissioner to consider

each proposed increase or decrease in the rates of health plans for individual health insurance, group and blanket health insurance, health insurance for small employers, nonprofit corporations for hospital, medical and dental services, health maintenance organizations, plans for dental care and prepaid limited health service organizations. **Section 44** of this bill clarifies that the existing procedures for considering a proposed increase or decrease do not apply to the insurers subject to the provisions of **section 36**. (NRS 686B.110)

Sections 88 and 89 of this bill revise existing provisions relating to health benefit plans by specifying that the group market and small group market being considered in these provisions must be the "small employer" group market. (NRS 687B.490, 687B.500)

Sections 51-85 of this bill establish provisions governing network plans. **Section 60** defines a network plan as a health benefit plan offered or issued by a health carrier under which the financing and delivery of health care services are provided, in whole or in part, through a defined set of providers of health care under contract with the health carrier. **Sections 52-59 and 61-64** define other terms for the regulation of network plans. **Section 65** requires a health carrier to comply with and ensure that network plans and related contracts comply with **sections 51-85**. **Sections 66, 71, 79, 81 and 84** require a health carrier to provide for notice to providers of health care concerning: (1) covered services; (2) the health carrier's policies and programs; (3) the providers' obligations to collect payments; (4) determinations of coverage; and (5) the inclusion of and status of a participating provider in the network plan. **Sections 67, 68, 70, 74 and 77** require a contract between a provider of health care and a health carrier to contain provisions which: (1) prohibit the provider from collecting excess amounts from covered persons; (2) require the continuation of health care services in the event of cessation of the operations of the health carrier; (3) require that written notice be provided to a participating provider of health care in certain circumstances; (4) require the provider to make health care records available under certain circumstances; and (5) prohibit the assignment or delegation of rights under the contract. **Section 69** provides that specified provisions in a contract between a provider of health care and a health carrier must be construed in favor of the covered person. **Section 72** prohibits a health carrier from offering inducement to a provider of health care to provide health care services which are less than medically necessary. **Section 73** requires that a health carrier allow a provider of health care to discuss all treatment options with a covered person and advocate for the covered person. **Section 78** governs the furnishing of covered services to all covered persons. **Section 80** prohibits a health carrier from penalizing a provider of health care who reports to state or federal authorities certain practices of the health carrier. **Section 82** requires a health carrier to establish procedures for dispute resolution between a provider of health care and the health carrier. **Section 83** prohibits a contract between a provider of health care and a health carrier from containing any provision which conflicts with the network plan or with any provision of **sections 51-85**. **Section 85** authorizes the Commissioner to adopt regulations to carry out **sections 51-85**.

Section 90 of this bill provides for the automatic suspension of the certificate of authority of a seller of prepaid contracts for funeral services if the seller does not file a replacement bond for a required surety bond in the event of the cancellation of the required surety bond. (NRS 689.185) **Section 91** of this bill similarly provides for the automatic suspension of the permit of a seller of prepaid contracts for burial services if the seller does not file a replacement bond for a required surety bond in the event of the cancellation of the required surety bond. (NRS 689.495)

Section 92 of this bill provides, with certain exceptions, that unified rate review templates and rate filing documentation of individual carriers are considered proprietary, constitute a trade secret and are not subject to disclosure by the Commissioner. **Sections 98, 110, 112 and 114** of this bill remove the notice

requirement regarding the discontinuance of a product: (1) of a health benefit plan; (2) of group health insurance; (3) offered to small employers; and (4) offered to small employers or purchasers through a voluntary purchasing group. (NRS 689A.630, 689B.560, 689C.310, 689C.470) **Sections 109, 113 and 134** of this bill remove the requirement that certain policies of group health insurance, health benefit plans and group contracts for hospital, medical or dental services include a provision regarding the point at which an insured's payment of coinsurance for a provider of health care who is not preferred is no longer required to be paid. (NRS 689B.061, 689C.350, 695B.185)

Section 111 of this bill deletes provisions governing the determination of whether an employer is small or large, and the applicability of other provisions after an employer is deemed large. (NRS 689C.111)

Sections 122-124 and 127-129 of this bill revise provisions relating to service contracts which are contracts pursuant to which a provider is obligated to the purchaser of the service contract to repair, replace or perform maintenance on, or indemnify or reimburse the purchaser for the costs of repairing, replacing or performing maintenance on, goods that are described in the service contract. (NRS 690C.080) **Section 123** sets forth the qualifications of a controlling person for the purposes of determining the controlling person of a provider of service contracts. **Section 127** adds to the requirements for a provider to apply for and obtain a certificate of registration to issue, sell or offer for sale service contracts, including providing certain personal and criminal history information about the controlling persons of the provider and verifying that the information in the application for a certificate of registration is accurate to the best of his or her knowledge. (NRS 690C.160) **Section 124** prohibits a provider from transferring its liability under a service contract except under specified conditions, including, without limitation, obtaining the approval of the Commissioner. **Section 128** revises the requirements governing the financial security which must be maintained by a provider, including, without limitation, expanded requirements concerning a reserve account. (NRS 690C.170) **Section 129** revises provisions which govern the notice required by a provider which ceases to do business in this State. (NRS 690C.240)

Section 130 of this bill deletes a requirement that the Commissioner is required to adopt regulations relating to reasonable rates for credit personal property insurance. (NRS 691C.340) However, **section 130** retains express authority for the Commissioner to adopt regulations concerning rates for credit personal property insurance an insurer may use without making certain filings. **Section 131** deletes a requirement that the Commissioner is required to adopt regulations relating to a refund of unearned premiums for credit personal property insurance. (NRS 691C.390)

Sections 132 and 142 of this bill require nonprofit corporations for hospital, medical or dental service and health maintenance organizations to contract with an insurance company to provide insurance, indemnity or reimbursement against the cost of services provided and sets forth requirements relating to the payment of claims made to insureds or enrollees, as applicable, in the case of the insolvency or impairment of such corporation or organization.

Existing law sets forth provisions regarding the insolvency of nonprofit corporation for hospital, medical or dental service. (NRS 695B.150) **Section 133** of this bill expands the requirements for determinations concerning the insolvency of such a corporation, adds provisions concerning the impairment of such a corporation and authorizes the Commissioner to adopt regulations concerning a determination that such a corporation is in a hazardous financial condition. **Sections 143, 152 and 156** of this bill establish similar provisions for health maintenance organizations, organizations for dental care and prepaid limited health service organizations.

Existing law clarifies that nonprofit hospital and medical or dental service corporations, health maintenance organizations, organizations for dental care and prepaid limited health service organizations are subject to certain other provisions of existing law. (NRS 695B.320, 695C.055, 695D.095, 695F.090) **Sections 138, 147, 154 and 157** of this bill revise such provisions to include additional requirements for applicability. **Section 144** of this bill requires each health maintenance organization to develop, submit to the Commissioner and put into effect a plan to provide for the continuation of benefits to enrollees in the event of the insolvency or impairment of the health maintenance organization. **Section 145** of this bill authorizes the Commissioner to take certain actions regarding the operation of a health maintenance organization if the Commissioner determines that, because of the financial condition of the health maintenance organization, the continued operation of the health maintenance organization may be hazardous to its enrollees or creditors or to the general public. **Section 146** of this bill addresses the conservation, rehabilitation and liquidation of health maintenance organizations. **Section 149** of this bill revises provisions governing examinations of health maintenance organizations by the Commissioner or an examiner designated by the Commissioner. (NRS 695C.310)

Section 153 of this bill requires an organization for dental care to maintain a capital account with a minimum net worth of not less than $500,000 unless a different amount is authorized by the Commissioner. **Section 155 and 158** of this bill revise requirements for organizations for dental care and prepaid limited health service organizations to maintain surety bonds or deposits by increasing the amount of such bonds or deposits from $250,000 to $500,000 and authorizing the Commissioner to increase the amount of such bonds or deposits under certain circumstances. (NRS 695D.170, 695F.200) **Section 158** also increases the minimum net worth a prepaid limited health service organization must maintain in a capital account from $200,000 to $500,000.

Existing law requires a managed care organization to report annually to the Commissioner regarding its methods for reviewing the quality of health care services provided to its insureds. (NRS 695G.130) **Section 159** of this bill changes the timeline for submitting such a report and requires that the report be submitted on a form prescribed by the Commissioner.

Sections 103-106, 139, 140, 148, 160 and 161 of this bill remove the State Board of Health from the provisions governing systems for resolving complaints of insureds. (NRS 689A.745, 689A.750, 689B.0285, 389B.029, 695B.380, 695B.390, 695C.080, 695G.200, 695G.220)

Section 168 repeals: (1) the requirement for certain insurers and the Commissioner to submit annual reports addressing loss prevention and control programs (NRS 680A.290, 690B.370); (2) the requirement for certain insurers to make certain disclosures (NRS 689A.390, 689A.400, 689A.690, 689B.027, 689B.028, 689C.270, 689C.280, 689C.440, 689C.450, 695B.172, 695B.174); and (3) the requirement for a prepaid limited health service organization to contract with an insurance company for certain purposes (NRS 695F.215).

Existing law sets forth that an employer who is a member of an association of self-insured public or private employers may terminate his or her membership at any time, as long as the member submits to the association a notice of intent to withdraw from the association at least 120 days before the effective date of withdrawal. Existing law further requires this notice of intent to withdraw to include a statement indicating that the member has replaced his or her membership to the association with a certain other type of insurance. (NRS 616B.386) **Section 166.3** of this bill amends existing law by requiring that the notice of intent to withdraw be deemed rescinded if the member does not provide to the association before the expiration of the 120-day period proof that the member has replaced his or her membership to the association with a certain other type of insurance.

Sections 17, 23, 40-43, 45-49, 87, 93-97, 99-102, 107, 108, 115, 116, 125, 126, 135, 136, 150 and 163 of this bill make conforming changes.

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 13, inclusive, of this act.

Sec. 2. ***As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 3 and 4 of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"Commissioner" means the Commissioner of Insurance and, if applicable:***

1. A deputy of the Commissioner; or

2. The Division.

Sec. 4. ***"Insurer" includes, without limitation:***

1. A captive insurer that has been issued a certificate of authority pursuant to chapter 694C of NRS;

2. A fraternal benefit society that has been issued a certificate of authority pursuant to chapter 695A of NRS;

3. A health maintenance organization that has been issued a certificate of authority pursuant to chapter 695C of NRS;

4. A nonprofit corporation for hospital, medical or dental services that has been issued a certificate of authority pursuant to chapter 695B of NRS;

5. An organization for dental care that has been issued a certificate of authority pursuant to chapter 695D of NRS;

6. A prepaid limited health service organization that has been issued a certificate of authority pursuant to chapter 695F of NRS;

7. A risk retention group that has been issued a certificate of registration pursuant to chapter 695E of NRS;

8. Any person who is engaged as principal and as indemnitor, surety or contractor in the business of entering into contracts of insurance; and

9. Any person purporting to be an insurer listed in subsections 1 to 8, inclusive, or in the process of organizing, or holding himself or herself out as organizing, or proposing to organize in this State for the purpose of becoming an insurer listed in subsections 1 to 8, inclusive.

Sec. 5. ***The provisions of this chapter apply to:***

1. All domestic insurers;

2. Any foreign insurer doing business in this State regarding whom an applicable official of the foreign insurer's state of

domicile has requested that the Commissioner apply the provisions of this chapter to the foreign insurer;

3. All persons purporting to be an insurer, or in the process of organizing, or holding themselves out as organizing, or proposing to organize in this State for the purpose of becoming an insurer; and

4. All other persons to whom the provisions of this chapter are otherwise expressly made applicable by law.

Sec. 6. *1. The Commissioner may place an insurer under administrative supervision if:*

(a) At any time, the Commissioner determines that:

(1) The insurer is in a hazardous financial condition as set forth in regulations adopted pursuant to NRS 680A.205 or 695B.150 or section 143, 152 or 156 of this act or any other applicable provision of this title;

(2) The insurer is in a hazardous financial condition pursuant to NRS 682A.510 or section 145 and 146 of this act or any other applicable provision of this title;

(3) The continued operation of the insurer transacting business in this State may be hazardous to the insureds or creditors of the insurer or to the general public;

(4) As described in subsection 5, the insurer appears to have exceeded its powers as granted by its license or certificate of authority, as applicable, or as granted by applicable law; or

(5) The insurer is conducting its business fraudulently; or

(b) The insurer agrees to be placed under administrative supervision.

2. If the Commissioner places an insurer under administrative supervision pursuant to subsection 1:

(a) The Commissioner shall promptly notify the insurer that the insurer has been placed under administrative supervision, and include with that notice:

(1) The determination, if any, made by the Commissioner pursuant to paragraph (a) of subsection 1;

(2) A written list of the actions which the insurer must take to satisfy the Commissioner that the placement of the insurer under administrative supervision pursuant to subsection 1 is no longer appropriate;

(3) The initial period of administrative supervision established pursuant to paragraph (b);

(4) The actions, if any, identified by the Commissioner pursuant to subsection 2 of section 7 of this act; and

(5) A statement that the provisions of this chapter govern the administrative supervision of the insurer.

(b) Except as otherwise provided in this paragraph, the initial period of administrative supervision begins upon the insurer's receipt of the notice described in paragraph (a) and ends 60 days after the date of the Commissioner's determination pursuant to paragraph (a) of subsection 1 or the date of the insurer's agreement pursuant to paragraph (b) of subsection 1, as applicable. The Commissioner may designate a different date for the end of the initial period of administrative supervision, if the Commissioner determines that a different date is appropriate and includes that date in the notice required by paragraph (a).

3. The insurer remains under administrative supervision pursuant to this section from the beginning of the initial period of administrative supervision established pursuant to paragraph (b) of subsection 2 until the date on which the insurer is released from administrative supervision by the Commissioner pursuant to paragraph (a) of subsection 4.

4. At the end of the initial period of supervision established pursuant to paragraph (b) of subsection 2 and at the end of any extended period of supervision established pursuant to paragraph (b) of this subsection, the Commissioner shall provide the insurer with notice and an opportunity for a hearing to determine whether the insurer has taken the actions specified pursuant to subparagraph (2) of paragraph (a) of subsection 2 to the satisfaction of the Commissioner. If the Commissioner determines that the insurer:

(a) Has taken such actions to the satisfaction of the Commissioner, the Commissioner shall release the insurer from administrative supervision; or

(b) Has not taken such actions to the satisfaction of the Commissioner, the Commissioner shall designate an extended period of supervision during which the insurer remains under administrative supervision.

5. For the purposes of subparagraph (2) of paragraph (a) of subsection 1, an insurer shall be deemed to have exceeded its powers if the insurer:

(a) Refused to permit the Commissioner, or an examiner authorized by the Commissioner, to examine its books, papers, accounts, records or affairs;

(b) Is a domestic insurer and unlawfully removed from this State books, papers, accounts or records necessary for an examination of the insurer;

(c) Failed or refused to promptly comply with any applicable statutes or regulations relating to financial reporting or any requests of the Commissioner relating thereto;

(d) Failed or refused to comply with an order of the Commissioner to make good, within the time prescribed by law, any prohibited deficiency in its capital, capital stock or surplus;

(e) Continued to transact insurance or write business in this State after its license or certificate of authority, as applicable, has been revoked or suspended by the Commissioner;

(f) Unlawfully, in violation of an order of the Commissioner, or without first having obtained written approval of the Commissioner if written approval is required by law, and whether accomplished by contract or otherwise:

(1) Completely reinsured its entire outstanding business; or

(2) Merged or substantially consolidated its entire property or business with another insurer;

(g) Engaged in any transaction in which it is not authorized to engage under the laws of this State; or

(h) Otherwise failed or refused to comply with a lawful order of the Commissioner.

Sec. 7. *1. During the period an insurer is under administrative supervision pursuant to section 6 of this act, the Commissioner or an appointee designated by the Commissioner shall serve as the administrative supervisor of the insurer.*

2. The Commissioner may identify any one or more actions specified in subsection 3 as actions which the insurer shall not take during the period the insurer remains under administrative supervision pursuant to section 6 of this act unless the insurer obtains approval in advance from the administrative supervisor designated pursuant to subsection 1.

3. If identified by the Commissioner pursuant to subsection 2, the insurer shall not, without obtaining approval in advance from the administrative supervisor:

(a) Dispose of, convey or encumber any of its assets or its business in force;

(b) Withdraw money from any of its bank accounts;

(c) Lend any of its money;

(d) Invest any of its money;

(e) Transfer any of its property;

(f) Incur any debt, obligation or liability;

(g) Merge or consolidate with another insurer or any other business entity as defined in NRS 682A.025;

(h) Approve new premiums or renew any policies;

(i) Enter into any new reinsurance contract or treaty;

(j) Terminate, surrender, forfeit, convert or lapse any insurance policy, certificate or contract, except for nonpayment of premiums due;

(k) Release, pay or refund premium deposits, accrued cash or loan values, unearned premiums or other reserves on any insurance policy, certificate or contract;

(l) Make any material change in management; or

(m) Increase any salary or benefit of an officer or director, increase the preferential payment of a bonus or dividend or increase any other payment deemed by the Commissioner to be preferential.

Sec. 8. *1. Notwithstanding any other provision of law and except as set forth in this section and NRS 239.0115, any proceedings and hearings, and any notices, correspondence, reports, records and other information in the possession of the Commissioner, relating to the administrative supervision of any insurer pursuant to this chapter are confidential by law and privileged, are not subject to subpoena, are not subject to discovery and are not admissible in evidence in any private civil action.*

2. The Commissioner may use the information specified in subsection 1 in the furtherance of any regulatory or legal action brought as part of his or her official duties, including, without limitation, his or her duties as a receiver pursuant to chapter 696B of NRS.

3. Neither the Commissioner nor any other person who received access to any information specified in subsection 1 while acting under the authority of the Commissioner may be permitted or required to testify in any private civil action concerning the information.

4. In order to assist in the performance of the regulatory duties of the Commissioner, the Commissioner may:

(a) Share the information specified in subsection 1 with:

(1) Other state, federal and international regulatory agencies, including, without limitation, members of any supervisory college as defined in NRS 692C.359;

(2) The National Association of Insurance Commissioners and its affiliates and subsidiaries;

(3) Third party consultants designated by the Commissioner; and

(4) State, federal and international law enforcement authorities, if the Commissioner determines that the disclosure is necessary or proper for the enforcement of the laws of this State or another state,

➥ provided that the recipient agrees to maintain the confidentiality of the applicable information specified in subsection 1. No waiver of any applicable privilege or claim of confidentiality occurs because of the sharing of information pursuant to this paragraph.

(b) Open any proceedings or hearings to the public or make public any other information specified in subsection 1 if the Commissioner determines that it is in the best interest of the public or in the best interest of the insurer, the insureds or creditors of the insurer, or the general public.

Sec. 9. *1. During the period an insurer is under administrative supervision pursuant to section 6 of this act, the insurer may contest any action taken or proposed to be taken by the administrative supervisor designated pursuant to subsection 1 of section 7 of this act on the ground that the action would not result in improving the condition of the insurer. To contest an action taken or proposed to be taken by the administrative supervisor, the insurer must submit a request for reconsideration to the administrative supervisor. If the administrative supervisor, upon reconsideration, denies the insurer's request, the insurer may request a review of the decision of the administrative supervisor pursuant to NRS 679B.310 to 679B.370, inclusive.*

2. Any action taken by the Commissioner pursuant to this chapter is subject to:

(a) Review pursuant to NRS 679B.310 to 679B.370, inclusive, and any regulations adopted pursuant thereto; and

(b) Judicial review pursuant to chapter 233B of NRS.

