

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.



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Legislative Counsel's Digest:

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

5 **Sections 2-13** of this bill authorize the Commissioner to place an insurer under
6 administrative supervision and set forth the requirements for such supervision.
7 **Section 6** authorizes the Commissioner to place an insurer under administrative
8 supervision under specified circumstances, including, without limitation, when the
9 insurer is in a hazardous financial condition, when the insurer appears to have
10 exceeded its powers or if an insurer agrees to be placed under such supervision.
11 **Section 6** further provides for the duration of the administrative supervision and the
12 release of the insurer from administrative supervision. **Section 7** designates the
13 Commissioner or an appointee thereof as the administrative supervisor of an insurer
14 under administrative supervision, authorizes the Commissioner to limit the actions
15 of such an insurer and lists various types of actions which the Commissioner may
16 prohibit the insurer from taking without obtaining advance approval from the
17 Commissioner or appointee. **Sections 3 and 4** define, for the purposes of **sections**
18 **2-13**, the terms "Commissioner" and "insurer." Both terms are currently defined for
19 the purposes of existing law, but **sections 3 and 4** provide more expansive
20 definitions for the purposes of **sections 2-13**. (NRS 679A.060, 679A.100) **Section 5**
21 expressly makes **sections 2-13** apply to insurers and other persons, including,
22 without limitation, a person purporting to be an insurer, organizing to be an insurer
23 or holding himself or herself out as organizing to be an insurer. **Section 8** governs
24 the use and confidentiality of information relating to the administrative supervision
25 of an insurer. **Section 9** establishes provisions governing the contesting or
26 reviewing of decisions made by the Commissioner or an appointee thereof pursuant
27 to **sections 2-13**. **Section 10** ensures that the Commissioner may institute
28 delinquency proceedings against an insurer without regard to whether the insurer is
29 or was under administrative supervision. **Section 11** authorizes the Commissioner,
30 a designee of the Commissioner and an attorney or other persons to meet, for
31 specified purposes, outside the presence of other persons. **Section 12** authorizes the
32 Commissioner to adopt regulations and to employ various persons to carry out
33 the administrative supervision of an insurer. **Section 12** further authorizes the
34 Commissioner to require the insurer under administrative supervision to pay the
35 compensation and expenses of the persons the Commissioner appoints and employs
36 for the purposes of the administrative supervision. **Section 13** provides that the
37 Commissioner and his or her employees and agents are not liable for actions taken
38 pursuant to **sections 2-13**.

39 **Section 14** of this bill revises the information the Commissioner is required to
40 collect regarding closed claims for medical malpractice. (NRS 679B.144) **Sections**
41 **117 and 118** remove the requirement to report certain information regarding closed
42 claims for medical malpractice. (NRS 690B.250, 690B.260) **Section 119** of this bill
43 revises requirements concerning professional liability insurance for essential
44 medical specialties. (NRS 690B.350) **Section 120** of this bill revises requirements
45 concerning information to be gathered and reports to be provided by the
46 Commissioner concerning medical malpractice insurance. (NRS 690B.360)

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

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



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

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

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

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

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

90 **Section 35** of this bill defines the term "large-deductible agreement" as certain
91 agreements in which the policyholder must bear the risk of loss of a specified
92 amount of \$25,000 or more per claim or occurrence covered under the policy of
93 industrial insurance. **Section 38** of this bill requires full collateralization of the
94 outstanding obligations owed under a large-deductible agreement and limits the
95 size of the policyholder's obligations under the large-deductible agreement. **Section**
96 **39** of this bill generally prohibits an insurer from issuing or renewing a policy of
97 industrial insurance which includes a large-deductible agreement if the insurer is in
98 a hazardous financial condition. **Section 37** of this bill limits the applicability of
99 **sections 38 and 39** to policies of industrial insurance with large-deductible
100 agreements which are issued by insurers with both ratings below specified levels
101 and surpluses below specified amounts. **Section 37** further specifies that **sections**
102 **38 and 39** only apply to policies of industrial insurance issued or renewed on or
103 after January 1, 2018, and which are not issued to a governmental entity. **Section**
104 **166** of this bill revises the definition of the term "tangible net worth" in relation to
105 industrial insurance, specifically self-insured employers and associations of self-
106 insured employees. (NRS 616A.330)

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



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

117 **Sections 88 and 89** of this bill revise existing provisions relating to health
118 benefit plans by specifying that the group market and small group market being
119 considered in these provisions must be the "small employer" group market. (NRS
120 687B.490, 687B.500)