Sec. 10. *Nothing in this chapter shall be construed to limit the authority of the Commissioner to institute delinquency proceedings against an insurer pursuant to chapter 696B of NRS for the purpose of conserving, rehabilitating, reorganizing or liquidating the insurer, without regard to whether the Commissioner has currently or previously placed the insurer under administrative supervision pursuant to section 6 of this act.*

Sec. 11. *Notwithstanding any other provision of law, at the time of any proceeding or during the pendency of any proceeding held pursuant to this chapter, the Commissioner may meet with an administrative supervisor designated by the Commissioner pursuant to subsection 1 of section 7 of this act, and with the attorney or other representative of the administrative supervisor designated pursuant to subsection 1 of section 7 of this act, without the presence of any other person:*

1. To carry out the duties of the Commissioner under this chapter; or

2. To allow the administrative supervisor to carry out his or her duties under this chapter.

Sec. 12. *The Commissioner may:*

1. Adopt any regulations necessary to carry out the purposes and provisions of this chapter;

2. In addition to an administrative supervisor designated by the Commissioner pursuant to subsection 1 of section 7 of this act, employ any other counsels, actuaries, clerks and assistants as the Commissioner deems necessary for the administrative supervision of an insurer; and

3. Require an insurer placed under administrative supervision to pay the compensation and expenses of the administrative supervisor designated by the Commissioner pursuant to subsection 1 of section 7 of this act and any other counsels, actuaries, clerks and assistants described in subsection 2.

Sec. 13. ***There shall be no liability on the part of, and no cause of action of any nature against, the Commissioner or any employee or agent of the Commissioner, or an administrative supervisor designated pursuant to subsection 1 of section 7 of this act, for any action taken by them in the performance of their powers and duties under this chapter.***

Sec. 14. NRS 679B.144 is hereby amended to read as follows:

679B.144 1. The Commissioner shall collect and maintain the information provided by insurers pursuant to NRS 690B.260 regarding each closed claim for medical malpractice filed against a person who is covered by a policy of insurance for medical malpractice in this state, including, without limitation:

(a) The cause of the loss;

(b) A description of the injury for which the claim was filed;

(c) The sex of the injured person;

(d) The names and number of defendants in each claim;

(e) The type of coverage provided;

(f) ~~[The amount of the initial, highest and last reserves of an insurer for each claim before final resolution of the claim by settlement or trial;~~

~~(g)]~~ The disposition of each claim;

~~[(h)]~~ ***(g)*** The amount of money awarded through settlement or by verdict;

~~[(i)]~~ ***(h)*** The sum of money paid to each claimant and the source of that sum;

~~[(j)]~~ ***(i)*** Any sum of money allocated to expenses for the adjustment of losses; and

~~[(k)]~~ ***(j)*** Any other information the Commissioner determines to be necessary or appropriate.

2. The Commissioner shall submit with the report to the Legislature required pursuant to NRS 679B.410 a summary of the information collected pursuant to this section.

3. The Commissioner ~~[shall]~~ ***may*** adopt regulations necessary to carry out the provisions of this section.

4. As used in this section, "policy of insurance for medical malpractice" means a policy that provides coverage for any medical professional liability of the insured under the policy.

Sec. 15. NRS 679B.240 is hereby amended to read as follows:

679B.240 To ascertain compliance with law, or relationships and transactions between any person and any insurer or proposed insurer, the Commissioner may, as often as he or she deems advisable, examine the accounts, records, documents and transactions relating to such compliance or relationships of:

1. Any ***producer of*** insurance ***,*** ~~[agent,]~~ solicitor, ~~[broker,]~~ surplus lines broker, general agent, adjuster, insurer representative, bail agent, motor club agent or any other licensee or any other person the Commissioner has reason to believe may be acting as or holding himself or herself out as any of the foregoing.

2. Any person having a contract under which the person enjoys in fact the exclusive or dominant right to manage or control an insurer.

3. Any insurance holding company or other person holding the shares of voting stock or the proxies of policyholders of a domestic insurer, to control the management thereof, as voting trustee or otherwise.

4. Any subsidiary of the insurer.

5. Any person engaged in this state in, or proposing to be engaged in this state in, or holding himself or herself out in this state as so engaging or proposing, or in this state assisting in, the promotion, formation or financing of an insurer or insurance holding corporation, or corporation or other group to finance an insurer or the production of its business.

6. Any independent review organization, as defined in NRS 695G.026.

Sec. 16. Chapter 680A of NRS is hereby amended by adding thereto a new section to read as follows:

1. Each insurer to which the Commissioner issues a certificate of authority shall notify the Commissioner of all material changes to the information provided by the insurer in its written application pursuant to NRS 680A.150, including, without limitation:

(a) Any change of address, such as a change to:

(1) The mailing address of the home office, or any other physical address, of the insurer; and

(2) Any other mailing address of the insurer, including, without limitation, the address used for general correspondence or for annual renewal notices;

(b) Any changes in the officers, directors or ownership of the insurer;

(c) Any changes to the manner of service of legal process against the insurer; and

(d) Any changes to the articles of incorporation, by-laws or power of attorney for the attorney-in-fact of the insurer.

2. The notice required by subsection 1 must be provided to the Commissioner within 30 days after the date on which the change occurs.

3. If an insurer changes its physical or mailing address without giving written notice and the Commissioner is unable to locate the insurer after diligent effort, the Commissioner may suspend or revoke the insurer's certificate of authority without a hearing. The mailing of a letter by certified mail, return receipt requested, addressed to the insurer at its last mailing address appearing on the records of the Division, and the return of the letter undelivered, constitutes a diligent effort by the Commissioner. In lieu of such a suspension or revocation, the Commissioner may levy upon the insurer, and the insurer shall pay forthwith, an administrative fine of not more than $2,000 for each act or violation.

Sec. 17. NRS 680A.095 is hereby amended to read as follows:

680A.095 1. Except as otherwise provided in subsection 3, an insurer which is not authorized to transact insurance in this State may not transact reinsurance with a domestic insurer in this State, by mail or otherwise, unless the insurer holds a certificate of authority as a reinsurer in accordance with the provisions of NRS 680A.010 to 680A.150, inclusive, 680A.160 to ~~[680A.290,]~~ ***680A.280,*** inclusive, ***and section 16 of this act,*** 680A.320 and 680A.330.

2. To qualify for authority only to transact reinsurance, an insurer must meet the same requirements for capital and surplus as are imposed on an insurer which is authorized to transact insurance in this State.

3. This section does not apply to the joint reinsurance of title insurance risks or to reciprocal insurance authorized pursuant to chapter 694B of NRS.

Sec. 18. NRS 680A.240 is hereby amended to read as follows:

680A.240 1. A property insurer or multiple line insurer authorized to transact insurance in Nevada shall have the right to issue property insurance policies under its own name and under additional "titles" or under additional "titles" duly registered by the insurer with the Commissioner.

2. ***A life insurer or multiple line insurer authorized to transact insurance in Nevada shall have the right to issue life or health insurance policies under its own name and under***

additional "titles" or under additional "titles" duly registered by the insurer with the Commissioner.

3. The Commissioner shall, upon the insurer's request, furnish to the insurer the form required for such registration, and the insurer shall pay the fee for registration as specified in NRS 680B.010 (fee schedule). Registered titles shall be shown on the insurer's certificate of authority and shall remain in effect for so long as the insurer's certificate of authority is in effect, subject to earlier termination of the registration at the insurer's request.

~~[3.]~~ ***4.*** All business transacted by the insurer under additional titles shall be included in business and transactions of the insurer to be shown by its annual statement filed with the Commissioner, for all purposes under this Code.

Sec. 19. NRS 680A.270 is hereby amended to read as follows:

680A.270 1. Each authorized insurer shall annually on or before March 1, or within any reasonable extension of time therefor which the Commissioner for good cause may have granted on or before that date, file with the Commissioner a full and true statement of its financial condition, transactions and affairs as of December 31 preceding. The statement must be:

(a) In the general form and context of, and require information as called for by, an annual statement as is currently in general and customary use in the United States for the type of insurer and kinds of insurance to be reported upon, with any useful or necessary modification or adaptation thereof, supplemented by additional information required by the Commissioner;

(b) Prepared in accordance with:

(1) The Annual Statement Instructions for the type of insurer to be reported on as adopted by the National Association of Insurance Commissioners for the year in which the insurer files the statement; and

(2) The Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners and effective on January 1, 2001, and as amended by the National Association of Insurance Commissioners after that date; and

(c) Verified by the oath of the insurer's president or vice president and secretary or actuary, as applicable, or, in the absence of the foregoing, by two other principal officers, or if a reciprocal insurer, by the oath of the attorney-in-fact, or its like officers if a corporation.

2. The statement of an alien insurer must be verified by its United States manager or other officer who is authorized to do so, and may relate only to the insurer's transactions and affairs in the United States unless the Commissioner requires otherwise. If the Commissioner requires a statement as to the insurer's affairs

throughout the world, the insurer shall file the statement with the Commissioner as soon as reasonably possible.

3. The Commissioner may refuse to continue, or may suspend or revoke, the certificate of authority of any insurer failing to file its annual statement when due.

4. At the time of filing, the insurer shall pay the fee for filing its annual statement as prescribed by NRS 680B.010.

5. The Commissioner may adopt regulations requiring each domestic, foreign and alien insurer which is authorized to transact insurance in this state to file the insurer's annual statement with the National Association of Insurance Commissioners or its successor organization.

6. Except as otherwise provided in NRS 239.0115, all ~~[ratios of financial analyses and synopses of examinations concerning insurers that are submitted to the Division by the National Association of Insurance Commissioners' Insurance Regulatory Information System]~~ ***work papers, documents and materials prepared pursuant to this section by or on behalf of the Division*** are confidential and ~~[may]~~ ***must*** not be disclosed by the Division.

7. To the extent that the Annual Statement Instructions referenced in subparagraph (1) of paragraph (b) of subsection 1 require the disclosure of compensation paid to or on behalf of an insurer's officers, directors or employees, the information may be filed with the Commissioner as an exhibit separate from the statement required by this section. Except as otherwise provided in NRS 239.0115, the compensation information described in this subsection is confidential and must not be disclosed by the Division.

Sec. 20. NRS 680A.280 is hereby amended to read as follows:

680A.280 1. Any insurer failing, without just cause beyond the reasonable control of the insurer, to file ~~[its]~~ ***an*** annual statement as required in NRS ***680A.265 and*** 680A.270 shall be required to pay a penalty of $100 for each day's delay, but not to exceed $3,000 in aggregate amount, to be recovered in the name of the State of Nevada by the Attorney General.

2. Any director, officer, agent or employee of any insurer who subscribes to, makes or concurs in making or publishing, any annual or other statement required by law, knowing the same to contain any material statement which is false, is guilty of a gross misdemeanor.

Sec. 21. NRS 680B.020 is hereby amended to read as follows:

680B.020 1. Notwithstanding the provisions of any general or special law, the possession of a license or certificate of authority issued under this Code shall be authorization to transact such business as indicated in such license or certificate of authority, and shall be in lieu of all licenses, whether for regulation or revenue,

required to transact insurance business within the State of Nevada; but each city, town or county may require a license for revenue purposes only for any insurance ~~[agent, broker,]~~ analyst, adjuster or managing general agent ***or producer of insurance*** whose principal place of business is located within such city or town, or within the county outside the cities and towns of the county, respectively.

2. This section shall not be modified or repealed by any law of general application enacted after January 1, 1972, unless expressly referred to or expressly repealed therein.

Sec. 22. Chapter 681A of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Commissioner may adopt regulations applicable to arrangements for reinsurance relating to:

(a) Life insurance policies with guaranteed non-level gross premiums or guaranteed non-level benefits;

(b) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(c) Variable annuities with guaranteed death or living benefits;

(d) Policies for long-term care insurance; or

(e) Such other life and health insurance and annuity products as to which the National Association of Insurance Commissioners adopts model regulatory requirements with respect to credit for reinsurance.

2. A regulation adopted pursuant to this section may require the ceding insurer, in calculating the amounts or forms of security required to be held pursuant to regulations adopted pursuant to this section, to use the Valuation Manual, as defined in NRS 681B.0071, which is in effect on the date as of which the calculation is made, to the extent applicable.

3. A regulation adopted pursuant to this section must not apply to a cession to an assuming insurer that:

(a) Is certified in this State or, if this State has not adopted regulations which provide for an assuming insurer to satisfy the requirements of NRS 681A.155 for credit to be allowed, certified in a minimum of five other states; or

(b) Maintains at least $250,000,000 in capital and surplus when determined in accordance with the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners, as amended, excluding the impact of any permitted or prescribed practices, and:

(1) Is licensed in at least 26 states; or

(2) Is licensed in at least 10 states, and licensed or accredited in at least 35 states.

Sec. 23. NRS 681A.140 is hereby amended to read as follows:

681A.140 As used in NRS 681A.140 to 681A.240, inclusive, ***and section 22 of this act,*** "qualified financial institution in the United States" means an institution that:

1. Is organized, or in the case of a branch or agency of a foreign banking organization in the United States licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers;

2. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies;

3. Is determined:

(a) By the Commissioner to meet the standards of financial condition and standing prescribed by the Commissioner; or

(b) By the National Association of Insurance Commissioners to meet the standards of financial condition and standing prescribed by the National Association of Insurance Commissioners; and

4. Is determined by the Commissioner to be otherwise acceptable.

Sec. 24. NRS 683A.060 is hereby amended to read as follows:

683A.060 1. A "managing general agent" is a person who:

(a) Negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer, including the management of a separate division, department ~~[of]~~ ***or*** underwriting office; ~~[or]~~ ***and***

(b) Acts as an agent for the insurer and with or without the authority, either separately or together with affiliates:

(1) Produces, directly or indirectly, and underwrites an amount of gross direct written premiums equal to or more than 5 percent of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year; and

(2) Adjusts or pays claims in excess of an amount determined by the Commissioner or negotiates reinsurance on behalf of the insurer.

2. A managing general agent includes a person with authority to appoint and to terminate the appointment of an agent for an insurer.

3. For the purposes of this chapter, the following are not managing general agents:

(a) An employee of the insurer;

(b) A manager of the United States branch of an alien insurer;

(c) An attorney authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange; and

(d) An underwriting manager who, pursuant to a contract, manages all or part of the insurance operations of the insurer, is

under common control with the insurer, is subject to the provisions of chapter 692C of NRS and whose compensation is not based on the volume of premiums written or the profit of the business written.

Sec. 25. NRS 683A.0892 is hereby amended to read as follows:

683A.0892 1. The Commissioner:

(a) Shall suspend or revoke the certificate of registration of an administrator if the Commissioner has determined, after notice and a hearing, that the administrator:

(1) Is in an unsound financial condition;

(2) Uses methods or practices in the conduct of business that are hazardous or injurious to insured persons or members of the general public; or

(3) Has failed to pay any judgment against the administrator in this State within 60 days after the judgment became final.

(b) May suspend or revoke the certificate of registration of an administrator if the Commissioner determines, after notice and a hearing, that the administrator:

(1) Has ~~[willfully]~~ ***knowingly*** violated or failed to comply with any provision of this Code, any regulation adopted pursuant to this Code or any order of the Commissioner;

(2) Has refused to be examined by the Commissioner or has refused to produce accounts, records or files for examination upon the request of the Commissioner;

(3) Has, without just cause, refused to pay claims or perform services pursuant to the administrator's contracts or has, without just cause, caused persons to accept less than the amount of money owed to them pursuant to the contracts, or has caused persons to employ an attorney or bring a civil action against the administrator to receive full payment or settlement of claims;

(4) Is affiliated with, managed by or owned by another administrator or an insurer who transacts insurance in this State without a certificate of authority or certificate of registration;

(5) Fails to comply with any of the requirements for a certificate of registration;

(6) Has been convicted of, or has entered a plea of guilty, guilty but mentally ill or nolo contendere to, a felony, whether or not adjudication was withheld;

(7) Has had his or her authority to act as an administrator in another state limited, suspended or revoked; or

(8) Has failed to file an annual report in accordance with NRS 683A.08528.

(c) May suspend or revoke the certificate of registration of an administrator if the Commissioner determines, after notice and a hearing, that a responsible person:

(1) Has refused to provide any information relating to the administrator's affairs or refused to perform any other legal obligation relating to an examination upon request by the Commissioner; or

(2) Has been convicted of, or has entered a plea of guilty, guilty but mentally ill or nolo contendere to, a felony committed on or after October 1, 2003, whether or not adjudication was withheld.

(d) May, upon notice to the administrator, suspend the certificate of registration of the administrator pending a hearing if:

(1) The administrator is impaired or insolvent;

(2) A proceeding for receivership, conservatorship or rehabilitation has been commenced against the administrator in any state; or

(3) The financial condition or the business practices of the administrator represent an imminent threat to the public health, safety or welfare of the residents of this State.

(e) May, in addition to or in lieu of the suspension or revocation of the certificate of registration of the administrator, impose a fine of $2,000 for each act or violation.

2. As used in this section, "responsible person" means any person who is responsible for or controls or is authorized to control or advise the affairs of an administrator, including, without limitation:

(a) A member of the board of directors, board of trustees, executive committee or other governing board or committee of the administrator;

(b) The president, vice president, chief executive officer, chief operating officer or any other principal officer of an administrator, if the administrator is a corporation;

(c) A partner or member of the administrator, if the administrator is a partnership, association or limited-liability company; and

(d) Any shareholder or member of the administrator who directly or indirectly holds 10 percent or more of the voting stock, voting securities or voting interest of the administrator.

Sec. 26. NRS 683A.301 is hereby amended to read as follows:

683A.301 1. An applicant for a license as a producer of insurance or a licensee who desires to use a name other than his or her true name as shown on the license shall submit a request for approval of the name and file with the Commissioner a certified copy of the certificate or any renewal certificate filed pursuant to chapter 602 of NRS. An incorporated applicant or licensee shall file with the Commissioner a document showing the corporation's true name and all fictitious names under which it conducts or intends to conduct business. A licensee shall file promptly with the

Commissioner a written notice of any change in or discontinuance of the use of a fictitious name.

2. The Commissioner may disapprove in writing the use of a true name, other than the true name of a natural person who is the applicant or licensee, or a fictitious name of any applicant or licensee, on any of the following grounds:

(a) The name interferes with or is deceptively similar to a name already filed and in use by another licensee.

(b) Use of the name may mislead the public in any respect.

(c) The name states or implies that the applicant or licensee is an insurer, motor club or hospital service plan or is entitled to engage in activities related to insurance not permitted under the license applied for or held.

(d) The name states or implies that the licensee is an underwriter, but:

(1) A natural person licensed as ~~[an agent or broker]~~ ***a producer of insurance*** for life insurance may describe himself or herself as an underwriter or "chartered life underwriter" if entitled to do so;

(2) A natural person licensed for property and casualty insurance may use the designation "chartered property and casualty underwriter" if entitled thereto; and

(3) ~~[An insurance agent or brokers']~~ ***A*** trade association ***for producers of insurance*** may use a name containing the word "underwriter."

(e) The licensee submits a request to use more than one fictitious name at a single business location.

3. A licensee shall not use a name after written notice from the Commissioner indicates that its use violates the provisions of this section. If the Commissioner determines that the use is justified by mitigating circumstances, the Commissioner may permit, in writing, the use of the name to continue for a specified reasonable period upon conditions imposed by the Commissioner for the protection of the public consistent with this section.

4. Paragraphs (a), (c) and (d) of subsection 2 do not apply to the true name of an organization which on July 1, 1965, held under that name a type of license similar to those governed by this chapter, or to a fictitious name used on July 1, 1965, by a natural person or organization holding such a license, if the fictitious name was filed with the Commissioner on or before July 1, 1965.

Sec. 27. NRS 683C.020 is hereby amended to read as follows:

683C.020 1. Except as otherwise provided in subsection 2, no person may engage in the business of an insurance consultant unless a license has been issued to the person by the Commissioner.

2. An insurance consultant's license is not required for:

(a) An attorney licensed to practice law in this State who is acting in his or her professional capacity;

(b) A licensed ~~[insurance agent,]~~ ***producer of insurance,*** broker or surplus lines broker;

(c) A trust officer of a bank who is acting in the normal course of his or her employment; or

(d) An actuary or a certified public accountant who provides information, recommendations, advice or services in his or her professional capacity.