121 **Sections 51-85** of this bill establish provisions governing network plans.
122 **Section 60** defines a network plan as a health benefit plan offered or issued by a
123 health carrier under which the financing and delivery of health care services are
124 provided, in whole or in part, through a defined set of providers of health care
125 under contract with the health carrier. **Sections 52-59 and 61-64** define other terms
126 for the regulation of network plans. **Section 65** requires a health carrier to comply
127 with and ensure that network plans and related contracts comply with **sections**
128 **51-85**. **Sections 66, 71, 79, 81 and 84** require a health carrier to provide for notice
129 to providers of health care concerning: (1) covered services; (2) the health carrier's
130 policies and programs; (3) the providers' obligations to collect payments; (4)
131 determinations of coverage; and (5) the inclusion of and status of a participating
132 provider in the network plan. **Sections 67, 68, 70, 74 and 77** require a contract
133 between a provider of health care and a health carrier to contain provisions which:
134 (1) prohibit the provider from collecting excess amounts from covered persons; (2)
135 require the continuation of health care services in the event of cessation of the
136 operations of the health carrier; (3) require that written notice be provided to a
137 participating provider of health care in certain circumstances; (4) require the
138 provider to make health care records available under certain circumstances; and (5)
139 prohibit the assignment or delegation of rights under the contract. **Section 69**
140 provides that specified provisions in a contract between a provider of health care
141 and a health carrier must be construed in favor of the covered person. **Section 72**
142 prohibits a health carrier from offering inducement to a provider of health care to
143 provide health care services which are less than medically necessary. **Section 73**
144 requires that a health carrier allow a provider of health care to discuss all treatment
145 options with a covered person and advocate for the covered person. **Section 78**
146 governs the furnishing of covered services to all covered persons. **Section 80**
147 prohibits a health carrier from penalizing a provider of health care who reports to
148 state or federal authorities certain practices of the health carrier. **Section 82** requires
149 a health carrier to establish procedures for dispute resolution between a provider of
150 health care and the health carrier. **Section 83** prohibits a contract between a
151 provider of health care and a health carrier from containing any provision which
152 conflicts with the network plan or with any provision of **sections 51-85**. **Section 85**
153 authorizes the Commissioner to adopt regulations to carry out **sections 51-85**.

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

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



165 requirement regarding the discontinuance of a product: (1) of a health benefit plan;
166 (2) of group health insurance; (3) offered to small employers; and (4) offered to
167 small employers or purchasers through a voluntary purchasing group. (NRS
168 689A.630, 689B.560, 689C.310, 689C.470) **Sections 109, 113 and 134** of this bill
169 remove the requirement that certain policies of group health insurance, health
170 benefit plans and group contracts for hospital, medical or dental services include a
171 provision regarding the point at which an insured's payment of coinsurance for a
172 provider of health care who is not preferred is no longer required to be paid. (NRS
173 689B.061, 689C.350, 695B.185)

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

177 **Sections 122-124 and 127-129** of this bill revise provisions relating to service
178 contracts which are contracts pursuant to which a provider is obligated to the
179 purchaser of the service contract to repair, replace or perform maintenance on, or
180 indemnify or reimburse the purchaser for the costs of repairing, replacing or
181 performing maintenance on, goods that are described in the service contract. (NRS
182 690C.080) **Section 123** sets forth the qualifications of a controlling person for the
183 purposes of determining the controlling person of a provider of service contracts.
184 **Section 127** adds to the requirements for a provider to apply for and obtain a
185 certificate of registration to issue, sell or offer for sale service contracts, including
186 providing certain personal and criminal history information about the controlling
187 persons of the provider and verifying that the information in the application for a
188 certificate of registration is accurate to the best of his or her knowledge. (NRS
189 690C.160) **Section 124** prohibits a provider from transferring its liability under a
190 service contract except under specified conditions, including, without limitation,
191 obtaining the approval of the Commissioner. **Section 128** revises the requirements
192 governing the financial security which must be maintained by a provider, including,
193 without limitation, expanded requirements concerning a reserve account. (NRS
194 690C.170) **Section 129** revises provisions which govern the notice required by a
195 provider which ceases to do business in this State. (NRS 690C.240)

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

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

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



219 Existing law clarifies that nonprofit hospital and medical or dental service
220 corporations, health maintenance organizations, organizations for dental care and
221 prepaid limited health service organizations are subject to certain other provisions
222 of existing law. (NRS 695B.320, 695C.055, 695D.095, 695F.090) **Sections 138,**
223 **147, 154 and 157** of this bill revise such provisions to include additional
224 requirements for applicability. **Section 144** of this bill requires each health
225 maintenance organization to develop, submit to the Commissioner and put into
226 effect a plan to provide for the continuation of benefits to enrollees in the event of
227 the insolvency or impairment of the health maintenance organization. **Section 145**
228 of this bill authorizes the Commissioner to take certain actions regarding the
229 operation of a health maintenance organization if the Commissioner determines
230 that, because of the financial condition of the health maintenance organization, the
231 continued operation of the health maintenance organization may be hazardous to its
232 enrollees or creditors or to the general public. **Section 146** of this bill addresses the
233 conservation, rehabilitation and liquidation of health maintenance organizations.
234 **Section 149** of this bill revises provisions governing examinations of health
235 maintenance organizations by the Commissioner or an examiner designated by the
236 Commissioner. (NRS 695C.310)

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

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

252 **Sections 103-106, 139, 140, 148, 160 and 161** of this bill remove the State
253 Board of Health from the provisions governing systems for resolving complaints of
254 insureds. (NRS 689A.745, 689A.750, 689B.0285, 389B.029, 695B.380, 695B.390,
255 695C.080, 695G.200, 695G.220)

256 **Section 168** repeals: (1) the requirement for certain insurers and the
257 Commissioner to submit annual reports addressing loss prevention and control
258 programs (NRS 680A.290, 690B.370); (2) the requirement for certain insurers to
259 make certain disclosures (NRS 689A.390, 689A.400, 689A.690, 689B.027,
260 689B.028, 689C.270, 689C.280, 689C.440, 689C.450, 695B.172, 695B.174); and
261 (3) the requirement for a prepaid limited health service organization to contract
262 with an insurance company for certain purposes (NRS 695F.215).