3. A person required to be licensed in this State who acts as an insurance consultant without a license is subject to an administrative fine of not more than $1,000 for each act or violation.

Sec. 28. NRS 684B.030 is hereby amended to read as follows:

684B.030 1. Before the issuance of a motor vehicle physical damage appraiser's license the applicant shall file with the Commissioner, and thereafter maintain in force while so licensed, a surety bond in the amount of $2,500 in favor of the people of the State of Nevada, executed by an authorized surety insurer approved by the Commissioner, and conditioned for the faithful performance of required duties.

2. The bond shall remain in force until the surety is released from liability by the Commissioner, or until cancelled by the surety. Without prejudice to any prior liability accrued, the surety may cancel the bond upon 30 days' advance written notice filed with the Commissioner.

3. A motor vehicle physical damage appraiser's license is automatically suspended if the appraiser does not file with the Commissioner a replacement bond before the date of cancellation of the previous bond. A replacement bond must meet all requirements of this section for the initial bond.

Sec. 29. NRS 685A.150 is hereby amended to read as follows:

685A.150 A licensed surplus lines broker may accept surplus lines business from any ~~[agent or broker]~~ ***producer of insurance*** licensed in this state for the kind of insurance involved and may compensate the ~~[agent or broker]~~ ***producer of insurance*** therefor.

Sec. 30. NRS 686A.290 is hereby amended to read as follows:

686A.290 1. ~~[An agent, broker, solicitor,]~~ ***A producer of insurance,*** examining physician, applicant or other person shall not knowingly or willfully make any false or fraudulent statement or representation in or with reference to any application for insurance.

2. A person who violates this section is guilty of a category D felony and shall be punished as provided in NRS 193.130. In addition to any other penalty, the court shall order the person to pay restitution.

Sec. 31. NRS 686A.350 is hereby amended to read as follows:

686A.350 1. A license to engage in the business of a company is not required of any:

(a) State or federally chartered building association or savings and loan association.

(b) State or federally chartered bank.

(c) State or federally chartered credit union.

(d) Thrift company licensed pursuant to chapter 677 of NRS.

(e) ~~[Insurance agent]~~ ***Producer of insurance*** financing his or her own accounts.

(f) Insurer authorized to do business in this state financing its own policies or those of an affiliated company.

(g) Business, in addition to those included in paragraphs (a) to (d), inclusive, which is licensed and regulated by the Division of Financial Institutions of the Department of Business and Industry.

2. The provisions of NRS 686A.330 to 686A.520, inclusive, other than those which concern licensing, apply to persons exempt from licensing pursuant to subsection 1.

Sec. 32. NRS 686A.420 is hereby amended to read as follows:

686A.420 1. An agreement executed in this state must be dated and signed by the insured. The printed portion of the agreement must be in not less than 8-point type. The agreement must include:

(a) The name and the address and telephone number of the business of the ***producer of*** insurance ~~[agent]~~ for the insurance contract to which the agreement relates;

(b) The name and the address of the business or residence of the insured;

(c) The name, address and telephone number of the company to which payments must be made;

(d) A brief description of any insurance policy involved; and

(e) Such other information as may be required by the Commissioner.

2. An agreement must have at its top in type which is more prominent than the text of the agreement, the words "Agreement For Financing Premium" or words of similar meaning. An agreement must contain a notice in type which is more prominent than the text of the agreement which reads as follows:

Notice:

1. Do not sign this agreement before you have read it or if it contains any blank spaces.

2. You are entitled to a copy of this agreement which is complete.

Sec. 33. NRS 686A.680 is hereby amended to read as follows:

686A.680 ***1.*** An insurer that uses information from a consumer credit report shall not:

~~[1.]~~ ***(a)*** Use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status or nationality of the consumer as a factor, or would otherwise lead to unfair or invidious discrimination.

~~[2.]~~ ***(b)*** Deny, cancel or fail to renew a policy on the basis of credit information unless the insurer also considers other applicable underwriting factors that are independent of credit information and not expressly prohibited by this section.

~~[3.]~~ ***(c)*** Base renewal rates for a policy upon credit information unless the insurer also considers other applicable factors independent of credit information.

~~[4.]~~ ***(d)*** Take an adverse action against an applicant or policyholder based on the applicant or policyholder not having a credit card account unless the insurer also considers other applicable factors independent of credit information.

~~[5.]~~ ***(e)*** Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating a policy unless the insurer does any one of the following:

~~[(a)]~~ ***(1)*** Treats the applicant or policyholder as otherwise approved by the Commissioner, after the insurer presents to the Commissioner information indicating that such an absence or inability relates to the risk for the insurer.

~~[(b)]~~ ***(2)*** Treats the applicant or policyholder as if the applicant or policyholder had neutral credit information, as defined by the insurer.

~~[(c)]~~ ***(3)*** Excludes the use of credit information as a factor, and uses only underwriting criteria other than credit information.

~~[6.]~~ ***(f)*** Take an adverse action against an applicant or policyholder based on credit information, unless an insurer obtains and uses a consumer credit report issued or an insurance score calculated within 90 days from the date the policy is first written or renewal is issued.

~~[7. Except as otherwise provided in this subsection, use credit information regarding a policyholder without obtaining an updated consumer credit report regarding the policyholder and recalculating the insurance score at least once every 36 months. At the time of the annual renewal of a policyholder's policy, the insurer shall, upon the request of the policyholder or the policyholder's agent, reunderwrite and rerate the policy based upon a current consumer credit report or insurance score. An insurer need not, at the request of a policyholder or the policyholder's agent, recalculate the insurance score of or obtain an updated consumer credit report of the policyholder more~~

~~frequently than once in any 12-month period. An insurer may, at its discretion, obtain an updated consumer credit report regarding a policyholder more frequently than once every 36 months, if to do so is consistent with the underwriting guidelines of the insurer. An insurer does not need to obtain an updated consumer credit report for a policyholder if any one of the following applies:~~

~~(a) The insurer is treating the policyholder as otherwise approved by the Commissioner.~~

~~(b) The policyholder is in the most favorably priced tier of the insurer and all affiliates of the insurer. With respect to such a policyholder, the insurer may elect to obtain an updated consumer credit report if to do so is consistent with the underwriting guidelines of the insurer.~~

~~(c) Credit information was not used for underwriting or rating the policyholder when the policy was initially written. The fact that credit information was not used initially does not preclude an insurer from using such information subsequently when underwriting or rating such a policyholder upon renewal, if to do so is consistent with the underwriting guidelines of the insurer.~~

~~(d) The insurer reevaluates the policyholder at least once every 36 months based upon underwriting or rating factors other than credit information.~~

~~8.~~ ***(g)*** Use the following as a negative factor in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy:

~~(a)~~ ***(1)*** Credit inquiries not initiated by the applicant or policyholder, or inquiries requested by the applicant or policyholder for his or her own credit information.

~~(b)~~ ***(2)*** Inquiries relating to insurance coverage, if so identified on the consumer credit report.

~~(c)~~ ***(3)*** Collection accounts relating to medical treatment, if so identified on the consumer credit report.

~~(d)~~ ***(4)*** Multiple lender inquiries, if identified on the consumer credit report as being related to home loans or mortgages and made within 30 days of one another, unless only one inquiry is considered.

~~(e)~~ ***(5)*** Multiple lender inquiries, if identified on the consumer credit report as being related to a loan for an automobile and made within 30 days of one another, unless only one inquiry is considered.

2. Except as otherwise provided in this subsection, at the time of the annual renewal of a policyholder's policy, an insurer that uses information from a consumer credit report shall, upon the request of the policyholder or the policyholder's agent, reunderwrite and rerate the policy based upon a current consumer

credit report or insurance score. An insurer need not, at the request of a policyholder or the policyholder's agent, recalculate the insurance score of or obtain an updated consumer credit report of the policyholder more frequently than once in any 12-month period.

Sec. 34. Chapter 686B of NRS is hereby amended by adding thereto the provisions set forth as sections 35 to 39, inclusive, of this act.

Sec. 35. *"Large-deductible agreement" means any combination of one or more policies, endorsements, contracts or security arrangements, which provide for the policyholder to bear the risk of loss of a specified amount of $25,000 or more per claim or occurrence covered under a policy of industrial insurance and which may be subject to an aggregate limit of the policyholder's reimbursement obligations.*

Sec. 36. *1. The Commissioner shall consider each proposed increase or decrease in the rate of a health plan issued pursuant to the provisions of chapter 689A, 689B, 689C, 695B, 695C, 695D or 695F of NRS, including, without limitation, long-term care and Medicare supplement plans, filed with the Commissioner pursuant to subsection 1 of NRS 686B.070. If the Commissioner finds that a proposed increase will result in a rate which is not in compliance with NRS 686B.050 or subsection 3 of NRS 686B.070, the Commissioner shall disapprove the proposal. The Commissioner shall approve or disapprove each proposal not later than 60 days after the proposal is determined by the Commissioner to be complete pursuant to subsection 4. If the Commissioner fails to approve or disapprove the proposal within that period, the proposal shall be deemed approved.*

2. Whenever an insurer has no legally effective rates as a result of the Commissioner's disapproval of rates or other act, the Commissioner shall on request specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by the Commissioner. When new rates become legally effective, the Commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis must not be required.

3. If the Commissioner disapproves a proposed rate pursuant to subsection 1, and an insurer requests a hearing to determine the validity of the action of the Commissioner, the insurer has the burden of showing compliance with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive, and

sections 35 to 39, inclusive, of this act. Any such hearing must be held:

(a) Within 30 days after the request for a hearing has been submitted to the Commissioner; or

(b) Within a period agreed upon by the insurer and the Commissioner.

➥ If the hearing is not held within the period specified in paragraph (a) or (b), or if the Commissioner fails to issue an order concerning the proposed rate for which the hearing is held within 45 days after the hearing, the proposed rate shall be deemed approved.

4. The Commissioner shall by regulation specify the documents or any other information which must be included in a proposal to increase or decrease a rate submitted to the Commissioner pursuant to subsection 1. Each such proposal shall be deemed complete upon its filing with the Commissioner, unless the Commissioner, within 15 business days after the proposal is filed with the Commissioner, determines that the proposal is incomplete because the proposal does not comply with the regulations adopted by the Commissioner pursuant to this subsection.

Sec. 37. *This section and sections 38 and 39 of this act apply to any policy of industrial insurance which:*

1. Is issued by an insurer which:

(a) Has a rating of less than "A-" from A.M. Best Company, Inc., or a substantially equivalent rating from another rating agency, as determined by the Commissioner; and

(b) Has less than $200,000,000 in surplus, with surplus calculated as the difference between the insurer's net admitted assets and the insurer's total liabilities;

2. Contains a large-deductible agreement;

3. Is not issued to a federal, state or local governmental entity; and

4. Is issued for delivery or renewed on or after January 1, 2018.

Sec. 38. *An insurer shall:*

1. Require full collateralization of the outstanding obligations owed under a large-deductible agreement using one of the following methods:

(a) A surety bond issued by a surety insurer authorized to transact such insurance in this State, and whose financial strength and size ratings from A.M. Best Company, Inc., are not less than "A" and "V," respectively, or are substantially equivalent ratings from another rating agency, as determined by the Commissioner;

(b) An irrevocable letter of credit issued by a financial institution with an office physically located within this State, and the deposits of which are federally insured; or

(c) Cash or securities held in trust by a third party or the insurer and subject to a trust agreement for the express purpose of securing the policyholder's obligation under a large-deductible agreement, provided that if the assets are held by the insurer, those assets may not be commingled with the insurer's other assets; and

2. Limit the size of the policyholder's obligations under a large-deductible agreement to 20 percent of the total net worth of the policyholder at the inception of the policy and again at each renewal, as determined by an audited financial statement as of the most recent fiscal year-end for which such a statement is available, with the total net worth of the policyholder calculated as the difference between the total assets and the total liabilities of the policyholder.

Sec. 39. ***Except when otherwise specifically approved by the Commissioner in writing or by electronic communication, any insurer determined to be in a hazardous financial condition pursuant to NRS 680A.205, or the equivalent provisions of law in any other state as determined by the Commissioner, is prohibited from issuing or renewing a policy that includes a large-deductible agreement.***

Sec. 40. NRS 686B.010 is hereby amended to read as follows:

686B.010 1. The Legislature intends that NRS 686B.010 to 686B.1799, inclusive, ***and sections 35 to 39, inclusive, of this act*** be liberally construed to achieve the purposes stated in subsection 2, which constitute an aid and guide to interpretation but not an independent source of power.

2. The purposes of NRS 686B.010 to 686B.1799, inclusive, ***and sections 35 to 39, inclusive, of this act*** are to:

(a) Protect policyholders and the public against the adverse effects of excessive, inadequate or unfairly discriminatory rates;

(b) Encourage, as the most effective way to produce rates that conform to the standards of paragraph (a), independent action by and reasonable price competition among insurers;

(c) Provide formal regulatory controls for use if independent action and price competition fail;

(d) Authorize cooperative action among insurers in the rate-making process, and to regulate such cooperation in order to prevent practices that tend to bring about monopoly or to lessen or destroy competition;

(e) Encourage the most efficient and economic marketing practices; and

(f) Regulate the business of insurance in a manner that will preclude application of federal antitrust laws.

Sec. 41. NRS 686B.020 is hereby amended to read as follows:

686B.020 As used in NRS 686B.010 to 686B.1799, inclusive, ***and sections 35 to 39, inclusive, of this act,*** unless the context otherwise requires:

1. "Advisory organization," except as limited by NRS 686B.1752, means any person or organization which is controlled by or composed of two or more insurers and which engages in activities related to rate making. For the purposes of this subsection, two or more insurers with common ownership or operating in this State under common ownership constitute a single insurer. An advisory organization does not include:
   (a) A joint underwriting association;
   (b) An actuarial or legal consultant; or
   (c) An employee or manager of an insurer.
2. "Market segment" means any line or kind of insurance or, if it is described in general terms, any subdivision thereof or any class of risks or combination of classes.
3. "Rate service organization" means any person, other than an employee of an insurer, who assists insurers in rate making or filing by:
   (a) Collecting, compiling and furnishing loss or expense statistics;
   (b) Recommending, making or filing rates or supplementary rate information; or
   (c) Advising about rate questions, except as an attorney giving legal advice.
4. "Supplementary rate information" includes any manual or plan of rates, statistical plan, classification, rating schedule, minimum premium, policy fee, rating rule, rule of underwriting relating to rates and any other information prescribed by regulation of the Commissioner.

Sec. 42. NRS 686B.030 is hereby amended to read as follows:

686B.030 1. Except as otherwise provided in subsection 2 and NRS 686B.125, the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and sections 35 to 39, inclusive, of this act*** 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. 43. NRS 686B.040 is hereby amended to read as follows:

686B.040 1. Except as otherwise provided in subsection 2, the Commissioner may by rule exempt any person or class of persons or any market segment from any or all of the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and sections 35 to 39, inclusive, of this act,*** if and to the extent that the Commissioner finds their application unnecessary to achieve the purposes of those sections.

2. The Commissioner may not, by rule or otherwise, exempt an insurer from the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and sections 35 to 39, inclusive, of this act*** with regard to 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.

Sec. 44. NRS 686B.110 is hereby amended to read as follows:

686B.110 1. ~~[The]~~ ***Except as otherwise provided in section 36 of this act, the*** Commissioner shall consider each proposed increase or decrease in the rate of any kind or line of insurance or subdivision thereof filed with the Commissioner pursuant to subsection 1 of NRS 686B.070. If the Commissioner finds that a proposed increase will result in a rate which is not in compliance with NRS 686B.050 or subsection 3 of NRS 686B.070, the Commissioner shall disapprove the proposal. The Commissioner shall approve or disapprove each proposal no later than 30 days after it is determined by the Commissioner to be complete pursuant to subsection 6. If the Commissioner fails to approve or disapprove the proposal within that period, the proposal shall be deemed approved.

2. If the Commissioner disapproves a proposed increase or decrease in any rate pursuant to subsection 1, the Commissioner shall send a written notice of disapproval to the insurer or the rate service organization that filed the proposal. The notice must set forth the reasons the proposal is not in compliance with NRS 686B.050 or subsection 3 of NRS 686B.070 and must be sent to the insurer or the rate service organization not more than 30 days after

the Commissioner determines that the proposal is complete pursuant to subsection 6.

3. Upon receipt of a written notice of disapproval from the Commissioner pursuant to subsection 2 or 6, the insurer or rate service organization may request that the Commissioner reconsider the proposed increase or decrease. The request for reconsideration must be received by the Commissioner not more than 30 days after the insurer or rate service organization receives the written notice of disapproval from the Commissioner, except that if the insurer or rate service organization requests, in writing, an extension of 30 additional days in which to request a reconsideration, the Commissioner shall grant the extension. A request for reconsideration submitted pursuant to this subsection may include, without limitation, any documents or other information for review by the Commissioner in reconsidering the proposal. The Commissioner shall approve or disapprove the proposal upon reconsideration not later than 30 days after receipt of the request for reconsideration and shall notify the insurer or rate service organization of his or her approval or disapproval.

4. Whenever an insurer has no legally effective rates as a result of the Commissioner's disapproval of rates or other act, the Commissioner shall on request specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by the Commissioner. When new rates become legally effective, the Commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis must not be required.

5. If the Commissioner disapproves a proposed rate pursuant to subsection 1 ~~[,]~~ ***or*** subsection 6 or upon reconsideration pursuant to subsection 3 **,** and an insurer requests a hearing to determine the validity of the action of the Commissioner, the insurer has the burden of showing compliance with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive ~~[.]~~ ***, and sections 35 to 39, inclusive, of this act.*** Any such hearing must be held:

(a) Within 30 days after the request for a hearing has been submitted to the Commissioner; or

(b) Within a period agreed upon by the insurer and the Commissioner.

➥ If the hearing is not held within the period specified in paragraph (a) or (b), or if the Commissioner fails to issue an order concerning the proposed rate for which the hearing is held within 45 days after the hearing, the proposed rate shall be deemed approved.

6. The Commissioner shall by regulation specify the documents or any other information which must be included in a proposal to increase or decrease a rate submitted to the Commissioner pursuant to subsection 1. Each such proposal shall be deemed complete upon its filing with the Commissioner, unless the Commissioner, within 15 business days after the proposal is filed with the Commissioner, determines that the proposal is incomplete because the proposal does not comply with the regulations adopted by the Commissioner pursuant to this subsection. The Commissioner shall notify the insurer or rate service organization if the Commissioner determines that the proposal is incomplete. The notice must be sent within 15 business days after the proposal is filed with the Commissioner and must set forth the documents or other information that is required to complete the proposal. The Commissioner may disapprove the proposal if the insurer or rate service organization fails to provide the documents or other information to the Commissioner within 30 days after the insurer or rate service organization receives the notice that the proposal is incomplete. If the Commissioner disapproves the proposal pursuant to this subsection, the Commissioner shall notify the insurer or rate service organization of that fact in writing.

Sec. 45. NRS 686B.115 is hereby amended to read as follows:

686B.115 1. Any hearing held by the Commissioner to determine whether rates comply with the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and sections 35 to 39, inclusive, of this act*** must be open to members of the public.

2. All costs for transcripts prepared pursuant to such a hearing must be paid by the insurer requesting the hearing.

3. At any hearing which is held by the Commissioner to determine whether rates comply with the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and sections 35 to 39, inclusive, of this act,*** and which involves rates 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, if a person is not otherwise authorized pursuant to this title to become a party to the hearing by intervention, the person is entitled to provide testimony at the hearing if, not later than 2 days before the date set for the hearing, the person files with the Commissioner a written statement which states:

(a) The name and title of the person;

(b) The interest of the person in the hearing; and

(c) A brief summary describing the purpose of the testimony the person will offer at the hearing.

4. If a person provides testimony at a hearing in accordance with subsection 3:

(a) The Commissioner may, if the Commissioner finds it necessary to preserve order, prevent inordinate delay or protect the rights of the parties at the hearing, place reasonable limitations on the duration of the testimony and prohibit the person from providing testimony that is not relevant to the issues raised at the hearing.