263 Existing law sets forth that an employer who is a member of an association of
264 self-insured public or private employers may terminate his or her membership at
265 any time, as long as the member submits to the association a notice of intent to
266 withdraw from the association at least 120 days before the effective date of
267 withdrawal. Existing law further requires this notice of intent to withdraw to
268 include a statement indicating that the member has replaced his or her membership
269 to the association with a certain other type of insurance. (NRS 616B.386) **Section**
270 **166.3** of this bill amends existing law by requiring that the notice of intent to
271 withdraw be deemed rescinded if the member does not provide to the association
272 before the expiration of the 120-day period proof that the member has replaced his
273 or her membership to the association with a certain other type of insurance.



274 Sections 17, 23, 40-43, 45-49, 87, 93-97, 99-102, 107, 108, 115, 116, 125, 126,
275 135, 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:

1 **Section 1.** Title 57 of NRS is hereby amended by adding
2 thereto a new chapter to consist of the provisions set forth as
3 sections 2 to 13, inclusive, of this act.

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

7 **Sec. 3.** *“Commissioner” means the Commissioner of*
8 *Insurance and, if applicable:*

9 1. *A deputy of the Commissioner; or*

10 2. *The Division.*

11 **Sec. 4.** *“Insurer” includes, without limitation:*

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

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

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

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

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

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

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

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

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

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

36 1. *All domestic insurers;*

37 2. *Any foreign insurer doing business in this State regarding*
38 *whom an applicable official of the foreign insurer’s state of*



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

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

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

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

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

12 (1) *The insurer is in a hazardous financial condition as set*
13 *forth in regulations adopted pursuant to NRS 680A.205 or*
14 *695B.150 or section 143, 152 or 156 of this act or any other*
15 *applicable provision of this title;*

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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



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

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

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

11 (1) Completely reinsured its entire outstanding business; or

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

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

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

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

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

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

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

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

34 (c) Lend any of its money;

35 (d) Invest any of its money;

36 (e) Transfer any of its property;

37 (f) Incur any debt, obligation or liability;

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

40 (h) Approve new premiums or renew any policies;

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

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



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

4 (l) Make any material change in management; or

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

42 **Sec. 12. The Commissioner may:**

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



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

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

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

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

19 679B.144 1. The Commissioner shall collect and maintain
20 the information provided by insurers pursuant to NRS 690B.260
21 regarding each closed claim for medical malpractice filed against a
22 person who is covered by a policy of insurance for medical
23 malpractice in this state, including, without limitation:

- 24 (a) The cause of the loss;
25 (b) A description of the injury for which the claim was filed;
26 (c) The sex of the injured person;
27 (d) The names and number of defendants in each claim;
28 (e) The type of coverage provided;
29 (f) ~~The amount of the initial, highest and last reserves of an~~
30 ~~insurer for each claim before final resolution of the claim by~~
31 ~~settlement or trial;~~

32 ~~(g)~~ (g) The disposition of each claim;
33 ~~(h)~~ (g) The amount of money awarded through settlement or
34 by verdict;

35 ~~(i)~~ (h) The sum of money paid to each claimant and the source
36 of that sum;

37 ~~(j)~~ (i) Any sum of money allocated to expenses for the
38 adjustment of losses; and

39 ~~(k)~~ (j) Any other information the Commissioner determines to
40 be necessary or appropriate.

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

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



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

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

5 679B.240 To ascertain compliance with law, or relationships
6 and transactions between any person and any insurer or proposed
7 insurer, the Commissioner may, as often as he or she deems
8 advisable, examine the accounts, records, documents and
9 transactions relating to such compliance or relationships of:

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

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

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

22 4. Any subsidiary of the insurer.

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

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

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

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

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

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

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

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



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

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

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

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

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

21 680A.095 1. Except as otherwise provided in subsection 3,
22 an insurer which is not authorized to transact insurance in this State
23 may not transact reinsurance with a domestic insurer in this State,
24 by mail or otherwise, unless the insurer holds a certificate of
25 authority as a reinsurer in accordance with the provisions of NRS
26 680A.010 to 680A.150, inclusive, 680A.160 to ~~680A.290,~~
27 **680A.280**, inclusive, **and section 16 of this act**, 680A.320 and
28 680A.330.

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

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

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

37 680A.240 1. A property insurer or multiple line insurer
38 authorized to transact insurance in Nevada shall have the right to
39 issue property insurance policies under its own name and under
40 additional "titles" or under additional "titles" duly registered by the
41 insurer with the Commissioner.

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



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

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

10 ~~3.4~~ 4. All business transacted by the insurer under additional
11 titles shall be included in business and transactions of the insurer to
12 be shown by its annual statement filed with the Commissioner, for
13 all purposes under this Code.

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

15 680A.270 1. Each authorized insurer shall annually on or
16 before March 1, or within any reasonable extension of time therefor
17 which the Commissioner for good cause may have granted on or
18 before that date, file with the Commissioner a full and true
19 statement of its financial condition, transactions and affairs as of
20 December 31 preceding. The statement must be:

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

27 (b) Prepared in accordance with:

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

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

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

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



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

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

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

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

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

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

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

30 680A.280 1. Any insurer failing, without just cause beyond
31 the reasonable control of the insurer, to file ~~its} an~~ annual statement
32 as required in NRS **680A.265 and** 680A.270 shall be required to pay
33 a penalty of \$100 for each day's delay, but not to exceed \$3,000 in
34 aggregate amount, to be recovered in the name of the State of
35 Nevada by the Attorney General.

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

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

41 680B.020 1. Notwithstanding the provisions of any general
42 or special law, the possession of a license or certificate of authority
43 issued under this Code shall be authorization to transact such
44 business as indicated in such license or certificate of authority, and
45 shall be in lieu of all licenses, whether for regulation or revenue,



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

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

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

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

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

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

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

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

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

26 *2. A regulation adopted pursuant to this section may require*
27 *the ceding insurer, in calculating the amounts or forms of security*
28 *required to be held pursuant to regulations adopted pursuant to*
29 *this section, to use the Valuation Manual, as defined in NRS*
30 *681B.0071, which is in effect on the date as of which the*
31 *calculation is made, to the extent applicable.*

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

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

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

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

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



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

2 681A.140 As used in NRS 681A.140 to 681A.240, inclusive,
3 *and section 22 of this act*, “qualified financial institution in the
4 United States” means an institution that:

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

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

12 3. Is determined:

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

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

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

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

21 683A.060 1. A “managing general agent” is a person who:

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

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

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

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

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

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

40 (a) An employee of the insurer;

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

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

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



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

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

6 683A.0892 1. The Commissioner:

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

10 (1) Is in an unsound financial condition;

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

10 (1) The administrator is impaired or insolvent;

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

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

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

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

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

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

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

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

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

37 683A.301 1. An applicant for a license as a producer of
38 insurance or a licensee who desires to use a name other than his or
39 her true name as shown on the license shall submit a request for
40 approval of the name and file with the Commissioner a certified
41 copy of the certificate or any renewal certificate filed pursuant to
42 chapter 602 of NRS. An incorporated applicant or licensee shall file
43 with the Commissioner a document showing the corporation's true
44 name and all fictitious names under which it conducts or intends to
45 conduct business. A licensee shall file promptly with the



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

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

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

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

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

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

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

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

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

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

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

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

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

42 683C.020 1. Except as otherwise provided in subsection 2,
43 no person may engage in the business of an insurance consultant
44 unless a license has been issued to the person by the Commissioner.

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



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

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

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

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

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

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

14 684B.030 1. Before the issuance of a motor vehicle physical
15 damage appraiser's license the applicant shall file with the
16 Commissioner, and thereafter maintain in force while so licensed, a
17 surety bond in the amount of \$2,500 in favor of the people of the
18 State of Nevada, executed by an authorized surety insurer approved
19 by the Commissioner, and conditioned for the faithful performance
20 of required duties.

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

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

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

32 685A.150 A licensed surplus lines broker may accept surplus
33 lines business from any ~~agent or broker~~ *producer of insurance*
34 licensed in this state for the kind of insurance involved and may
35 compensate the ~~agent or broker~~ *producer of insurance* therefor.

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

37 686A.290 1. ~~An agent, broker, solicitor,~~ *A producer of*
38 *insurance*, examining physician, applicant or other person shall not
39 knowingly or willfully make any false or fraudulent statement or
40 representation in or with reference to any application for insurance.

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



1 **Sec. 31.** NRS 686A.350 is hereby amended to read as follows:
2 686A.350 1. A license to engage in the business of a
3 company is not required of any:

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

6 (b) State or federally chartered bank.

7 (c) State or federally chartered credit union.

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

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

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

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

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

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

20 686A.420 1. An agreement executed in this state must be
21 dated and signed by the insured. The printed portion of the
22 agreement must be in not less than 8-point type. The agreement
23 must include:

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

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

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

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

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

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

39

40 Notice:

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

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



* A B 8 3 R 2 *

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

2 686A.680 **1.** An insurer that uses information from a
3 consumer credit report shall not:

4 ~~1-1~~ **(a)** Use an insurance score that is calculated using income,
5 gender, address, zip code, ethnic group, religion, marital status or
6 nationality of the consumer as a factor, or would otherwise lead to
7 unfair or invidious discrimination.