(b) The Commissioner shall consider all relevant testimony provided by the person at the hearing in determining whether the rates comply with the provisions of NRS 686B.010 to 686B.1799, inclusive ~~.~~ ***, and sections 35 to 39, inclusive, of this act.***

Sec. 46. NRS 686B.1751 is hereby amended to read as follows:

686B.1751 As used in NRS 686B.1751 to 686B.1799, inclusive, ***and sections 35, 37, 38 and 39 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 686B.1752 to 686B.1762, inclusive, ***and section 35 of this act*** have the meanings ascribed to them in those sections.

Sec. 47. NRS 686B.1763 is hereby amended to read as follows:

686B.1763 1. NRS 686B.1751 to 686B.1799, inclusive, ***and sections 35, 37, 38 and 39 of this act,*** apply to insurers providing industrial insurance and to the Advisory Organization designated by the Commissioner. The Commissioner shall administer the provisions of these sections.

2. These provisions apply to all industrial insurance issued in this state except reinsurance.

Sec. 48. NRS 686B.1789 is hereby amended to read as follows:

686B.1789 A hearing required by any of the provisions of NRS 686B.1751 to 686B.1799, inclusive, ***and sections 35, 37, 38 and 39 of this act,*** is governed by NRS 679B.310 to 679B.370, inclusive, except that any limits of time imposed by NRS 686B.1751 to 686B.1799, inclusive, ***and sections 35, 37, 38 and 39 of this act,*** control.

Sec. 49. NRS 686B.1793 is hereby amended to read as follows:

686B.1793 1. An insurer or other person who violates any provision of NRS 686B.1751 to 686B.1799, inclusive, ***and sections 35, 37, 38 and 39 of this act,*** shall, upon the order of the Commissioner, pay an administrative fine not to exceed $1,000 for each violation and not to exceed $10,000 for each willful violation. These administrative fines are in addition to any other penalty provided by law. Any insurer using a rate before it has been filed with the Commissioner as required by NRS 686B.1775, shall be deemed to have committed a separate violation for each day the insurer failed to file the rate.

2. The Commissioner may suspend or revoke the license of any advisory organization or insurer who fails to comply with an order within the time specified by the Commissioner or any extension of that time made by the Commissioner. Any suspension of a license is effective for the time stated by the Commissioner in his or her order or until the order is modified, rescinded or reversed.

3. The Commissioner, by written order, may impose a penalty or suspend a license pursuant to this section only after written notice to the insurer, organization or plan for apportioned risks and a hearing.

Sec. 50. Chapter 687B of NRS is hereby amended by adding thereto the provisions set forth as sections 51 to 85, inclusive, of this act.

Sec. 51. ***As used in sections 51 to 85, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 52 to 64, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 52. ***"Covered person" means a policyholder, subscriber, enrollee or other person participating in a network plan.***

Sec. 53. ***"Evidence of coverage" means any certificate, agreement or contract issued to a covered person by a health carrier setting forth the coverage to which the covered person is entitled pursuant to a network plan.***

Sec. 54. ***"Health benefit plan" has the meaning ascribed to it in NRS 695G.019.***

Sec. 55. ***"Health care services" has the meaning ascribed to it in NRS 695G.022.***

Sec. 56. ***"Health carrier" has the meaning ascribed to it in NRS 695G.024.***

Sec. 57. ***"Intermediary" means a person authorized to negotiate and execute a contract between a provider of health care and a health carrier entered into for the purposes of a network plan, whether the person acts on behalf of the provider of health care or the health carrier.***

Sec. 58. ***"Medically necessary" has the meaning ascribed to it in NRS 695G.055.***

Sec. 59. ***"Network" means a defined set of providers of health care who are under contract with a health carrier to provide health care services pursuant to a network plan offered or issued by the health carrier.***

Sec. 60. ***"Network plan" means a health benefit plan offered or issued by a health carrier under which the financing and delivery of health care services, including, without limitation, items and services paid for as health care services, are provided, in whole or in part, through a defined set of providers of health care***

under contract with the health carrier. The term does not include an arrangement for the financing of premiums.

Sec. 61. *"Participating provider of health care" means a provider of health care who, under a contract with a health carrier, has agreed to provide health care services to covered persons pursuant to a network plan with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.*

Sec. 62. *"Primary care physician" has the meaning ascribed to it in NRS 695G.060.*

Sec. 63. *"Provider of health care" has the meaning ascribed to it in NRS 695G.070.*

Sec. 64. *"Utilization review" has the meaning ascribed to it in NRS 695G.080.*

Sec. 65. *If a health carrier offers or issues a network plan, the health carrier shall, with regard to that network plan:*

1. Comply with all applicable requirements set forth in sections 51 to 85, inclusive, of this act;

2. As applicable, ensure that each contract entered into for the purposes of the network plan between a participating provider of health care and the health carrier complies with the requirements set forth in sections 51 to 85, inclusive, of this act; and

3. As applicable, ensure that the network plan complies with the requirements set forth in sections 51 to 85, inclusive, of this act.

Sec. 66. *A health carrier which offers or issues a network plan shall, with regard to that network plan, establish a mechanism by which each participating provider of health care in the network will be notified on an ongoing basis of the specific health care services which are covered by the network plan and for which the participating provider of health care will be responsible, including, without limitation, any restrictions or conditions on the health care services.*

Sec. 67. *Each contract entered into for the purposes of a network plan between a participating provider of health care and the health carrier must include, without limitation, a provision which is substantially similar to the following:*

> *Provider of health care agrees that in no event, including but not limited to, nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary or breach of this agreement, shall the provider of health care bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or*

have any recourse against, a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for health care services provided pursuant to this agreement. This agreement does not prohibit the provider of health care from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. This agreement does not prohibit a provider of health care (except for a provider of health care who is employed full-time on the staff of the health carrier and has agreed to provide health care services exclusively to the health carrier's covered persons and no others) and a covered person from agreeing to continue health care services solely at the expense of the covered person, as long as the provider of health care has clearly informed the covered person that the health carrier may not cover or continue to cover a specific health care service or health care services. Except as provided herein, this agreement does not prohibit the provider of health care from pursuing any available legal remedy.

Sec. 68. *Each contract entered into for the purposes of a network plan between a participating provider of health care and the health carrier must provide that in the event of the insolvency of the health carrier or any applicable intermediary, or in the event of any other cessation of operations of the health carrier or intermediary, the participating provider of health care must continue to deliver health care services covered by the network plan to a covered person without billing the covered person for any amount other than coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, until the earlier of:*

1. The date of the cancellation of the covered person's coverage under the network plan pursuant to NRS 687B.310, including, without limitation, any extension of coverage provided pursuant to:

(a) The terms of the contract between the covered person and the health carrier;

(b) NRS 689A.04036, 689B.0303, 695B.1901, 695C.1691 and 695G.164, as applicable; or

(c) Any applicable federal law for covered persons who are in an active course of treatment or totally disabled; or

2. The date on which the contract between the health carrier and the provider of health care would have terminated if the health carrier or intermediary, as applicable, had remained in

operation, including, without limitation, any extension of coverage provided pursuant to:

(a) The terms of the contract between the covered person and the health carrier;

(b) NRS 689A.04036, 689B.0303, 695B.1901, 695C.1691 and 695G.164, as applicable; or

(c) Any applicable federal law for covered persons who are in an active course of treatment or totally disabled.

Sec. 69. *The provisions included in a contract to comply with the requirements set forth in sections 67 and 68 of this act shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for the termination, including, without limitation, the insolvency of the health carrier or any applicable intermediary, and shall supersede any oral or written contrary agreement between a participating provider of health care and a covered person or the representative of a covered person if the contrary agreement is inconsistent with provisions included in the contract to comply with the requirements set forth in sections 67 and 68 of this act.*

Sec. 70. *Each contract entered into for the purposes of a network plan between a participating provider of health care and the health carrier must provide that written notice must be provided to the participating provider of health care as soon as practicable in the event:*

1. That a court determined the health carrier or any applicable intermediary to be insolvent; or

2. Of any other cessation of operations of the health carrier or any applicable intermediary.

Sec. 71. *A health carrier which offers or issues a network plan shall notify each participating provider of health care in the network of the responsibilities of the participating provider of health care with respect to any applicable administrative policies and programs of the health carrier including, without limitation, any applicable administrative policies and programs concerning:*

1. Terms of payment;

2. Utilization review;

3. Quality assessment and improvement;

4. Credentialing;

5. Procedures for grievances and appeals;

6. Requirements for data reporting;

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

8. Requirements for confidentiality; and

9. Any applicable federal or state programs.

Sec. 72. *A health carrier which offers or issues a network plan shall not offer an inducement to a participating provider of health care in the network that would encourage or otherwise incent the participating provider of health care to deliver health care services to a covered person which are less than those which are medically necessary.*

Sec. 73. *A health carrier which offers or issues a network plan shall not prohibit a participating provider of health care in the network from:*

1. Discussing any specific treatment option or all treatment options with a covered person irrespective of the position of the health carrier on the treatment options;

2. Advocating on behalf of a covered person within any utilization review process or any process for grievances or appeals established by the health carrier or a person contracting with the health carrier; or

3. Advocating on behalf of a covered person in accordance with any rights or remedies available under applicable state or federal law.

Sec. 74. *Each contract entered into for the purposes of a network plan between a participating provider of health care and the health carrier must require the participating provider of health care to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of or amend their medical and health records.*

Sec. 75. (Deleted by amendment.)

Sec. 76. (Deleted by amendment.)

Sec. 77. *Each contract entered into for the purposes of a network plan between a participating provider of health care and the health carrier must prohibit the health carrier and the participating provider of health care from assigning or delegating the rights and responsibilities of either party under the contract without the prior written consent of the other party.*

Sec. 78. *1. A health carrier which offers or issues a network plan shall ensure that participating providers of health care in the network are responsible for furnishing covered services to all covered persons without regard to the participation of the covered person in the network plan as a private purchaser of the network plan or as a participant in a publicly financed program of health care services.*

2. This section does not apply to circumstances when the participating provider of health care should not render services due to limitations arising from a lack of training, experience or skill or licensing restrictions.

Sec. 79. *A health carrier which offers or issues a network plan shall notify the participating providers of health care in the network of his or her obligations, if any, to collect applicable coinsurance, copayments or deductibles from a covered person pursuant to the evidence of coverage, or of the obligations, if any, of the participating provider of health care to notify a covered person of the personal financial obligations of the covered person for health care services that are not covered.*

Sec. 80. *A health carrier which offers or issues a network plan shall not penalize a participating provider of health care in the network because the participating provider of health care, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes the health or welfare of a covered person.*

Sec. 81. *A health carrier which offers or issues a network plan shall establish a mechanism by which a participating provider of health care in the network may, in a timely manner at the time health care services are to be provided, determine whether the person to whom the health care services are to be provided is a covered person or is within a grace period for the payment of a premium during which the health carrier may hold a claim for health care services pending receipt of the payment of the premium.*

Sec. 82. *A health carrier which offers or issues a network plan shall establish procedures for the resolution of administrative, payment or other disputes between a participating provider of health care in the network and the health carrier.*

Sec. 83. *1. A contract entered into for the purposes of a network plan between a participating provider of health care and the health carrier must not contain a provision that conflicts with any provision in the network plan or any requirement set forth in sections 51 to 85, inclusive, of this act.*

2. At the time a participating provider of health care signs a contract described in subsection 1, the health carrier and, if applicable, the intermediary shall notify the participating provider of health care of all provisions of the contract and all documents incorporated by reference in the contract.

3. While a contract described in subsection 1 is in force, the health carrier shall provide timely notice to the participating provider of health care of any changes to the provisions of the

contract or the documents incorporated by reference in the contract that would result in a material change in the contract.

4. For the purposes of subsection 3, the contract must define what is to be considered timely notice and what is to be considered a material change.

Sec. 84. ***A health carrier which offers or issues a network plan shall inform a participating provider of health care with whom the health carrier has contracted for the purposes of the network plan of the status of the participating provider of health care as a provider of health care in the network plan and the status and inclusion of the participating provider of health care on any list of providers of health care maintained by the health carrier. The health carrier shall provide in a timely manner the information required by this section to the participating provider of health care:***

1. Upon the request of the participating provider of health care; and

2. Upon any change to the status or inclusion of the participating provider of health care as described in this section.

Sec. 85. ***The Commissioner may adopt any regulations necessary to carry out the purposes and provisions of sections 51 to 85, inclusive, of this act.***

Sec. 86. NRS 687B.385 is hereby amended to read as follows:

687B.385 An insurer shall not ***refuse to issue,*** cancel, refuse to renew or increase the premium for renewal of a policy of motor vehicle insurance covering private passenger cars or commercial vehicles as a result of any ~~[claims]~~ ***:***

1. Claims made under ~~[the]~~ ***any*** policy ***of insurance*** with respect to which the insured was not at fault ~~[.]~~ ***;***

2. Claims made under any policy of insurance for which the insurer has not made any payment or for which the insurer recovered the entirety of the insurer's payment on the claim by means of salvage, subrogation or another mechanism; or

3. Inquiries made regarding an actual or potential claim under any policy of insurance regarding:

(a) The existence of insurance coverage for any matter; or

(b) Any hypothetical or informational matter pertaining to insurance.

Sec. 87. NRS 687B.470 is hereby amended to read as follows:

687B.470 1. ~~["Health]~~ ***As used in NRS 687B.470 to 687B.500, inclusive, "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. 88. NRS 687B.490 is hereby amended to read as follows:

687B.490 1. A carrier that offers coverage in the ***small employer*** 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. When making any determination concerning the availability and accessibility of the services of any network plan or proposed network plan pursuant to this section, the Commissioner shall consider services that may be provided through telehealth, as defined in NRS 629.515, pursuant to the network plan or proposed network plan to be available services.

8. As used in this section ~~[, "network]~~ ***:***

(a) "Network plan" has the meaning ascribed to it in NRS 689B.570.

(b) "Small employer" has the meaning ascribed to it in NRS 689C.095.

Sec. 89. NRS 687B.500 is hereby amended to read as follows:

687B.500 1. The premium rate charged by a health insurer for health benefit plans offered in the individual or small ***employer*** 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.

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

Sec. 90. NRS 689.185 is hereby amended to read as follows:

689.185 1. Except as otherwise provided in subsection 2:

(a) Before the issuance of a certificate of authority, the seller shall post with the Commissioner and thereafter maintain in force a

bond in the principal sum of $50,000 issued by an authorized corporate surety in favor of the State of Nevada, or a deposit of cash or negotiable securities or a combination of cash and negotiable securities. If a deposit is made in lieu of a bond, the deposit must at all times have a market value of not less than the amount of the bond required by the Commissioner.

(b) The bond or deposit must be held for the benefit of buyers of prepaid contracts, and other persons as their interests may appear, who may be damaged by misuse or diversion of money by the seller or the agents of the seller, or to satisfy any judgments against the seller for failure to perform a prepaid contract. The aggregate liability of the surety for all breaches of the conditions of the bond must not exceed the sum of the bond. The surety on the bond has the right to cancel the bond upon giving 30 days' notice to the Commissioner and thereafter is relieved of liability for any breach of condition occurring after the effective date of the cancellation.

(c) ***A certificate of authority issued to a seller is automatically suspended if the seller does not file with the Commissioner a replacement bond before the date of cancellation of the previous bond. A replacement bond must meet all requirements of this subsection for the initial bond.***

(d) The Commissioner shall release the bond or deposit after the seller has ceased doing business as such and the Commissioner is satisfied of the nonexistence of any obligation or liability of the seller for which the bond or deposit was held.

2. The Commissioner may waive the requirements of subsection 1 if the seller agrees:

(a) To offer for sale only prepaid contracts that are payable solely from the proceeds of a policy of life insurance; and

(b) Not to collect any money from the purchaser of a prepaid contract.

Sec. 91. NRS 689.495 is hereby amended to read as follows:

689.495 1. Except as otherwise provided in subsection 2:

(a) Before the issuance of a permit to a seller, the seller shall post with the Commissioner and thereafter maintain in force a bond in the principal sum of $50,000 issued by an authorized corporate surety in favor of the State of Nevada, or a deposit of cash or negotiable securities or a combination of cash and negotiable securities. If a deposit is made in lieu of a bond, the deposit must at all times have a market value not less than the amount of the bond required by the Commissioner.

(b) The bond or deposit must be held for the benefit of buyers of prepaid contracts, and other persons as their interests may appear, who may be damaged by misuse or diversion of money by the seller or the agents of the seller, or to satisfy any judgments against the

seller for failure to perform a prepaid contract. The aggregate liability of the surety for all breaches of the conditions of the bond must not exceed the sum of the bond. The surety on the bond has the right to cancel the bond upon giving 30 days' notice to the Commissioner and thereafter is relieved of liability for any breach of condition occurring after the effective date of the cancellation.

(c) ***A permit issued to a seller is automatically suspended if the seller does not file with the Commissioner a replacement bond before the date of cancellation of the previous bond. A replacement bond must meet all requirements of this subsection for the initial bond.***

(d) The Commissioner shall release the bond or deposit after the seller has ceased doing business as such and the Commissioner is satisfied of the nonexistence of any obligation or liability of the seller for which the bond or deposit was held.

2. The Commissioner may waive the requirements of subsection 1 if the seller agrees:

(a) To offer for sale only prepaid contracts that are payable solely from the proceeds of a policy of life insurance; and

(b) Not to collect any money from the purchaser of a prepaid contract.

Sec. 92. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An individual carrier shall make the unified rate review template and rate filing documentation used by the individual carrier and any information and documents described in any regulations adopted pursuant to 689A.700 available to the Commissioner upon request. Except in cases of violations of the provisions of this chapter, the unified rate review template and rate filing documentation used by an individual carrier are considered proprietary, constitute a trade secret and are 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.

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

Sec. 93. 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 section 92 of this act,*** and 689C.610 to 689C.940, inclusive, relating to the program of reinsurance.

Sec. 94. NRS 689A.04033 is hereby amended to read as follows:

689A.04033 1. A policy of health insurance must provide coverage for medical treatment which a policyholder or subscriber 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 policyholder or subscriber has signed, before participating in the clinical trial or study, a statement of consent indicating that the policyholder or subscriber 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 policyholder or subscriber.

(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 policy of health insurance.

(c) The cost of any routine health care services that would otherwise be covered under the policy of health insurance for a policyholder or subscriber participating in a Phase I clinical trial or study.

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

(e) Health care services required for the clinically appropriate monitoring of the policyholder or subscriber 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 policyholder or subscriber 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 689A.04036, 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 insurer has contracted for such services. If the insurer has not contracted for the provision of such services, the insurer shall pay the provider the rate of reimbursement that is paid to other providers with whom the insurer 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 policyholder or subscriber 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 policyholder or subscriber.

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 policyholder's or subscriber's policy of health insurance, 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 policyholder or subscriber 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 policyholder or subscriber.

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

5. An insurer who delivers or issues for delivery a policy of health insurance 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 policyholder or subscriber, 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. An insurer who delivers or issues for delivery a policy specified in subsection 1 shall:

(a) Include in ~~[the]~~ ***any*** disclosure ~~[required pursuant to NRS 689A.390]~~ ***of the coverage provided by the policy*** notice to each policyholder and subscriber under the policy of the availability of the benefits required by this section.

(b) 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 policy.

7. A policy of health insurance 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 policy that conflicts with this section is void.

8. An insurer who delivers or issues for delivery a policy specified in subsection 1 is immune from liability for:

(a) Any injury to a policyholder or subscriber caused by:

(1) Any medical treatment provided to the policyholder or subscriber 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 policyholder or subscriber 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 a policyholder's or subscriber'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. 95. NRS 689A.0427 is hereby amended to read as follows:

689A.0427 1. No policy of health insurance that provides coverage for hospital, medical or surgical expenses may be delivered or issued for delivery in this state unless the policy 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 a policy specified in subsection 1:

(a) Shall include in ~~[the]~~ ***any*** disclosure ~~[required pursuant to NRS 689A.390]~~ ***of the coverage provided by the policy*** notice to each policyholder and subscriber under the policy of the availability of the benefits required by this section.