8 ~~1-2~~ **(b)** Deny, cancel or fail to renew a policy on the basis of
9 credit information unless the insurer also considers other applicable
10 underwriting factors that are independent of credit information and
11 not expressly prohibited by this section.

12 ~~1-3~~ **(c)** Base renewal rates for a policy upon credit information
13 unless the insurer also considers other applicable factors
14 independent of credit information.

15 ~~1-4~~ **(d)** Take an adverse action against an applicant or
16 policyholder based on the applicant or policyholder not having a
17 credit card account unless the insurer also considers other applicable
18 factors independent of credit information.

19 ~~1-5~~ **(e)** Consider an absence of credit information or an inability
20 to calculate an insurance score in underwriting or rating a policy
21 unless the insurer does any one of the following:

22 ~~1-a~~ **(1)** Treats the applicant or policyholder as otherwise
23 approved by the Commissioner, after the insurer presents to the
24 Commissioner information indicating that such an absence or
25 inability relates to the risk for the insurer.

26 ~~1-b~~ **(2)** Treats the applicant or policyholder as if the applicant
27 or policyholder had neutral credit information, as defined by the
28 insurer.

29 ~~1-c~~ **(3)** Excludes the use of credit information as a factor, and
30 uses only underwriting criteria other than credit information.

31 ~~1-6~~ **(f)** Take an adverse action against an applicant or
32 policyholder based on credit information, unless an insurer obtains
33 and uses a consumer credit report issued or an insurance score
34 calculated within 90 days from the date the policy is first written or
35 renewal is issued.

36 ~~1-7. Except as otherwise provided in this subsection, use credit~~
37 ~~information regarding a policyholder without obtaining an updated~~
38 ~~consumer credit report regarding the policyholder and recalculating~~
39 ~~the insurance score at least once every 36 months. At the time of the~~
40 ~~annual renewal of a policyholder's policy, the insurer shall, upon the~~
41 ~~request of the policyholder or the policyholder's agent, reunderwrite~~
42 ~~and rerate the policy based upon a current consumer credit report or~~
43 ~~insurance score. An insurer need not, at the request of a policyholder~~
44 ~~or the policyholder's agent, recalculate the insurance score or~~
45 ~~obtain an updated consumer credit report of the policyholder more~~



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

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

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

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

20 ~~—(d) The insurer reevaluates the policyholder at least once every~~
21 ~~36 months based upon underwriting or rating factors other than~~
22 ~~credit information.~~

23 ~~—8.1 (g) Use the following as a negative factor in any insurance~~
24 ~~scoring methodology or in reviewing credit information for the~~
25 ~~purpose of underwriting or rating a policy:~~

26 ~~[(a)] (1) Credit inquiries not initiated by the applicant or~~
27 ~~policyholder, or inquiries requested by the applicant or policyholder~~
28 ~~for his or her own credit information.~~

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

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

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

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

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



1 *credit report or insurance score. An insurer need not, at the*
2 *request of a policyholder or the policyholder's agent, recalculate*
3 *the insurance score of or obtain an updated consumer credit*
4 *report of the policyholder more frequently than once in any*
5 *12-month period.*

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

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

16 **Sec. 36.** 1. *The Commissioner shall consider each proposed*
17 *increase or decrease in the rate of a health plan issued pursuant to*
18 *the provisions of chapter 689A, 689B, 689C, 695B, 695C, 695D or*
19 *695F of NRS, including, without limitation, long-term care and*
20 *Medicare supplement plans, filed with the Commissioner pursuant*
21 *to subsection 1 of NRS 686B.070. If the Commissioner finds that a*
22 *proposed increase will result in a rate which is not in compliance*
23 *with NRS 686B.050 or subsection 3 of NRS 686B.070, the*
24 *Commissioner shall disapprove the proposal. The Commissioner*
25 *shall approve or disapprove each proposal not later than 60 days*
26 *after the proposal is determined by the Commissioner to be*
27 *complete pursuant to subsection 4. If the Commissioner fails to*
28 *approve or disapprove the proposal within that period, the*
29 *proposal shall be deemed approved.*

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

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



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

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

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

7 ↪ If the hearing is not held within the period specified in
8 paragraph (a) or (b), or if the Commissioner fails to issue an order
9 concerning the proposed rate for which the hearing is held within
10 45 days after the hearing, the proposed rate shall be deemed
11 approved.

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

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

24 1. Is issued by an insurer which:

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

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

31 2. Contains a large-deductible agreement;

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

34 4. Is issued for delivery or renewed on or after January 1,
35 2018.

36 **Sec. 38.** An insurer shall:

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

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



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

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

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

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

25 ***Sec. 40.*** NRS 686B.010 is hereby amended to read as follows:
26 686B.010 1. The Legislature intends that NRS 686B.010 to
27 686B.1799, inclusive, ***and sections 35 to 39, inclusive, of this act***
28 be liberally construed to achieve the purposes stated in subsection 2,
29 which constitute an aid and guide to interpretation but not an
30 independent source of power.

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

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

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

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

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

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



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

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

4 686B.020 As used in NRS 686B.010 to 686B.1799, inclusive,
5 *and sections 35 to 39, inclusive, of this act*, unless the context
6 otherwise requires:

7 1. "Advisory organization," except as limited by NRS
8 686B.1752, means any person or organization which is controlled
9 by or composed of two or more insurers and which engages in
10 activities related to rate making. For the purposes of this subsection,
11 two or more insurers with common ownership or operating in this
12 State under common ownership constitute a single insurer. An
13 advisory organization does not include:

- 14 (a) A joint underwriting association;
- 15 (b) An actuarial or legal consultant; or
- 16 (c) An employee or manager of an insurer.

17 2. "Market segment" means any line or kind of insurance or, if
18 it is described in general terms, any subdivision thereof or any class
19 of risks or combination of classes.

20 3. "Rate service organization" means any person, other than an
21 employee of an insurer, who assists insurers in rate making or filing
22 by:

- 23 (a) Collecting, compiling and furnishing loss or expense
24 statistics;
- 25 (b) Recommending, making or filing rates (b) supplementary rate
26 information; or
- 27 (c) Advising about rate questions, except as an attorney giving
28 legal advice.

29 4. "Supplementary rate information" includes any manual or
30 plan of rates, statistical plan, classification, rating schedule,
31 minimum premium, policy fee, rating rule, rule of underwriting
32 relating to rates and any other information prescribed by regulation
33 of the Commissioner.

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

35 686B.030 1. Except as otherwise provided in subsection 2
36 and NRS 686B.125, the provisions of NRS 686B.010 to 686B.1799,
37 inclusive, *and sections 35 to 39, inclusive, of this act* apply to all
38 kinds and lines of direct insurance written on risks or operations in
39 this State by any insurer authorized to do business in this State,
40 except:

- 41 (a) Ocean marine insurance;
- 42 (b) Contracts issued by fraternal benefit societies;
- 43 (c) Life insurance and credit life insurance;
- 44 (d) Variable and fixed annuities;
- 45 (e) Credit accident and health insurance;



- 1 (f) Property insurance for business and commercial risks;
 - 2 (g) Casualty insurance for business and commercial risks other
 - 3 than insurance covering the liability of a practitioner licensed
 - 4 pursuant to chapters 630 to 640, inclusive, of NRS;
 - 5 (h) Surety insurance;
 - 6 (i) Health insurance offered through a group health plan
 - 7 maintained by a large employer; and
 - 8 (j) Credit involuntary unemployment insurance.
- 9 2. The exclusions set forth in paragraphs (f) and (g) of
- 10 subsection 1 extend only to issues related to the determination or
- 11 approval of premium rates.

12 **Sec. 43.** NRS 686B.040 is hereby amended to read as follows:

13 686B.040 1. Except as otherwise provided in subsection 2,

14 the Commissioner may by rule exempt any person or class of

15 persons or any market segment from any or all of the provisions of

16 NRS 686B.010 to 686B.1799, inclusive, *and sections 35 to 39,*

17 *inclusive, of this act,* if and to the extent that the Commissioner

18 finds their application unnecessary to achieve the purposes of those

19 sections.

20 2. The Commissioner may not, by rule or otherwise, exempt an

21 insurer from the provisions of NRS 686B.010 to 686B.1799,

22 inclusive, *and sections 35 to 39, inclusive, of this act* with regard to

23 insurance covering the liability of a practitioner licensed pursuant to

24 chapter 630, 631, 632 or 633 of NRS for a breach of the

25 practitioner's professional duty toward a patient.

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

27 686B.110 1. ~~The~~ *Except as otherwise provided in section*

28 *36 of this act, the* Commissioner shall consider each proposed

29 increase or decrease in the rate of any kind or line of insurance or

30 subdivision thereof filed with the Commissioner pursuant to

31 subsection 1 of NRS 686B.070. If the Commissioner finds that a

32 proposed increase will result in a rate which is not in compliance

33 with NRS 686B.050 or subsection 3 of NRS 686B.070, the

34 Commissioner shall disapprove the proposal. The Commissioner

35 shall approve or disapprove each proposal no later than 30 days after

36 it is determined by the Commissioner to be complete pursuant to

37 subsection 6. If the Commissioner fails to approve or disapprove the

38 proposal within that period, the proposal shall be deemed approved.

39 2. If the Commissioner disapproves a proposed increase or

40 decrease in any rate pursuant to subsection 1, the Commissioner

41 shall send a written notice of disapproval to the insurer or the rate

42 service organization that filed the proposal. The notice must set

43 forth the reasons the proposal is not in compliance with NRS

44 686B.050 or subsection 3 of NRS 686B.070 and must be sent to the

45 insurer or the rate service organization not more than 30 days after



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

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

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

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

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

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

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



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

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

23 686B.115 1. Any hearing held by the Commissioner to
24 determine whether rates comply with the provisions of NRS
25 686B.010 to 686B.1799, inclusive, *and sections 35 to 39, inclusive,*
26 *of this act* must be open to members of the public.