(b) Shall 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 policy.

3. A policy of health insurance 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 policy 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 an insured person after the insured person 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 insured person and which requires modification of the insured person'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. 96. NRS 689A.470 is hereby amended to read as follows:

689A.470 As used in NRS 689A.470 to 689A.740, inclusive, ***and section 92 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 689A.475 to 689A.600, inclusive, have the meanings ascribed to them in those sections.

Sec. 97. NRS 689A.615 is hereby amended to read as follows:

689A.615 For the purposes of NRS 689A.470 to 689A.740, inclusive ~~[:]~~ ***, and section 92 of this act:***

1. Any plan, fund or program which would not be, but for section 2721(e) of the Public Health Service Act, as amended by Public Law 104-191, as that section existed on July 16, 1997, an employee welfare benefit plan and which is established or maintained by a partnership to the extent that the plan, fund or program provides medical care to current or former partners in the partnership or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, must be treated, subject to subsection 2, as an employee welfare benefit plan which is a group health plan.

2. In the case of a group health plan, a partnership shall be deemed to be the employer of each partner.

Sec. 98. 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]~~ ***product*** 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]~~ ***product*** 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]~~ ***product*** at least ~~[180]~~ ***90*** 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]~~ ***product*** 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]~~ ***product*** 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 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. 99. NRS 689A.700 is hereby amended to read as follows:

689A.700 The Commissioner may adopt regulations ~~[to carry out the provisions of this section and NRS 689A.690 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 ~~[.]~~ ***, and section 92 of this act.***

Sec. 100. NRS 689A.715 is hereby amended to read as follows:

689A.715 1. An employee welfare benefit plan for providing benefits for employees of more than one employer under which individual health insurance coverage is provided must comply with the provisions of NRS 679B.139 and 689A.470 to 689A.740, inclusive, ***and section 92 of this act,*** and the regulations adopted by the Commissioner pursuant thereto.

2. As used in this section, the term "employee welfare benefit plan for providing benefits for employees of more than one employer" is intended to be equivalent to the term "employee welfare benefit plan which is a multiple employer welfare arrangement" as used in federal statutes and regulations.

Sec. 101. NRS 689A.725 is hereby amended to read as follows:

689A.725 For the purposes of NRS 689A.470 to 689A.740, inclusive, ***and section 92 of this act,*** a plan for coverage of a bona fide association must:

1. Conform with ***any regulations adopted pursuant to*** NRS ~~[689A.690 and]~~ 689A.700 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.

Sec. 102. NRS 689A.740 is hereby amended to read as follows:

689A.740 The Commissioner shall adopt regulations as necessary to carry out the provisions of NRS 689A.470 to 689A.740, inclusive ~~[.]~~ ***, and section 92 of this act.***

Sec. 103. NRS 689A.745 is hereby amended to read as follows:

689A.745 1. Except as otherwise provided in subsection 4, each insurer that issues a policy of health insurance in this State shall establish a system for resolving any complaints of an insured concerning health care services covered under the policy. The system must be approved by the Commissioner ***.*** ~~[in consultation with the State Board of Health.]~~

2. A system for resolving complaints established pursuant to subsection 1 must include an initial investigation, a review of the complaint by a review board and a procedure for appealing a determination regarding the complaint. The majority of the members on a review board must be insureds who receive health care services pursuant to a policy of health insurance issued by the insurer.

3. The Commissioner ~~[or the State Board of Health]~~ may examine the system for resolving complaints established pursuant to subsection 1 at such times as ~~[either]~~ ***the Commissioner*** deems necessary or appropriate.

4. Each insurer that issues a policy of health insurance in this State that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care shall provide a system for resolving any complaints of an insured concerning those health care services that complies with the provisions of NRS 695G.200 to 695G.310, inclusive.

Sec. 104. NRS 689A.750 is hereby amended to read as follows:

689A.750 1. Each insurer that issues a policy of health insurance in this State shall submit to the Commissioner ~~[and the State Board of Health]~~ an annual report regarding its system for resolving complaints established pursuant to subsection 1 of NRS 689A.745 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 any 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 insurer 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. 105. NRS 689B.0285 is hereby amended to read as follows:

689B.0285 1. Except as otherwise provided in subsection 4, each insurer that issues a policy of group health insurance in this State shall establish a system for resolving any complaints of an insured concerning health care services covered under the policy. The system must be approved by the Commissioner ***.*** ~~[in consultation with the State Board of Health.]~~

2. A system for resolving complaints established pursuant to subsection 1 must include an initial investigation, a review of the complaint by a review board and a procedure for appealing a determination regarding the complaint. The majority of the members on a review board must be insureds who receive health care services pursuant to a policy of group health insurance issued by the insurer.

3. The Commissioner ~~[or the State Board of Health]~~ may examine the system for resolving complaints established pursuant to subsection 1 at such times as ~~[either]~~ ***the Commissioner*** deems necessary or appropriate.

4. Each insurer that issues a policy of group health insurance in this State that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care shall provide a system for resolving any complaints of an insured concerning the health care services that complies with the provisions of NRS 695G.200 to 695G.310, inclusive.

Sec. 106. NRS 689B.029 is hereby amended to read as follows:

689B.029 1. Each insurer that issues a policy of group health insurance in this State shall submit to the Commissioner ~~[and the State Board of Health]~~ an annual report regarding its system for resolving complaints established pursuant to subsection 1 of NRS 689B.0285 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 any 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 insurer 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. 107. NRS 689B.0306 is hereby amended to read as follows:

689B.0306 1. A policy of group health insurance must provide coverage for medical treatment which a person insured under the group policy 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 person.

(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 policy of group health insurance.

(c) The cost of any routine health care services that would otherwise be covered under the policy of group health insurance for an insured participating 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 689B.0303, 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 insurer has contracted for such services. If the insurer has not contracted for the provision of such services, the insurer shall pay the provider the rate of reimbursement that is paid to other providers with whom the insurer 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 group policy 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 group policy.

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 policy of group health insurance, 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. An insurer who delivers or issues for delivery a policy of group health insurance 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. An insurer who delivers or issues for delivery a policy of group health insurance specified in subsection 1 shall:

(a) Include in ~~[the]~~ ***any*** disclosure ~~[required pursuant to NRS 689B.027]~~ ***of the coverage provided by the policy*** notice to each group policyholder of the availability of the benefits required by this section.

(b) 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 policy.

7. A policy of group health insurance 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 policy that conflicts with this section is void.

8. An insurer who delivers or issues for delivery a policy of group health insurance specified in subsection 1 is immune from liability for:

(a) Any injury to the 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. 108. NRS 689B.0357 is hereby amended to read as follows:

689B.0357 1. No group policy of health insurance that provides coverage for hospital, medical or surgical expenses may be delivered or issued for delivery in this state unless the policy 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 a policy specified in subsection 1:

(a) Shall include in ~~[the]~~ ***any*** disclosure ~~[required pursuant to NRS 689B.027]~~ ***of the coverage provided by the policy*** notice to each policyholder and subscriber under the policy of the availability of the benefits required by this section.

(b) Shall 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 policy.

3. A policy 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 policy 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 employee or member of the insured group after the employee or member 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 employee or member of the insured group and which requires modification of his or her 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. 109. 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 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.

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.

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.~~

~~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.

~~[5.]~~ ***4.*** 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. 110. 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]~~ ***to employers*** 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 ***affected employers and*** persons covered ~~[by the discontinued insurance]~~ pursuant to paragraph (b).

(b) The carrier notifies each ***affected employer and*** 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]~~ ***90*** 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]~~ ***affected employer*** 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]~~ ***product*** 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 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. 111. NRS 689C.111 is hereby amended to read as follows:

689C.111 ~~[1. If an employer was not in existence throughout the entire preceding calendar year, the determination of whether the employer is a small or large employer must be based on the average number of employees reasonably expected to be employed on business days in the current calendar year.~~

~~2. Except as otherwise provided by specific statute, the provisions of this chapter that apply to a small employer at the time that a carrier issues a health benefit plan to the small employer pursuant to the provisions of this chapter continue to apply at least until the plan anniversary following the date on which the small employer no longer meets the requirements of being a small employer.~~

~~3.]~~ An employee leasing company which has more than 50 employees, including leased employees at client locations, and which sponsors a fully insured health benefit plan for those employees shall be deemed to be a large employer for the purposes of this chapter.

Sec. 112. 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]~~ ***90*** 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 geographic service area of this state, the provisions of this section apply only to the operations of the carrier in that service area.

Sec. 113. 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. 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.

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 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.~~

~~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.

Sec. 114. NRS 689C.470 is hereby amended to read as follows:

689C.470 1. Except as otherwise provided in NRS 689C.360 to 689C.600, inclusive, a carrier shall renew a contract as to all insured small employers that are members of a voluntary purchasing group and their employees and dependents at the request of the purchaser unless:

(a) Required premiums are not paid;

(b) The insured employer or other purchaser is guilty of fraud or misrepresentation;

(c) Provisions of the contract are breached;

(d) The number or percentage of employees covered under the contract is less than the number or percentage of eligible employees required by the contract;

(e) The employer or purchaser is no longer engaged in the business in which it was engaged on the effective date of the contract; or

(f) The Commissioner finds that the continuation of the coverage is not in the best interests of the persons insured under the contract or would impair the carrier's ability to meet its contractual obligations. If nonrenewal occurs as a result of findings pursuant to this subsection, the Commissioner shall assist affected persons in replacing coverage.

2. A carrier may discontinue ~~[~~issuance and renewal of a form of~~]~~ a product ~~[~~of a health benefit plan~~]~~ offered to a small employer or purchasers pursuant to NRS 689C.360 to 689C.600, inclusive, ~~[~~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 ~~[~~offering and renewing the form of~~]~~ the product at least 60 days before the carrier notifies the affected small employers and purchasers pursuant to paragraph (b).

(b) The carrier notifies each affected small employer and purchaser ~~[~~, and the Commissioner and the chief regulatory officer for insurance in each state in which any affected small employer is located or employee resides,~~]~~ of the decision of the carrier to discontinue ~~[~~offering the form of~~]~~ the product. The notice must be made at least ~~[~~180~~]~~ ***90*** 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 and purchaser 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 claim experience of the affected small employers and 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.

3. A carrier may discontinue the issuance and renewal of a health benefit plan offered to a voluntary purchasing group pursuant to this chapter only through a bona fide association if:

(a) The membership of the small employer who employs the members of the voluntary purchasing group or the purchaser in the association was the basis for the provision of coverage;

(b) The membership of that small employer or the purchaser 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 the purchaser or his or her dependent.

Sec. 115. NRS 689C.520 is hereby amended to read as follows:

689C.520 1. Before the issuance of a certificate of registration, each voluntary purchasing group shall, to the satisfaction of the Commissioner:

(a) Establish the conditions of membership in the group and require as a condition of membership that all employers include all their eligible employees. The group may not differentiate among classes of membership on the basis of the kind of employment, race, religion, sex, education, health or income. The group shall set reasonable fees for membership which will finance all reasonable and necessary costs incurred in administering the group.

(b) Provide to members of the group and their eligible employees ***any applicable disclosures of the coverage provided by any proposed contracts and any applicable*** information ~~[meeting the requirements of NRS 689C.440 regarding]~~ ***regarding available benefits and carriers provided by*** any proposed contracts.

2. In addition to the information required pursuant to subsection 1, a voluntary purchasing group shall provide annually to members of the group information regarding available benefits and carriers.

Sec. 116. NRS 690B.200 is hereby amended to read as follows:

690B.200 As used in NRS 690B.200 to ~~[690B.370,]~~ ***690B.360,*** inclusive, unless the context otherwise requires, the words and terms defined in NRS 690B.210 to 690B.240, inclusive, have the meanings ascribed to them in those sections.

Sec. 117. NRS 690B.250 is hereby amended to read as follows:

690B.250 Except as more is required in NRS 630.3067 and 633.526:

1. Each insurer which issues a policy of insurance covering the liability of a practitioner licensed pursuant to chapters 630 to 640, inclusive, of NRS for a breach of his or her professional duty toward a patient shall report to the board which licensed the practitioner within 45 days each settlement or award made or judgment rendered by reason of a claim, if the settlement, award or judgment is for

more than $5,000, giving the name ~~[and address]~~ of the claimant and the practitioner and the circumstances of the case.

2. A practitioner licensed pursuant to chapters 630 to 640, inclusive, of NRS who does not have insurance covering liability for a breach of his or her professional duty toward a patient shall report to the board which issued the practitioner's license within 45 days of each settlement or award made or judgment rendered by reason of a claim, if the settlement, award or judgment is for more than $5,000, giving the practitioner's name **,** ~~[and address,]~~ the name ~~[and address]~~ of the claimant and the circumstances of the case.

3. These reports are public records and must be made available for public inspection within a reasonable time after they are received by the licensing board.

Sec. 118. NRS 690B.260 is hereby amended to read as follows:

690B.260 1. Each insurer which issues a policy of insurance covering the liability of a physician licensed under chapter 630 of NRS or an osteopathic physician licensed under chapter 633 of NRS for a breach of his or her professional duty toward a patient shall, within 45 days after the end of a calendar quarter, submit a report to the Commissioner concerning each claim that was closed during that calendar quarter under such a policy of insurance issued by the insurer and any change during that calendar quarter to any claim under such a policy of insurance issued by the insurer that was closed during a previous calendar quarter. The report must include, without limitation:

(a) The name ~~[and address]~~ of the claimant and the insured under each policy;

(b) A statement setting forth the circumstances of that case;

(c) Information indicating whether any payment was made on a claim and the amount of the payment, if any; and

(d) The information specified in subsection 1 of NRS 679B.144 for each claim.

2. An insurer who fails to comply with the provisions of subsection 1 is subject to the imposition of an administrative fine pursuant to NRS 679B.460.

3. The Commissioner shall, within 30 days after receiving a report from an insurer pursuant to this section, submit a report to the Board of Medical Examiners or the State Board of Osteopathic Medicine, as applicable, setting forth the information provided to the Commissioner by the insurer pursuant to this section.

Sec. 119. NRS 690B.350 is hereby amended to read as follows:

690B.350 1. ***The requirements of this section apply only if, after a hearing convened at the discretion of the Commissioner,***

the Commissioner determines that the market for professional liability insurance issued to any class, type or specialty of practitioner licensed pursuant to chapter 630, 631 or 633 of NRS is not competitive and that such insurance is unavailable or unaffordable for a substantial number of such practitioners.

2. If the Commissioner convenes a hearing pursuant to subsection 1 and issues a finding that the market for professional liability insurance issued to any class, type or specialty of practitioner licensed pursuant to chapter 630, 631 or 633 of NRS is not competitive, the Commissioner may designate that class, type or specialty of practitioner to be an essential medical specialty.

3. Except as otherwise provided in this section, if an insurer intends to cancel, terminate or otherwise not renew all policies of professional liability insurance that it has issued to any class, type or specialty of practitioner licensed pursuant to chapter 630, 631 or 633 of NRS, the insurer must provide 120 days' notice of its intended action to the Commissioner and the practitioners before its intended action becomes effective.

~~[2.]~~ ***4.*** If an insurer intends to cancel, terminate or otherwise not renew a specific policy of professional liability insurance that it has issued to a practitioner who is practicing in one or more of the essential medical specialties designated by the Commissioner:

(a) The insurer must provide 120 days' notice to the practitioner before its intended action becomes effective; and

(b) The Commissioner may require the insurer to delay its intended action for a period of not more than 60 days if the Commissioner determines that a replacement policy is not readily available to the practitioner.

~~[3.]~~ ***5.*** If an insurer intends to cancel, terminate or otherwise not renew all policies of professional liability insurance that it has issued to practitioners who are practicing in one or more of the essential medical specialties designated by the Commissioner:

(a) The insurer must provide 120 days' notice of its intended action to the Commissioner and the practitioners before its intended action becomes effective; and

(b) The Commissioner may require the insurer to delay its intended action for a period of not more than 60 days if the Commissioner determines that replacement policies are not readily available to the practitioners.

~~[4. On or before April 1 of each year, the Commissioner shall:~~

~~(a) Determine whether there are any medical specialties in this State which are essential as a matter of public policy and which must be protected pursuant to this section from certain adverse actions relating to professional liability insurance that may impair~~

~~the availability of those essential medical specialties to the residents of this State; and~~

~~(b) Make a list containing the essential medical specialties designated by the Commissioner and provide the list to each insurer that issues policies of professional liability insurance to practitioners who are practicing in one or more of the essential medical specialties.~~

~~5.~~ ***6.*** The Commissioner may adopt any regulations that are necessary to carry out the provisions of this section.

~~6. Until the Commissioner determines which, if any, medical specialties are to be designated as essential medical specialties, the following medical specialties shall be deemed to be essential medical specialties for the purposes of this section:~~

~~(a) Emergency medicine.~~

~~(b) Neurosurgery.~~

~~(c) Obstetrics and gynecology.~~

~~(d) Orthopedic surgery.~~

~~(e) Pediatrics.~~

~~(f) Trauma surgery.~~

Sec. 120. NRS 690B.360 is hereby amended to read as follows:

690B.360 1. The Commissioner ~~shall~~ ***may*** collect all information which is pertinent to monitoring whether an insurer that issues professional liability insurance for a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS is complying with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive ~~.~~ ***, and sections 35 to 39, inclusive, of this act.*** Such information ~~must~~ ***may*** include, without limitation:

(a) The amount of gross premiums collected with regard to each medical specialty;

(b) Information relating to loss ratios;

(c) Information reported pursuant to NRS ~~690B.250;~~ ***690B.260;*** and

(d) Information reported pursuant to NRS 679B.430 and 679B.440.

2. In addition to the information collected pursuant to subsection 1, the Commissioner may request any additional information from an insurer:

(a) Whose rates and credit utilization are materially different from other insurers in the market for professional liability insurance for a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS in this State;

(b) Whose credit utilization shows a substantial change from the previous year; or

(c) Whose information collected pursuant to subsection 1 indicates a potentially adverse trend.

3. If the Commissioner requests additional information from an insurer pursuant to subsection 2, the Commissioner ~~[shall:]~~ ***may:***

(a) Determine whether the additional information offers a reasonable explanation for the results described in paragraph (a), (b) or (c) of subsection 2; and

(b) Take any steps permitted by law that are necessary and appropriate to assure the ongoing stability of the market for professional liability insurance for a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS in this State.

4. On an ongoing basis, the Commissioner ~~[shall:~~

~~(a) Analyze]~~ ***may analyze*** and evaluate the information collected pursuant to this section to determine trends in and measure the health of the market for professional liability insurance for a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS in this State **.** ~~[; and~~

~~(b) Prepare]~~

5. If the Commissioner convenes a hearing pursuant to subsection 1 of NRS 690B.350 and determines that the market for professional liability insurance issued to any class, type or specialty of practitioner licensed pursuant to chapter 630, 631 or 633 of NRS is not competitive and that such insurance is unavailable or unaffordable for a substantial number of such practitioners, the Commissioner shall prepare and submit a report of the Commissioner's findings and recommendations to the Director of the Legislative Counsel Bureau for transmittal to members of the Legislature **.** ~~[on or before November 15 of each year.]~~

Sec. 121. Chapter 690C of NRS is hereby amended by adding thereto the provisions set forth as sections 122, 123 and 124 of this act.

Sec. 122. ***"Controlling person" means a person who qualifies as a controlling person of a provider pursuant to section 123 of this act.***

Sec. 123. ***A person is a controlling person of a provider if the person:***

1. Is an officer of the provider; or

2. Possesses the authority to set the policy and direct the management of the business entity in connection with its service contract business.

Sec. 124. ***1. Except as otherwise provided in this section, a provider shall not transfer any liability relating to a service contract to another provider or any other person, including,***

without limitation, another provider or other person with whom the original provider has merged or plans to merge.