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

29 3. At any hearing which is held by the Commissioner to
30 determine whether rates comply with the provisions of NRS
31 686B.010 to 686B.1799, inclusive, *and sections 35 to 39, inclusive,*
32 *of this act*, and which involves rates for insurance covering the
33 liability of a practitioner licensed pursuant to chapter 630, 631, 632
34 or 633 of NRS for a breach of the practitioner's professional duty
35 toward a patient, if a person is not otherwise authorized pursuant to
36 this title to become a party to the hearing by intervention, the person
37 is entitled to provide testimony at the hearing if, not later than 2
38 days before the date set for the hearing, the person files with the
39 Commissioner a written statement which states:

40 (a) The name and title of the person;

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

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

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



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

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

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

12 686B.1751 As used in NRS 686B.1751 to 686B.1799,
13 inclusive, *and sections 35, 37, 38 and 39 of this act*, unless the
14 context otherwise requires, the words and terms defined in NRS
15 686B.1752 to 686B.1762, inclusive, *and section 35 of this act* have
16 the meanings ascribed to them in those sections.

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

19 686B.1763 1. NRS 686B.1751 to 686B.1799, inclusive, *and*
20 *sections 35, 37, 38 and 39 of this act*, apply to insurers providing
21 industrial insurance and to the Advisory Organization designated by
22 the Commissioner. The Commissioner shall administer the
23 provisions of these sections.

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

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

28 686B.1789 A hearing required by any of the provisions of NRS
29 686B.1751 to 686B.1799, inclusive, *and sections 35, 37, 38 and 39*
30 *of this act*, is governed by NRS 679B.310 to 679B.370, inclusive,
31 except that any limits of time imposed by NRS 686B.1751 to
32 686B.1799, inclusive, *and sections 35, 37, 38 and 39 of this act*,
33 control.

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

36 686B.1793 1. An insurer or other person who violates any
37 provision of NRS 686B.1751 to 686B.1799, inclusive, *and sections*
38 *35, 37, 38 and 39 of this act*, shall, upon the order of the
39 Commissioner, pay an administrative fine not to exceed \$1,000 for
40 each violation and not to exceed \$10,000 for each willful violation.
41 These administrative fines are in addition to any other penalty
42 provided by law. Any insurer using a rate before it has been filed
43 with the Commissioner as required by NRS 686B.1775, shall be
44 deemed to have committed a separate violation for each day the
45 insurer failed to file the rate.



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

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

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

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

18 **Sec. 52.** *“Covered person” means a policyholder, subscriber,
19 enrollee or other person participating in a network plan.*

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

24 **Sec. 54.** *“Health benefit plan” has the meaning ascribed to it
25 in NRS 695G.019.*

26 **Sec. 55.** *“Health care services” has the meaning ascribed to
27 it in NRS 695G.022.*

28 **Sec. 56.** *“Health carrier” has the meaning ascribed to it in
29 NRS 695G.024.*

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

35 **Sec. 58.** *“Medically necessary” has the meaning ascribed to
36 it in NRS 695G.055.*

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

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



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

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

9 **Sec. 62.** *“Primary care physician” has the meaning ascribed*
10 *to it in NRS 695G.060.*

11 **Sec. 63.** *“Provider of health care” has the meaning ascribed*
12 *to it in NRS 695G.070.*

13 **Sec. 64.** *“Utilization review” has the meaning ascribed to it*
14 *in NRS 695G.080.*

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

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

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

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

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

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

39
40 *Provider of health care agrees that in no event, including*
41 *but not limited to, nonpayment by the health carrier or*
42 *intermediary, insolvency of the health carrier or*
43 *intermediary or breach of this agreement, shall the provider*
44 *of health care bill, charge, collect a deposit from, seek*
45 *compensation, remuneration or reimbursement from, or*



1 *have any recourse against, a covered person or a person*
2 *(other than the health carrier or intermediary) acting on*
3 *behalf of the covered person for health care services*
4 *provided pursuant to this agreement. This agreement does*
5 *not prohibit the provider of health care from collecting*
6 *coinsurance, deductibles or copayments, as specifically*
7 *provided in the evidence of coverage, or fees for uncovered*
8 *services delivered on a fee-for-service basis to covered*
9 *persons. This agreement does not prohibit a provider of*
10 *health care (except for a provider of health care who is*
11 *employed full-time on the staff of the health carrier and has*
12 *agreed to provide health care services exclusively to the*
13 *health carrier's covered persons and no others) and a*
14 *covered person from agreeing to continue health care*
15 *services solely at the expense of the covered person, as long*
16 *as the provider of health care has clearly informed the*
17 *covered person that the health carrier may not cover or*
18 *continue to cover a specific health care service or health*
19 *care services. Except as provided herein, this agreement*
20 *does not prohibit the provider of health care from pursuing*
21 *any available legal remedy.*

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

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

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

39 *(b) NRS 689A.04036, 689B.0303, 695B.1901, 695C.1691 and*
40 *695G.164, as applicable; or*

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

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



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

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

5 *(b) NRS 689A.04036, 689B.0303, 695B.1901, 695C.1691 and*
6 *695G.164, as applicable; or*

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

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

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

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

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

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

35 *1. Terms of payment;*

36 *2. Utilization review;*

37 *3. Quality assessment and improvement;*

38 *4. Credentialing;*

39 *5. Procedures for grievances and appeals;*

40 *6. Requirements for data reporting;*

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

44 *8. Requirements for confidentiality; and*

45 *9. Any applicable federal or state programs.*



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

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

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

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

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

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

30 **Sec. 75.** (Deleted by amendment.)