2. A provider may transfer a liability relating to a service contract to another provider or any other person if, before the liability is transferred:

(a) The original provider submits a proposal to the Commissioner to transfer the liability; and

(b) The Commissioner approves the proposal pursuant to subsection 3.

3. The Commissioner may approve a proposal made by a provider pursuant to subsection 2 if the Commissioner determines, after reviewing the financial condition of the provider or other person to whom the liability is proposed to be transferred, that the proposed recipient of the transfer has adequate financial resources to enable the proposed recipient to pay in full and in a timely manner all liabilities proposed to be transferred to the proposed recipient.

4. The provisions of this section do not apply to any transaction relating to a contractual liability insurance policy into which the provider enters to satisfy the requirements of NRS 690C.170.

Sec. 125. NRS 690C.010 is hereby amended to read as follows:

690C.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 690C.020 to 690C.080, inclusive, ***and section 122 of this act,*** have the meanings ascribed to them in those sections.

Sec. 126. NRS 690C.100 is hereby amended to read as follows:

690C.100 1. The provisions of this title do not apply to:

(a) A warranty;

(b) A maintenance agreement;

(c) A service contract provided by a public utility on its transmission device if the service contract is regulated by the Public Utilities Commission of Nevada;

(d) A service contract sold or offered for sale to a person who is not a consumer;

(e) A service contract for goods if the purchase price of the goods is less than $250; or

(f) ~~[Except as otherwise provided in NRS 690C.240, a]~~ ***A*** service contract issued, sold or offered for sale by a vehicle dealer on vehicles sold by the dealer, if the dealer is licensed pursuant to NRS 482.325 and the service contract obligates either the dealer or the manufacturer of the vehicle, or an affiliate of the dealer or manufacturer, to provide all services under the service contract.

2. The sale of a service contract pursuant to this chapter does not constitute the business of insurance for the purposes of 18 U.S.C. §§ 1033 and 1034.

3. As used in this section:

(a) "Maintenance agreement" means a contract for a limited period that provides only for scheduled maintenance.

(b) "Warranty" means a warranty provided solely by a manufacturer, importer or seller of goods for which the manufacturer, importer or seller did not receive separate consideration and that:

(1) Is not negotiated or separated from the sale of the goods;

(2) Is incidental to the sale of the goods; and

(3) Guarantees to indemnify the consumer for defective parts, mechanical or electrical failure, labor or other remedial measures required to repair or replace the goods.

Sec. 127. NRS 690C.160 is hereby amended to read as follows:

690C.160 1. A provider who wishes to issue, sell or offer for sale service contracts in this state must submit to the Commissioner:

(a) A registration application on a form prescribed by the Commissioner;

(b) Proof that the provider has complied with the requirements for ***financial*** security set forth in NRS 690C.170;

(c) A copy of each type of service contract the provider proposes to issue, sell or offer for sale;

(d) The name, address and telephone number of each administrator with whom the provider intends to contract; ~~[and]~~

(e) A fee of $1,000 and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110 ~~[.]~~ ***; and***

(f) The following information for each controlling person:

(1) Whether the person, in the last 10 years, has been:

(I) Convicted of a felony or misdemeanor of which an essential element is fraud;

(II) Insolvent or adjudged bankrupt;

(III) Refused a license or registration as a service contract provider or had an existing license or registration as a service contract provider suspended or revoked by any state or governmental agency or authority; or

(IV) Fined by any state or governmental agency or authority in any matter regarding service contracts; and

(2) Whether there are any pending criminal actions against the person other than moving traffic violations.

2. In addition to the fee required by subsection 1, a provider must pay a fee of $25 for each type of service contract the provider files with the Commissioner.

3. A certificate of registration is valid for 1 year after the date the Commissioner issues the certificate to the provider. A provider may renew his or her certificate of registration if, before the certificate expires, the provider submits to the Commissioner ~~[an]~~ ***:***

(a) An application on a form prescribed by the Commissioner ~~[.~~ ~~a]~~ ***;***

(b) A fee of $1,000 and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110 ~~[.]~~ ***; and***

(c) The information required by paragraph (f) of subsection 1:

(1) If an existing controlling person has had a change in any of the information previously submitted to the Commissioner; or

(2) For a controlling person who has not previously submitted the information required by paragraph (f) of subsection 1 to the Commissioner.

4. All fees paid pursuant to this section are nonrefundable.

5. Each application submitted pursuant to this section, including, without limitation, an application for renewal, must:

(a) Be signed by an executive officer, if any, of the provider or, if the provider does not have an executive officer, by a controlling person of the provider; and

(b) Have attached to it an affidavit signed by the person described in paragraph (a) which meets the requirements of subsection 6.

6. Before signing the application described in subsection 5, the person who signs the application shall verify that the information provided is accurate to the best of his or her knowledge.

Sec. 128. NRS 690C.170 is hereby amended to read as follows:

690C.170 ***1.*** To be issued a certificate of registration, a provider must comply with one of the following ~~[:~~

~~1.]~~ ***to provide for financial security:***

(a) Purchase a contractual liability insurance policy which insures the obligations of each service contract the provider issues, sells or offers for sale. The contractual liability insurance policy must ~~[be]~~ ***:***

(1) Be issued by an insurer which is licensed, registered or otherwise authorized to transact insurance in this state or pursuant to the provisions of chapter 685A of NRS.

(2) Contain a provision prohibiting the insurer from terminating the policy until a notice of termination has been mailed or delivered to the Commissioner at least 60 days prior to the termination of the policy. Any such termination shall not

reduce the responsibility of the insurer for service contracts issued by the provider prior to the effective date of termination.

~~[2.]~~ ***(b)*** Maintain a reserve account ***in this State*** and deposit with the Commissioner security as provided in this subsection. The reserve account must contain at all times an amount of money equal to at least 40 percent of the unearned gross consideration received by the provider for any unexpired service contracts. ***The reserve account must be kept separate from the operating accounts of the provider and must be clearly identified as the "(Provider's Name) Nevada Service Contracts Funded Reserve Account."*** The Commissioner may examine the reserve account at any time. The provider shall also deposit with the Commissioner security in an amount that is equal to $25,000 or 10 percent of the unearned gross consideration received by the provider for any unexpired service contracts, whichever is greater. The security must be:

~~[(a)]~~ ***(1)*** A surety bond issued by a surety company authorized to do business in this State;

~~[(b)]~~ ***(2)*** Securities of the type eligible for deposit pursuant to NRS 682B.030;

~~[(c)]~~ ***(3)*** Cash;

~~[(d)]~~ ***(4)*** An irrevocable letter of credit issued by a financial institution approved by the Commissioner; or

~~[(e)]~~ ***(5)*** In any other form prescribed by the Commissioner.

~~[3.]~~ ***(c)*** Maintain, or be a subsidiary of a parent company that maintains, a net worth or stockholders' equity of at least $100,000,000. Upon request, a provider shall provide to the Commissioner a copy of the most recent Form 10-K report or Form 20-F report filed by the provider or parent company of the provider with the Securities and Exchange Commission within the previous year. If the provider or parent company is not required to file those reports with the Securities and Exchange Commission, the provider shall provide to the Commissioner a copy of the most recently audited financial statements of the provider or parent company. If the net worth or stockholders' equity of the parent company of the provider is used to comply with the requirements of this subsection, the parent company must guarantee to carry out the duties of the provider under any service contract issued or sold by the provider.

2. A provider shall not use any money in a reserve account described in paragraph (b) of subsection 1 for any purpose other than to pay an obligation of the provider under an unexpired service contract.

3. A provider shall maintain the financial security required by subsection 1 until:

(a) The provider ceases doing business in this State; and

(b) The provider has performed or otherwise satisfied all liabilities and obligations under all unexpired service contracts issued by the provider.

4. If the certificate of registration of a provider has not expired and the provider fails to maintain the financial security required by subsection 1, including, without limitation, if the financial security is cancelled or lapses, the provider shall not issue or sell a service contract on or after the effective date of such failure until the provider submits to the Commissioner proof satisfactory to the Commissioner that the provider is in compliance with subsection 1.

Sec. 129. NRS 690C.240 is hereby amended to read as follows:

690C.240 1. A provider ~~[who, whether directly or through a vehicle dealer licensed pursuant to NRS 482.325, enters into a vehicle service contract with a buyer]~~ shall, within 30 days after ceasing doing business in this State, notify ~~[any buyer who purchased such a contract]~~ ***the Commissioner and each holder of an unexpired service contract*** in writing of the fact that the provider has ceased doing business in this State **.** ~~[if the specified period of the vehicle service contract has not yet expired.]~~

2. The provisions of this section do not:

(a) Render a service contract void pursuant to NRS 690C.250;

(b) Cancel a service contract pursuant to NRS 690C.270; or

(c) Release the provider from any liability imposed by a violation of any provision of this chapter.

~~[3. As used in this section:~~

~~(a) "Buyer" means the buyer of a vehicle service contract.~~

~~(b) "Vehicle service contract" means a contract pursuant to which a provider, in exchange for separately stated consideration, is obligated for a specified period to a buyer to repair, replace or perform maintenance on, or indemnify or reimburse the buyer for the costs of repairing, replacing or performing maintenance on, a motor vehicle which is described in the vehicle service contract and which has an operational or structural failure as a result of a defect in materials, workmanship or normal wear and tear, including, without limitation, a contract that includes a provision for incidental payment of indemnity under limited circumstances, including, without limitation, towing, rental and emergency road service.]~~

Sec. 130. NRS 691C.340 is hereby amended to read as follows:

691C.340 ~~[1. The Commissioner shall, by regulation, establish reasonable rates as described in this chapter and in accordance with the standards established in NRS 686B.050 and 686B.060. The rates must be reasonable in relation to the benefits~~

~~provided and must not be excessive, inadequate or unfairly discriminatory.~~

~~2.~~] The Commissioner may, by regulation, establish rates that an insurer may use without filing pursuant to NRS 691C.320. In establishing such rates, the Commissioner shall consider and apply the following factors:

~~(a)~~] *1.* Actual and expected loss experience;

~~(b)~~] *2.* General and administrative expenses;

~~(c)~~] *3.* Loss settlement and adjustment expenses;

~~(d)~~] *4.* Reasonable creditor compensation;

~~(e)~~] *5.* The manner in which premiums are charged;

~~(f)~~] *6.* Other acquisition costs;

~~(g)~~] *7.* Reserves;

~~(h)~~] *8.* Taxes;

~~(i)~~] *9.* Regulatory license fees and fund assessments;

~~(j)~~] *10.* Reasonable insurer profit; and

~~(k)~~] *11.* Other relevant data consistent with generally accepted actuarial standards.

Sec. 131. NRS 691C.390 is hereby amended to read as follows:

691C.390 1. Each individual policy or certificate of insurance must provide for a refund of unearned premiums if the credit personal property insurance is cancelled before the scheduled date of termination of the insurance.

2. Except as otherwise provided in this section, any refund must be provided to the person to whom it is entitled as soon as practicable after the date of cancellation of the insurance.

3. ~~[The Commissioner shall, by regulation, establish the minimum amount of unearned premiums that must remain outstanding at the time of cancellation in order for a person to be entitled to a refund. If the amount of unearned premiums that remains outstanding at the time of cancellation is less than the minimum amount established by regulation, the person is not entitled to a refund.~~

~~4.~~] The formula that an insurer uses to determine the amount of a refund must be submitted to and approved by the Commissioner before it is used.

Sec. 132. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A corporation organized under this chapter shall contract with an insurance company licensed in this State or authorized to do business in this State for the provision of insurance, indemnity or reimbursement against the cost of hospital services, medical services and dental services which are provided by the corporation.

2. The contract of insurance required by subsection 1 must include a provision that, in the case of the insolvency or impairment of the corporation, the insurance company will pay all claims made by an insured for the period for which a premium has been or will be paid to the corporation for the insured. The contract of insurance required by subsection 1 must specifically provide for the:

(a) Continuation of benefits to each insured for the period for which a premium has been or will be paid to the corporation for the insured until the expiration or termination of the insured's contract with the corporation;

(b) Continuation of benefits for each insured who is receiving inpatient services in a medical facility or facility for the dependent at the time of the insolvency or impairment of the corporation until the inpatient services are no longer medically necessary and the insured is discharged from the medical facility or facility for the dependent; and

(c) Payment of a provider of health care not affiliated with the corporation who provided medically necessary services to an insured, as described in the insured's contract with the corporation, the insured's policy or the insured's evidence of coverage.

3. As used in this section:

(a) "Facility for the dependent" has the meaning ascribed to it in NRS 449.0045.

(b) "Impairment" means that a corporation organized under this chapter is not insolvent and has been:

(1) Deemed to be impaired pursuant to NRS 695B.150; or

(2) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(c) "Insolvency" or "insolvent" means that a corporation organized under this chapter has been:

(1) Deemed to be insolvent pursuant to NRS 695B.150;

(2) Declared insolvent by a court of competent jurisdiction; or

(3) Placed under an order of liquidation by a court of competent jurisdiction.

(d) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(e) "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

(f) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 133. NRS 695B.150 is hereby amended to read as follows:

695B.150 ***1.*** A corporation organized under this chapter shall be deemed to be insolvent if ~~[its]~~ ***:***

(a) The corporation fails to meet its obligations as they mature;

(b) The assets of the corporation are less than the sum of its liabilities and the minimum surplus required to be maintained by the corporation under this Code for authority to transact the kinds of insurance transacted; and

(c) The reserve fund ***of the corporation*** is ~~[impaired so as to be]~~ less than the amounts set forth in NRS 695B.140.

2. In addition to the provisions of subsection 1, a corporation organized under this chapter shall be deemed to be insolvent as otherwise expressly provided in this Code.

3. For the purposes of determining ~~[such]~~ insolvency ***pursuant to subsection 1 or 2*** and the financial condition of the corporation, for the purposes of preparation of annual statements, and for all other purposes not otherwise expressly provided for in this chapter, the corporation is subject to all requirements of the laws of the State of Nevada as to assets, liabilities and reserves which are applicable to mutual nonassessable life or health insurers.

4. A corporation organized under this chapter shall be deemed to be impaired if the assets of the corporation are less than the sum of its liabilities and the minimum surplus required to be maintained by the corporation under this Code for authority to transact the kinds of insurance transacted.

5. The Commissioner may adopt regulations to define when a corporation organized under this chapter is considered to be in a hazardous financial condition and to set forth the standards to be considered by the Commissioner in determining whether the continued operation of such a corporation transacting business in this State may be considered to be hazardous to its insureds or creditors or to the general public.

6. If the Commissioner determines after a hearing that any corporation organized under this chapter is in a hazardous financial condition, the Commissioner may, instead of suspending or revoking the certificate of authority of the corporation, limit the certificate of authority as the Commissioner deems reasonably necessary to correct, eliminate or remedy any conduct, condition or ground that is deemed to be a cause of the hazardous financial condition.

7. An order or decision of the Commissioner under this section is subject to review in accordance with NRS 679B.310 to

679B.370, inclusive, at the request of any party to the proceedings whose interests are substantially affected.

Sec. 134. NRS 695B.185 is hereby amended to read as follows:

695B.185 A group contract for hospital, medical or dental services 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 copayment required to be paid by the insured to a preferred provider of health care and the copayment required to be paid by the insured to a provider of health care who is not preferred.

5. 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. ~~[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.]~~ 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 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.]~~ *7.* Must require the corporation 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. 135. NRS 695B.1903 is hereby amended to read as follows:

695B.1903 1. A policy of health insurance issued by a medical services corporation must provide coverage for medical treatment which a person insured under the policy 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 person.

(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 policy of health insurance.

(c) The cost of any routine health care services that would otherwise be covered under the policy of health insurance for an insured participating 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 695B.1901, 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 medical services corporation has contracted for such services. If the medical services corporation has not contracted for the provision of such services, the medical services corporation shall pay the provider the rate of reimbursement that is paid to other providers with whom the medical services corporation 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 policy 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 policy.

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 policy of health insurance, 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 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 medical services corporation that delivers or issues for delivery a policy of health insurance 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 medical services corporation that delivers or issues for delivery a policy of health insurance specified in subsection 1 shall:

(a) Include in ~~[the]~~ ***any*** disclosure ~~[required pursuant to NRS 695B.172]~~ ***of the coverage provided by the policy*** notice to each person insured under the policy of the availability of the benefits required by this section.

(b) 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 policy.

7. A policy of health insurance 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 policy that conflicts with this section is void.

8. A medical services corporation that delivers or issues for delivery a policy of health insurance specified in subsection 1 is immune from liability for:

(a) Any injury to the 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. 136. NRS 695B.1927 is hereby amended to read as follows:

695B.1927 1. No contract for hospital or medical service that provides coverage for hospital, medical or surgical expenses may be delivered or issued for delivery in this state unless the contract 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 a contract specified in subsection 1:

(a) Shall include in ~~[the]~~ ***any*** disclosure ~~[required pursuant to NRS 695B.172]~~ ***of the coverage provided by the contract*** notice to each policyholder or subscriber covered under the contract of the availability of the benefits required by this section.

(b) Shall 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 contract.

3. A contract for hospital or medical service 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 contract 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 a person covered under the contract after the person 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 person covered under the contract and which requires modification of the person'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. 137. NRS 695B.290 is hereby amended to read as follows:

695B.290 Any agent of a nonprofit hospital or medical or dental service corporation who acts as such in the solicitation, negotiation, procurement or making of a hospital service or medical or dental care contract shall be qualified, examined and licensed in the same manner and pay the same fees as provided for ~~[health insurance agents]~~ ***a producer of insurance*** in NRS 680B.010 (fee schedule), chapter 683A of NRS and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110.

Sec. 138. NRS 695B.320 is hereby amended to read as follows:

695B.320 ***1.*** Nonprofit hospital and medical or dental service corporations are subject to the provisions of this chapter, and to the provisions of chapters 679A and 679B of NRS, 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, 687B.500 and chapters ***692B,*** 692C ***, 693A*** and 696B of NRS, to the extent applicable and not in conflict with the express provisions of this chapter.

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

Sec. 139. NRS 695B.380 is hereby amended to read as follows:

695B.380 1. Except as otherwise provided in subsection 4, each insurer that issues a contract for hospital or medical services in this State shall establish a system for resolving any complaints of an insured concerning health care services covered under the policy. The system must be approved by the Commissioner ***.*** ~~[in consultation with the State Board of Health.]~~

2. A system for resolving complaints established pursuant to subsection 1 must include an initial investigation, a review of the complaint by a review board and a procedure for appealing a determination regarding the complaint. The majority of the members on a review board must be insureds who receive health care services pursuant to a contract for hospital or medical services issued by the insurer.

3. The Commissioner ~~[or the State Board of Health]~~ may examine the system for resolving complaints established pursuant to subsection 1 at such times as ~~[either]~~ ***the Commissioner*** deems necessary or appropriate.

4. Each insurer that issues a contract specified in subsection 1 shall, if the contract provides, delivers, arranges for, pays for or

reimburses any cost of health care services through managed care, provide a system for resolving any complaints of an insured concerning those health care services that complies with the provisions of NRS 695G.200 to 695G.310, inclusive.

Sec. 140. NRS 695B.390 is hereby amended to read as follows:

695B.390 1. Each insurer that issues a contract for hospital or medical services in this State shall submit to the Commissioner ~~[and the State Board of Health]~~ an annual report regarding its system for resolving complaints established pursuant to subsection 1 of NRS 695B.380 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 any 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 insurer 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. 141. Chapter 695C of NRS is hereby amended by adding thereto the provisions set forth as sections 142 to 146, inclusive, of this act.

Sec. 142. ***1. A health maintenance organization shall contract with an insurance company licensed in this State or authorized to do business in this State for the provision of insurance, indemnity or reimbursement against the cost of health care services which are provided by the health maintenance organization.***

2. The contract of insurance required by subsection 1 must include a provision that, in the case of the insolvency or impairment of the health maintenance organization, the insurance company will pay all claims made by an enrollee for the period for which a premium has been or will be paid to the health maintenance organization for the enrollee. The contract of insurance required by subsection 1 must specifically provide for the:

(a) Continuation of benefits to each enrollee for the period for which a premium has been or will be paid to the health maintenance organization for the enrollee until the expiration or

termination of the enrollee's contract with the health maintenance organization;

(b) Continuation of benefits for each enrollee who is receiving inpatient services in a medical facility or facility for the dependent at the time of the insolvency or impairment of the health maintenance organization until the inpatient services are no longer medically necessary and the enrollee is discharged from the medical facility or facility for the dependent; and

(c) Payment of a provider of health care not affiliated with the health maintenance organization who provided medically necessary services to an enrollee, as described in the enrollee's evidence of coverage.

3. As used in this section:

(a) "Facility for the dependent" has the meaning ascribed to it in NRS 449.0045.

(b) "Impairment" means that a health maintenance organization is not insolvent and has been:

(1) Deemed to be impaired pursuant to section 143 of this act; or

(2) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(c) "Insolvency" or "insolvent" means that a health maintenance organization has been:

(1) Deemed to be insolvent pursuant to section 143 of this act;

(2) Declared insolvent by a court of competent jurisdiction; or

(3) Placed under an order of liquidation by a court of competent jurisdiction.

(d) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(e) "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

(f) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 143. *1. A health maintenance organization shall be deemed to be insolvent if:*

(a) The health maintenance organization fails to meet its obligations as they mature; and

(b) The assets of the health maintenance organization are less than the sum of its liabilities and the minimum surplus required to be maintained by the health maintenance organization under this Code for authority to transact business in this State.

2. In addition to the provisions of subsection 1, a health maintenance organization shall be deemed to be insolvent as otherwise expressly provided in this Code.

3. A health maintenance organization shall be deemed to be impaired if the assets of the health maintenance organization are less than the sum of its liabilities and the minimum surplus required to be maintained by the health maintenance organization under this Code for authority to transact business in this State.

4. The Commissioner may adopt regulations to define when a health maintenance organization is considered to be in a hazardous financial condition and to set forth the standards to be considered by the Commissioner in determining whether the continued operation of a health maintenance organization transacting business in this State may be considered to be hazardous to its enrollees or creditors or to the general public.

5. If the Commissioner determines after a hearing that any health maintenance organization is in a hazardous financial condition, the Commissioner may, instead of suspending or revoking the certificate of authority of the health maintenance organization, limit the certificate of authority as the Commissioner deems reasonably necessary to correct, eliminate or remedy any conduct, condition or ground that is deemed to be a cause of the hazardous financial condition.

6. An order or decision of the Commissioner under this section is subject to review in accordance with NRS 679B.310 to 679B.370, inclusive, at the request of any party to the proceedings whose interests are substantially affected.

Sec. 144. *1. Each health maintenance organization shall develop, submit to the Commissioner for approval and, after such approval, put into effect a plan to provide for the continuation of benefits to enrollees in the event of the insolvency or impairment of the health maintenance organization, including, without limitation, the benefits described in subsection 2 of section 142 of this act. A plan developed pursuant to this subsection must include, without limitation:*

(a) A contract of insurance which complies with the requirements of section 142 of this act; and

(b) Provisions in each contract between the health maintenance organization and a provider which obligate the provider, in the event of the health maintenance organization's insolvency or impairment, to provide all covered services as described in the contract to enrollees through the periods of time described in subsection 2 of section 142 of this act.

2. Before approving a plan submitted pursuant to subsection 1, the Commissioner may require the health maintenance organization to include in the plan:

(a) Reserves or additional reserves for protection against insolvency or impairment;

(b) Letters of credit acceptable to the Commissioner; and

(c) Any other arrangements determined by the Commissioner to be appropriate to ensure the continuation of benefits as described in subsection 2 of section 142 of this act to enrollees.

Sec. 145. *1. If the Commissioner determines that, because of the financial condition of a health maintenance organization, the continued operation of the health maintenance organization is or may be hazardous to its enrollees or creditors or to the general public, or that the health maintenance organization has violated any law of this State to which the health maintenance organization is subject, the Commissioner may, after notice and a hearing, order the health maintenance organization to take any action the Commissioner deems reasonably necessary to correct, eliminate or remedy the condition or violation, including, without limitation:*

(a) Reducing the total amount of the present and potential liability of the health maintenance organization for benefits by reinsurance or any other method acceptable to the Commissioner;

(b) Suspending, limiting or reducing the volume of new business being written or accepted by the health maintenance organization for any period of time specified by the Commissioner;

(c) Reducing the expenses of the health maintenance organization by any method acceptable to the Commissioner; and

(d) Increasing the capital and surplus of the health maintenance organization by contribution.

2. The Commissioner may adopt regulations to:

(a) Set standards and criteria for early warning that the continued operation of a health maintenance organization may be hazardous to its enrollees or creditors or to the general public; and

(b) For the purposes of subsection 1, set standards for evaluating the financial condition of a health maintenance organization.

3. The authority conferred upon the Commissioner pursuant to this section is in addition to the authority of the Commissioner pursuant to chapter 696B of NRS. Any order issued by the Commissioner pursuant to this section may, at the discretion of the Commissioner, be in addition to any order issued by the Commissioner pursuant to chapter 696B of NRS.

Sec. 146. ***1. Any conservation, rehabilitation or liquidation of a health maintenance organization shall be deemed to be the conservation, rehabilitation or liquidation of an insurer and must be conducted under the supervision of the Commissioner pursuant to chapter 696B of NRS.***

2. The Commissioner may apply to a court of competent jurisdiction for an order directing the Commissioner to conserve, rehabilitate or liquidate a health maintenance organization:

(a) Upon any ground provided in chapter 696B of NRS; or

(b) If, as determined by the Commissioner, the continued operation of the health maintenance organization is or may be hazardous to its enrollees or creditors or to the general public.

3. In the event of a rehabilitation or liquidation of a health maintenance organization, a claim of an enrollee or of a beneficiary of an enrollee shall be deemed to have the same priority as would be provided to a claim of a policyholder or insured of an insurer, or of a beneficiary of such a policyholder or insured, in the event of the rehabilitation or liquidation of the insurer.

4. In the event of a distribution of the general assets of a health maintenance organization:

(a) If an enrollee is liable to a provider for health care services provided pursuant to and covered by the applicable health care plan, that liability shall be deemed to be a claim of the enrollee for distribution of the general assets of the health maintenance organization.

(b) A provider under contract with the health maintenance organization who is obligated by law or contract to hold an enrollee harmless from liability for health care services provided pursuant to and covered by the applicable health care plan shall be deemed to have a priority for distribution of the general assets of the health maintenance organization immediately following that of an enrollee as described in this section and immediately preceding any other priority for distribution which, pursuant to this section and chapter 696B of NRS, would follow that of an enrollee.

Sec. 147. NRS 695C.055 is hereby amended to read as follows:

695C.055 1. The provisions of NRS 449.465, 679A.200, 679B.700, ***subsections 6 and 7 of NRS 680A.270,*** subsections 2, 4, 18, 19 and 32 of NRS 680B.010, NRS 680B.020 to 680B.060, inclusive, chapter 686A of NRS, NRS 687B.500 and ~~[chapter]~~ ***chapters 692C 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. 148. NRS 695C.080 is hereby amended to read as follows:

695C.080 1. The 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 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.

2. Within 90 days of receipt of the application for issuance of a certificate of authority, the Commissioner shall certify whether the proposed health maintenance organization meets the requirements of subsection 1. If the Commissioner certifies that the health maintenance organization does not meet such requirements, it shall specify in what respects it is deficient.

Sec. 149. 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]~~ ***, but*** not less frequently than once every 3 years.

2. The 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]~~ ***any compliance program used by a health maintenance organization and any report, as determined to be appropriate by the Commissioner, regarding the health maintenance organization***

produced by an organization which examines best practices in the insurance industry. The Commissioner shall make such an examination as often as ~~[it]~~ ***the Commissioner*** deems ***it*** necessary for the protection of the interests of the people of this State ~~[. An examination must be made]~~ ***, but*** not less frequently than once every 3 years.

3. ~~[Every]~~ ***In making an examination pursuant to subsection 1 or 2, the Commissioner:***

(a) Shall determine whether the health maintenance organization is in compliance with this Code, including, without limitation, whether any relationship or transaction between the health maintenance organization and any another health maintenance organization is in compliance with this Code; and

(b) May examine any account, record, document or transaction of any health maintenance organization or any provider which relates to:

(1) Compliance with this Code by the health maintenance organization which is the subject of the examination;

(2) Any relationship or transaction between the health maintenance organization which is the subject of the examination and any other health maintenance organization; or

(3) Any relationship or transaction between the health maintenance organization which is the subject of the examination and any provider.

4. Except as otherwise provided in this subsection, for the purposes of an examination pursuant to subsection 1 or 2, each health maintenance organization and provider shall ***, upon the request of the Commissioner or an examiner designated by the Commissioner,*** submit its books and records relating to ~~[the]~~ ***any applicable*** health care plan to ~~[an examination made pursuant to subsection 1 or 2 and in every way facilitate the examination.]~~ ***the Commissioner or the examiner, as applicable.*** Medical records of natural persons and records of physicians providing service pursuant to a contract ~~[to the]~~ ***with a*** health maintenance organization are not subject to such examination, although the records ***, except privileged medical information,*** are subject to subpoena upon a showing of good cause. For the purpose of examinations, the Commissioner may administer oaths to, and examine the officers and agents of ~~[the]~~ ***a*** health maintenance organization and the principals of ~~[such]~~ providers concerning their business.

~~[4.]~~ ***5.*** The expenses of examinations pursuant to this section must be assessed against the ***health maintenance*** organization being examined and remitted to the Commissioner.

~~[5.]~~ ***6.*** In lieu of ~~[such]~~ ***an*** examination ~~[,]~~ ***pursuant to this section,*** the Commissioner may accept the report of an examination

made by the insurance commissioner ~~[or the state board of health]~~ of another state ~~[.]~~ ***or an applicable regulatory agency of another state.***

Sec. 150. 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 Commissioner certifies that the health maintenance organization:

(1) Does not meet the requirements of subsection 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 ~~[,]~~ ***or creditors or to the general public;***

(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. 151. Chapter 695D of NRS is hereby amended by adding thereto the provisions set forth as sections 152 and 153 of this act.

Sec. 152. ***1. The Commissioner may adopt regulations to define when an organization for dental care is considered to be in a hazardous financial condition and to set forth the standards to be considered by the Commissioner in determining whether the continued operation of an organization for dental care transacting business in this State may be considered to be hazardous to its members or creditors or to the general public.***

2. If the Commissioner determines after a hearing that any organization for dental care is in a hazardous financial condition, the Commissioner may, instead of suspending or revoking the certificate of authority of the organization, limit the certificate of authority as the Commissioner deems reasonably necessary to correct, eliminate or remedy any conduct, condition or ground that is deemed to be a cause of the hazardous financial condition.

3. An order or decision of the Commissioner under this section is subject to review in accordance with NRS 679B.310 to 679B.370, inclusive, at the request of any party to the proceedings whose interests are substantially affected.

Sec. 153. ***Each organization for dental care which receives a certificate of authority shall maintain a capital account with a net worth of not less than $500,000 unless a lesser amount is permitted in writing by the Commissioner. The account must not be obligated for any accrued liabilities and must consist of cash, securities or a combination thereof which is acceptable to the Commissioner.***

Sec. 154. NRS 695D.095 is hereby amended to read as follows:

695D.095 ***1.*** An organization for dental care is not exempt from the provisions of NRS 679B.700. If an organization is an admitted health insurer, as that term is defined in NRS 449.450, it is not exempt from the fees imposed pursuant to NRS 449.465.

2. For the purposes of this section and the provisions set forth in subsection 1, an organization for dental care is included in the meaning of the term "insurer."

Sec. 155. NRS 695D.170 is hereby amended to read as follows:

695D.170 1. ~~[Before]~~ ***Except as otherwise provided in this section, before*** a certificate of authority may be issued to an organization for dental care:

(a) The officers responsible for operating the organization must file with the Commissioner a collective fidelity bond for $1,000,000; and

(b) The organization must file with the Commissioner a surety bond in the sum of ~~[$250,000]~~ ***$500,000*** or deposit with the Commissioner cash or securities acceptable to the Commissioner in the sum of ~~[$250,000,]~~ ***$500,000,***

➥ to guarantee the organization's performance pursuant to this chapter.

2. If the bond is furnished in:

(a) Cash, the Commissioner shall deposit the money in the State Treasury for credit to the Fund for Bonds of Organizations for Dental Care which is hereby created as a trust fund.

(b) Negotiable securities, the principal must be placed without restriction at the disposal of the Commissioner, but any income must inure to the benefit of the organization.

3. The Commissioner may reduce the ***required amount of the*** organization's ***surety*** bond or deposit:

(a) To $125,000, if the obligations assumed by the organization under the plan can be satisfied for less than $125,000.

(b) To any amount if the organization demonstrates that it has commitments of money from federal, state or municipal governments or their political subdivisions or other comparable

resources which are sufficient to ensure the ability of the organization to satisfy its obligations.

4. ***The Commissioner may increase the required amount of the organization's surety bond or deposit to any amount the Commissioner determines to be appropriate pursuant to subsection 5 if the Commissioner determines that the current level of the surety bond or deposit is insufficient to provide protection to the members in the event of:***

(a) Insolvency; or

(b) A determination by the Commissioner that the organization is in a hazardous financial condition.

5. When determining the appropriate amount of an increase pursuant to subsection 4, the Commissioner must base his or her determination on the type, volume and nature of premiums written and premiums assumed by the organization.

6. The amount of the organization's surety bond or deposit required pursuant to this section:

(a) Is in addition to any reserve required by this chapter and any reserve established by the organization according to good business and accounting practices for incurred but unreported claims and other similar claims;

(b) May increase the amount of net worth required pursuant to this chapter; and

(c) May increase the amount of risk-based capital required pursuant to NRS 681B.550.

7. Any final judgment against the organization which is unpaid is a lien on the ***surety*** bond or deposit and is subject to execution 30 days after entry of the judgment. Any ***surety*** bond or deposit which is reduced by this lien must be increased by the organization to the amount required by this section within 90 days after the judgment is paid.

~~[5.]~~ ***8.*** If an organization is dissolved, liquidated or otherwise terminated:

(a) That amount of the ***surety*** bond or deposit which is necessary to satisfy the outstanding obligations of the organization may not be withdrawn for at least 3 years after the certificate of authority has been terminated.

(b) Any balance remaining after money has been withheld to pay the organization's debts and liens must be paid to the organization by the Commissioner no later than 90 days after the certificate of authority has been terminated.

Sec. 156. Chapter 695F of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Commissioner may adopt regulations to define when a prepaid limited health service organization is considered to be in a

hazardous financial condition and to set forth the standards to be considered by the Commissioner in determining whether the continued operation of a prepaid limited health service organization transacting business in this State may be considered to be hazardous to its enrollees or creditors or to the general public.

2. If the Commissioner determines after a hearing that any prepaid limited health service organization is in a hazardous financial condition, the Commissioner may, instead of suspending or revoking the prepaid limited health service organization's certificate of authority, limit the certificate of authority of the prepaid limited health service organization as the Commissioner deems reasonably necessary to correct, eliminate or remedy any conduct, condition or ground that is deemed to be a cause of the hazardous financial condition.

3. An order or decision of the Commissioner under this section is subject to review in accordance with NRS 679B.310 to 679B.370, inclusive, at the request of any party to the proceedings whose interests are substantially affected.

Sec. 157. NRS 695F.090 is hereby amended to read as follows:

695F.090 ***1.*** Prepaid limited health service organizations are subject to the provisions of this chapter and to the following provisions, to the extent reasonably applicable:

~~[1.]~~ ***(a)*** NRS 687B.310 to 687B.420, inclusive, concerning cancellation and nonrenewal of policies.

~~[2.]~~ ***(b)*** NRS 687B.122 to 687B.128, inclusive, concerning readability of policies.

~~[3.]~~ ***(c)*** The requirements of NRS 679B.152.

~~[4.]~~ ***(d)*** The fees imposed pursuant to NRS 449.465.

~~[5.]~~ ***(e)*** NRS 686A.010 to 686A.310, inclusive, concerning trade practices and frauds.

~~[6.]~~ ***(f)*** The assessment imposed pursuant to NRS 679B.700.

~~[7.]~~ ***(g)*** Chapter 683A of NRS.

~~[8.]~~ ***(h)*** To the extent applicable, the provisions of NRS 689B.340 to 689B.580, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance.

~~[9.]~~ ***(i)*** NRS 689A.035, 689A.0463, 689A.410, 689A.413 and 689A.415.

~~[10.]~~ ***(j)*** 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.]~~ ***(k)*** Chapter 692C of NRS, concerning holding companies.

~~[12.]~~ ***(l)*** NRS 689A.637, concerning health centers.

2. For the purposes of this section and the provisions set forth in subsection 1, a prepaid limited health service organization is included in the meaning of the term "insurer."

Sec. 158. NRS 695F.200 is hereby amended to read as follows:

695F.200 ~~[Each]~~

1. Except as otherwise provided in this section, each prepaid limited health service organization which receives a certificate of authority shall maintain a:

~~[1.]~~ ***(a)*** Capital account with a net worth of not less than ~~[$200,000]~~ ***$500,000*** unless a lesser amount is permitted in writing by the Commissioner. The account must not be obligated for any accrued liabilities and must consist of cash, securities or a combination thereof which is acceptable to the Commissioner.

~~[2.]~~ ***(b)*** Surety bond or deposit of cash or securities for the protection of enrollees of not less than ~~[$250,000.]~~ ***$500,000.***

2. The Commissioner may increase the required amount of the organization's capital account and the surety bond or deposit to any amounts the Commissioner determines to be appropriate pursuant to subsection 3 if the Commissioner determines that such an increase is necessary to:

(a) Assist the Commissioner in the performance of his or her regulatory duties;

(b) Ensure that the organization complies with the requirements of this Code; or

(c) Ensure the solvency of the organization.

3. When determining the appropriate amount of an increase pursuant to subsection 2, the Commissioner must base his or her determination on the type, volume and nature of premiums written and premiums assumed by the organization.

4. The amount of the organization's capital account and surety bond or deposit required pursuant to this section:

(a) Is in addition to any reserve required by this chapter and any reserve established by the organization according to good business and accounting practices for incurred but unreported claims and other similar claims; and

(b) May increase the amount of risk-based capital required pursuant to NRS 681B.550.

5. The amount of the organization's surety bond or deposit required pursuant to this section may increase the amount of net worth required pursuant to this section.

Sec. 159. 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, each managed care organization shall file with the Commissioner, ~~[on or before March 1 of each year,]~~ ***with its annual filing made pursuant to NRS 686B.070 of forms and rates relating to policies of insurance for individuals and small employer groups,*** 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, 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.]~~ ***The report must be submitted on a form prescribed by the Commissioner.***

2. 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.

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

Sec. 160. 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 may examine the system for resolving complaints established pursuant to this section at such times as ~~[either]~~ ***the Commissioner*** deems necessary or appropriate.

Sec. 161. NRS 695G.220 is hereby amended to read as follows:

695G.220 1. Each managed care organization shall submit to the Commissioner 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. 162. (Deleted by amendment.)

Sec. 163. NRS 239.010 is hereby amended to read as follows:

239.010 1. Except as otherwise provided in this section and NRS 1.4683, 1.4687, 1A.110, 41.071, 49.095, 62D.420, 62D.440, 62E.516, 62E.620, 62H.025, 62H.030, 62H.170, 62H.220, 62H.320, 75A.100, 75A.150, 76.160, 78.152, 80.113, 81.850, 82.183, 86.246,

86.54615, 87.515, 87.5413, 87A.200, 87A.580, 87A.640, 88.3355, 88.5927, 88.6067, 88A.345, 88A.7345, 89.045, 89.251, 90.730, 91.160, 116.757, 116A.270, 116B.880, 118B.026, 119.260, 119.265, 119.267, 119.280, 119A.280, 119A.653, 119B.370, 119B.382, 120A.690, 125.130, 125B.140, 126.141, 126.161, 126.163, 126.730, 127.007, 127.057, 127.130, 127.140, 127.2817, 130.312, 130.712, 136.050, 159.044, 172.075, 172.245, 176.015, 176.0625, 176.09129, 176.156, 176A.630, 178.39801, 178.4715, 178.5691, 179.495, 179A.070, 179A.165, 179A.450, 179D.160, 200.3771, 200.3772, 200.5095, 200.604, 202.3662, 205.4651, 209.392, 209.3925, 209.419, 209.521, 211A.140, 213.010, 213.040, 213.095, 213.131, 217.105, 217.110, 217.464, 217.475, 218A.350, 218E.625, 218F.150, 218G.130, 218G.240, 218G.350, 228.270, 228.450, 228.495, 228.570, 231.069, 231.1473, 233.190, 237.300, 239.0105, 239.0113, 239B.030, 239B.040, 239B.050, 239C.140, 239C.210, 239C.230, 239C.250, 239C.270, 240.007, 241.020, 241.030, 241.039, 242.105, 244.264, 244.335, 250.087, 250.130, 250.140, 250.150, 268.095, 268.490, 268.910, 271A.105, 281.195, 281A.350, 281A.440, 281A.550, 284.4068, 286.110, 287.0438, 289.025, 289.080, 289.387, 289.830, 293.5002, 293.503, 293.558, 293B.135, 293D.510, 331.110, 332.061, 332.351, 333.333, 333.335, 338.070, 338.1379, 338.16925, 338.1725, 338.1727, 348.420, 349.597, 349.775, 353.205, 353A.049, 353A.085, 353A.100, 353C.240, 360.240, 360.247, 360.255, 360.755, 361.044, 361.610, 365.138, 366.160, 368A.180, 372A.080, 378.290, 378.300, 379.008, 385A.830, 385B.100, 387.626, 387.631, 388.1455, 388.259, 388.501, 388.503, 388.513, 388.750, 391.035, 392.029, 392.147, 392.264, 392.271, 392.850, 394.167, 394.1698, 394.447, 394.460, 394.465, 396.3295, 396.405, 396.525, 396.535, 398.403, 408.3885, 408.3886, 408.3888, 408.5484, 412.153, 416.070, 422.2749, 422.305, 422A.342, 422A.350, 425.400, 427A.1236, 427A.872, 432.205, 432B.175, 432B.280, 432B.290, 432B.407, 432B.430, 432B.560, 433.534, 433A.360, 439.840, 439B.420, 440.170, 441A.195, 441A.220, 441A.230, 442.330, 442.395, 445A.665, 445B.570, 449.209, 449.245, 449.720, 450.140, 453.164, 453.720, 453A.610, 453A.700, 458.055, 458.280, 459.050, 459.3866, 459.555, 459.7056, 459.846, 463.120, 463.15993, 463.240, 463.3403, 463.3407, 463.790, 467.1005, 480.365, 481.063, 482.170, 482.5536, 483.340, 483.363, 483.575, 483.659, 483.800, 484E.070, 485.316, 503.452, 522.040, 534A.031, 561.285, 571.160, 584.583, 584.655, 587.877, 598.0964, 598.098, 598A.110, 599B.090, 603.070, 603A.210, 604A.710, 612.265, 616B.012, 616B.015, 616B.315, 616B.350, 618.341, 618.425, 622.310, 623.131, 623A.137, 624.110, 624.265, 624.327, 625.425, 625A.185, 628.418, 628B.230, 628B.760, 629.047, 629.069, 630.133, 630.30665,

630.336, 630A.555, 631.368, 632.121, 632.125, 632.405, 633.283, 633.301, 633.524, 634.055, 634.214, 634A.185, 635.158, 636.107, 637.085, 637B.288, 638.087, 638.089, 639.2485, 639.570, 640.075, 640A.220, 640B.730, 640C.400, 640C.745, 640C.760, 640D.190, 640E.340, 641.090, 641A.191, 641B.170, 641C.760, 642.524, 643.189, 644.446, 645.180, 645.625, 645A.050, 645A.082, 645B.060, 645B.092, 645C.220, 645C.225, 645D.130, 645D.135, 645E.300, 645E.375, 645G.510, 645H.320, 645H.330, 647.0945, 647.0947, 648.033, 648.197, 649.065, 649.067, 652.228, 654.110, 656.105, 661.115, 665.130, 665.133, 669.275, 669.285, 669A.310, 671.170, 673.430, 675.380, 676A.340, 676A.370, 677.243, 679B.122, 679B.152, 679B.159, 679B.190, 679B.285, 679B.690, 680A.270, 681A.440, 681B.260, 681B.410, 681B.540, 683A.0873, 685A.077, 686A.289, 686B.170, 686C.306, 687A.110, 687A.115, 687C.010, 688C.230, 688C.480, 688C.490, 692A.117, 692C.190, 692C.3536, 692C.3538, 692C.354, 692C.420, 693A.480, 693A.615, 696B.550, 703.196, 704B.320, 704B.325, 706.1725, 706A.230, 710.159, 711.600, ***and sections 8 and 92 of this act,*** sections 35, 38 and 41 of chapter 478, Statutes of Nevada 2011 and section 2 of chapter 391, Statutes of Nevada 2013 and unless otherwise declared by law to be confidential, all public books and public records of a governmental entity must be open at all times during office hours to inspection by any person, and may be fully copied or an abstract or memorandum may be prepared from those public books and public records. Any such copies, abstracts or memoranda may be used to supply the general public with copies, abstracts or memoranda of the records or may be used in any other way to the advantage of the governmental entity or of the general public. This section does not supersede or in any manner affect the federal laws governing copyrights or enlarge, diminish or affect in any other manner the rights of a person in any written book or record which is copyrighted pursuant to federal law.

2. A governmental entity may not reject a book or record which is copyrighted solely because it is copyrighted.

3. A governmental entity that has legal custody or control of a public book or record shall not deny a request made pursuant to subsection 1 to inspect or copy or receive a copy of a public book or record on the basis that the requested public book or record contains information that is confidential if the governmental entity can redact, delete, conceal or separate the confidential information from the information included in the public book or record that is not otherwise confidential.

4. A person may request a copy of a public record in any medium in which the public record is readily available. An officer,

employee or agent of a governmental entity who has legal custody or control of a public record:

(a) Shall not refuse to provide a copy of that public record in a readily available medium because the officer, employee or agent has already prepared or would prefer to provide the copy in a different medium.

(b) Except as otherwise provided in NRS 239.030, shall, upon request, prepare the copy of the public record and shall not require the person who has requested the copy to prepare the copy himself or herself.

Sec. 164. NRS 266.355 is hereby amended to read as follows:

266.355 1. Except as otherwise provided in subsections 3, 4 and 5, the city council may:

(a) Except as otherwise provided in NRS 268.0881 to 268.0888, inclusive, 598D.150 and 640C.100, regulate all businesses, trades and professions.

(b) Except as otherwise provided in NRS 576.128, fix, impose and collect a license tax for revenue upon all businesses, trades and professions.

2. The city council may establish any equitable standard to be used in fixing license taxes required to be collected pursuant to this section.

3. The city council may license insurance ~~[agents, brokers,]~~ analysts, adjusters and managing general agents ***and producers of insurance*** within the limitations and under the conditions prescribed in NRS 680B.020.

4. A city council shall not require that a person who is licensed as a contractor pursuant to chapter 624 of NRS obtain more than one license to engage in the business of contracting or pay more than one license tax related to engaging in the business of contracting, regardless of the number of classifications or subclassifications of licensing for which the person is licensed pursuant to chapter 624 of NRS.

5. The city council shall not require a person to obtain a license or pay a license tax on the sole basis that the person is a professional. As used in this subsection, "professional" means a person who:

(a) Holds a license, certificate, registration, permit or similar type of authorization issued by a regulatory body as defined in NRS 622.060, or who is regulated pursuant to the Nevada Supreme Court Rules; and

(b) Practices his or her profession for any type of compensation as an employee.

Sec. 165. NRS 269.170 is hereby amended to read as follows:

269.170 1. Except as otherwise provided in subsection 5 and NRS 576.128, 598D.150 and 640C.100, the town board or board of county commissioners may, in any unincorporated town:

(a) Fix and collect a license tax on, and regulate, having due regard to the amount of business done by each person so licensed, and all places of business and amusement so licensed, as follows:

(1) Artisans, artists, assayers, auctioneers, bakers, banks and bankers, barbers, boilermakers, cellars and places where soft drinks are kept or sold, clothes cleaners, foundries, laundries, lumberyards, manufacturers of soap, soda, borax or glue, markets, newspaper publishers, pawnbrokers, funeral directors and wood and coal dealers.

(2) Bootmakers, cobblers, dressmakers, milliners, shoemakers and tailors.

(3) Boardinghouses, hotels, lodging houses, restaurants and refreshment saloons.

(4) Barrooms, gaming, manufacturers of liquors and other beverages, and saloons.

(5) Billiard tables, bowling alleys, caravans, circuses, concerts and other exhibitions, dance houses, melodeons, menageries, shooting galleries, skating rinks and theaters.

(6) Corrals, hay yards, livery and sale stables and wagon yards.

(7) Electric light companies, illuminating gas companies, power companies, telegraph companies, telephone companies and water companies.

(8) Carts, drays, express companies, freight companies, job wagons, omnibuses and stages.

(9) Brokers, commission merchants, factors, general agents, mercantile agents, merchants, traders and stockbrokers.

(10) Drummers, hawkers, peddlers and solicitors.

(11) Insurance ~~[agents, brokers,]~~ analysts, adjusters and managing general agents ***and producers of insurance*** within the limitations and under the conditions prescribed in NRS 680B.020.

(b) Fix and collect a license tax upon all professions, trades or business within the town not specified in paragraph (a).

2. No license to engage in business as a seller of tangible personal property may be granted unless the applicant for the license presents written evidence that:

(a) The Department of Taxation has issued or will issue a permit for this activity, and this evidence clearly identifies the business by name; or

(b) Another regulatory agency of the State has issued or will issue a license required for this activity.

3. Any license tax levied for the purposes of NRS 244A.597 to 244A.655, inclusive, constitutes a lien upon the real and personal property of the business upon which the tax was levied until the tax is paid. The lien must be enforced in the same manner as liens for ad valorem taxes on real and personal property. The town board or other governing body of the unincorporated town may delegate the power to enforce such liens to the county fair and recreation board.

4. The governing body or the county fair and recreation board may agree with the Department of Taxation for the continuing exchange of information concerning taxpayers.

5. The town board or board of county commissioners shall not require a person to obtain a license or pay a license tax on the sole basis that the person is a professional. As used in this subsection, "professional" means a person who:

(a) Holds a license, certificate, registration, permit or similar type of authorization issued by a regulatory body as defined in NRS 622.060, or who is regulated pursuant to the Nevada Supreme Court Rules; and

(b) Practices his or her profession for any type of compensation as an employee.

Sec. 166. NRS 616A.330 is hereby amended to read as follows:

616A.330 "Tangible net worth" means the value of all the assets, minus the value of all the liabilities, of ***a self-insured employer or*** an association of self-insured private employers ~~[or of a member of such an association]~~ except:

1. Goodwill or excess cost over the fair market value of assets.

2. Any other items listed in the assets that are deemed unacceptable by the Commissioner because they cannot be justified or because they do not directly support the ability of the ***self-insured employer or*** association ~~[or the member]~~ to pay a claim.

Sec. 166.3. NRS 616B.386 is hereby amended to read as follows:

616B.386 1. If an employer wishes to become a member of an association of self-insured public or private employers, the employer must:

(a) Submit an application for membership to the board of trustees or third-party administrator of the association; and

(b) Enter into an indemnity agreement as required by NRS 616B.353.

2. The membership of the applicant becomes effective when each member of the association approves the application or on a later date specified by the association. The application for membership and the action taken on the application must be maintained as permanent records of the board of trustees.

3. Each member who is a member of an association during the 12 months immediately following the formation of the association must:

(a) Have a tangible net worth of at least $500,000; or

(b) Have had a reported payroll for the previous 12 months which would have resulted in a manual premium of at least $15,000, calculated in accordance with a manual prepared pursuant to subsection 4 of NRS 686B.1765.

4. An employer who seeks to become a member of the association after the 12 months immediately following the formation of the association must meet the requirement set forth in paragraph (a) or (b) of subsection 3 unless the Commissioner adjusts the requirement for membership in the association after conducting an annual review of the actuarial solvency of the association pursuant to subsection 1 of NRS 616B.353.

5. An association of self-insured private employers may apply to the Commissioner for authority to determine the amount of tangible net worth and manual premium that an employer must have to become a member of the association. The Commissioner shall approve the application if the association:

(a) Has been certified to act as an association for at least the 3 consecutive years immediately preceding the date on which the association filed the application with the Commissioner;

(b) Has, as determined by the Commissioner, either:

(1) A combined tangible net worth of all members in the association of at least $5,000,000; or

(2) Combined net cash flows from operating activities plus net cash flows from financing activities of all members in the association of five times the average of claims paid for each of the last 3 years or $7,500,000, whichever is less;

(c) Has at least 15 members; and

(d) Has not been required to meet informally with the Commissioner pursuant to subsection 1 of NRS 616B.431 during the 18-month period immediately preceding the date on which the association filed the application with the Commissioner or, if the association has been required to attend such a meeting during that period, has not had its certificate withdrawn before the date on which the association filed the application.

6. An association of self-insured private employers may apply to the Commissioner for authority to determine the documentation demonstrating solvency that an employer must provide to become a member of the association. The Commissioner shall approve the application if the association:

(a) Has been certified to act as an association for at least the 3 consecutive years immediately preceding the date on which the association filed the application with the Commissioner;

(b) Has, as determined by the Commissioner, either:

(1) A combined tangible net worth of all members in the association of at least $5,000,000; or

(2) Combined net cash flows from operating activities plus net cash flows from financing activities of all members in the association of five times the average of claims paid for each of the last 3 years or $7,500,000, whichever is less; and

(c) Has at least 15 members.

7. The Commissioner may withdraw approval of an application submitted pursuant to subsection 5 or 6 if the Commissioner determines the association has ceased to comply with any of the requirements set forth in subsection 5 or 6, as applicable.

8. A member of an association ***of self-insured public or private employers*** may terminate his or her membership at any time. To terminate his or her membership, a member must submit to the association's administrator a notice of intent to withdraw from the association at least 120 days before the effective date of withdrawal. The notice of intent to withdraw ~~[must include a statement indicating]~~ ***shall be deemed rescinded if the member does not provide to the association before the expiration of the 120-day period proof*** that the member has:

(a) Been certified as a self-insured employer pursuant to NRS 616B.312;

(b) Become a member of another association of self-insured public or private employers; or

(c) Become insured by a private carrier.

9. The members of an association may cancel the membership of any member of the association in accordance with the bylaws of the association.

10. The association shall:

(a) Within 30 days after the addition of an employer to the membership of the association, notify the Commissioner of the addition and:

(1) If the association has not received authority from the Commissioner pursuant to subsection 5 or 6, as applicable, provide to the Commissioner all information and assurances for the new member that were required from each of the original members of the association upon its organization; or

(2) If the association has received authority from the Commissioner pursuant to subsection 5 or 6, as applicable, provide to the Commissioner evidence that is satisfactory to the Commissioner that the new member is a member or associate

member of the bona fide trade association as required pursuant to paragraph (a) of subsection 2 of NRS 616B.350, a copy of the indemnity agreement that jointly and severally binds the new member, the other members of the association and the association that is required to be executed pursuant to paragraph (a) of subsection 1 of NRS 616B.353 and any other information the Commissioner may reasonably require to determine whether the amount of security deposited with the Commissioner pursuant to paragraph (d) or (e) of subsection 1 of NRS 616B.353 is sufficient, but such information must not exceed the information required to be provided to the Commissioner pursuant to subparagraph (1);

(b) Notify the Commissioner and the Administrator of the termination or cancellation of the membership of any member of the association within 10 days after the termination or cancellation; and

(c) At the expense of the member whose membership is terminated or cancelled, maintain coverage for that member for 60 days after notice is given pursuant to paragraph (b), unless the association first receives notice from the Administrator that the member has:

(1) Been certified as a self-insured employer pursuant to NRS 616B.312;

(2) Become a member of another association of self-insured public or private employers; or

(3) Become insured by a private carrier.

11. If a member of an association changes his or her name or form of organization, the member remains liable for any obligations incurred or any responsibilities imposed pursuant to chapters 616A to 617, inclusive, of NRS under the member's former name or form of organization.

12. An association is liable for the payment of any compensation required to be paid by a member of the association pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS during the member's period of membership. The insolvency or bankruptcy of a member does not relieve the association of liability for the payment of the compensation.

Sec. 166.5. 1. The provisions of NRS 689A.630, as amended by section 98 of this act, apply to any discontinuation of a product that occurs on or after the effective date of section 98 of this act.

2. The provisions of NRS 689B.560, as amended by section 110 of this act, apply to any discontinuation of a product offered to employers that occurs on or after the effective date of section 110 of this act.

3. The provisions of NRS 689C.310, as amended by section 112 of this act, apply to any discontinuation of a product offered to

small employers that occurs on or after the effective date of section 112 of this act.

4. The provisions of NRS 689C.470, as amended by section 114 of this act, apply to any discontinuation of a product offered to a small employer or purchasers pursuant to NRS 689C.360 to 689C.600, inclusive, that occurs on or after the effective date of section 114 of this act.

Sec. 167. The provisions of subsection 1 of NRS 218D.380 do not apply to any provision of this act which adds or revises a requirement to submit a report to the Legislature.

Sec. 168. NRS 680A.290, 689A.390, 689A.400, 689A.690, 689B.027, 689B.028, 689C.270, 689C.280, 689C.330, 689C.440, 689C.450, 690B.370, 695B.172, 695B.174 and 695F.215 are hereby repealed.

Sec. 169. 1. Sections 98, 110, 112 and 114 of this act become effective upon passage and approval.

2. This section and sections 1 to 97, inclusive, 99 to 109, inclusive, 111, 113, 115 to 152, inclusive, 154 , 156, 157 and 159 to 168, inclusive, of this act become effective:

(a) Upon passage and approval for the purpose of adopting regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On July 1, 2017, for all other purposes.

3. Sections 153, 155 and 158 of this act become effective:

(a) Upon passage and approval for the purpose of adopting regulations and performing any other preparatory administrative acts that are necessary to carry out the provisions of this act; and

(b) On January 1, 2018, for all other purposes.

LEADLINES OF REPEALED SECTIONS

680A.290 Loss prevention reports and programs.

689A.390 Summary of coverage: Contents of disclosure; approval by Commissioner.

689A.400 Summary of coverage: Copy to be provided before policy issued; policy may not be offered unless summary approved by Commissioner.

689A.690 Information required to be disclosed as part of solicitation and sales materials; information required to be maintained at place of business.

689B.027 Summary of coverage: Contents of disclosure; approval by Commissioner; copy to be made available to employer or producer acting on behalf of employer.

689B.028 Summary of coverage: Copy to be provided before policy issued; policy may not be offered unless summary approved by Commissioner.

689C.270 Regulations concerning disclosures by carrier to small employer; copy of disclosure to be made available to small employer.

689C.280 Carrier to provide required disclosures to small employer before issuing policy of insurance.

689C.330 When insurer is required to allow employee to continue coverage after employee is no longer covered by health benefit plan.

689C.440 Regulations regarding required disclosures by carrier.

689C.450 Carrier to provide disclosure before issuing contract.

690B.370 Annual report on loss prevention and control programs.

695B.172 Summary of coverage: Contents of disclosure; approval by Commissioner.

695B.174 Summary of coverage: Copy to be provided before policy issued; policy not to be offered unless summary approved by Commissioner.

695F.215 Required contract with insurance company for provision of insurance, indemnity or reimbursement against cost of health care services.

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