31 **Sec. 76.** (Deleted by amendment.)

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

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



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

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

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

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

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

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

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

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



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

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

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

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

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

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

23 **Sec. 86.** NRS 687B.385 is hereby amended to read as follows:
24 687B.385 An insurer shall not *refuse to issue*, cancel, refuse to
25 renew or increase the premium for renewal of a policy of motor
26 vehicle insurance covering private passenger cars or commercial
27 vehicles as a result of any ~~claims~~ :

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

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

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

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

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

39 **Sec. 87.** NRS 687B.470 is hereby amended to read as follows:
40 687B.470 1. ~~“Health”~~ *As used in NRS 687B.470 to*
41 *687B.500, inclusive, “health benefit plan” means a policy, contract,*
42 *certificate or agreement offered by a carrier to provide for, deliver*
43 *payment for, arrange for the payment of, pay for or reimburse any of*
44 *the costs of health care services. Except as otherwise provided in*



1 this section, the term includes catastrophic health insurance policies
2 and a policy that pays on a cost-incurred basis.

3 2. The term does not include:

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

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

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

9 (d) Workers' compensation or similar insurance;

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

12 (f) Credit insurance;

13 (g) Coverage for on-site medical clinics;

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

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

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

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

25 (a) Limited-scope dental or vision benefits;

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

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

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

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

39 (b) Hospital indemnity or other fixed indemnity insurance.

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

42 (a) Medicare supplemental health insurance as defined in section
43 1882(g)(1) of the Social Security Act, 42 U.S.C. § 1395ss, as that
44 section existed on July 16, 1997;



* A B 8 3 R 2 *

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

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

6 **Sec. 88.** NRS 687B.490 is hereby amended to read as follows:

7 687B.490 1. A carrier that offers coverage in the *small*
8 *employer* group or individual market must, before making any
9 network plan available for sale in this State, demonstrate the
10 capacity to deliver services adequately by applying to the
11 Commissioner for the issuance of a network plan and submitting a
12 description of the procedures and programs to be implemented to
13 meet the requirements described in subsection 2.

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

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

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

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

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

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

41 5. The Commissioner shall, not less than once each year, or
42 more often if deemed necessary by the Commissioner for the
43 protection of the interests of the people of this State, make a
44 determination concerning the availability and accessibility of the



1 health care services of any network plan approved pursuant to this
2 section.

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

6 7. When making any determination concerning the availability
7 and accessibility of the services of any network plan or proposed
8 network plan pursuant to this section, the Commissioner shall
9 consider services that may be provided through telehealth, as
10 defined in NRS 629.515, pursuant to the network plan or proposed
11 network plan to be available services.

12 8. As used in this section ~~f~~, **“network”**:

13 (a) **“Network plan”** has the meaning ascribed to it in
14 NRS 689B.570.

15 (b) **“Small employer”** has the meaning ascribed to it in
16 **NRS 689C.095.**

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

18 687B.500 1. The premium rate charged by a health insurer
19 for health benefit plans offered in the individual or small **employer**
20 group market may vary with respect to the particular plan or
21 coverage involved based solely on these characteristics:

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

24 (b) Geographic rating area;

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

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

36 2. The provisions of subsection 1:

37 (a) Apply to a fraternal benefit society organized under chapter
38 695A of NRS; and

39 (b) Do not apply to grandfathered plans.

40 **3. As used in this section, “small employer”** has the meaning
41 **ascribed to it in NRS 689C.095.**

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

43 689.185 1. Except as otherwise provided in subsection 2:

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



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

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

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

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

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

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

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

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

33 689.495 1. Except as otherwise provided in subsection 2:

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

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



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

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

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

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

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

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

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

24 *1. An individual carrier shall make the unified rate review*
25 *template and rate filing documentation used by the individual*
26 *carrier and any information and documents described in any*
27 *regulations adopted pursuant to 689A.700 available to the*
28 *Commissioner upon request. Except in cases of violations of the*
29 *provisions of this chapter, the unified rate review template and*
30 *rate filing documentation used by an individual carrier are*
31 *considered proprietary, constitute a trade secret and are not*
32 *subject to disclosure by the Commissioner to persons outside of the*
33 *Division except as agreed to by the individual carrier or as ordered*
34 *by a court of competent jurisdiction.*

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

38 **Sec. 93.** NRS 689A.020 is hereby amended to read as follows:

39 689A.020 Nothing in this chapter applies to or affects:

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

42 2. Any group or blanket policy.

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



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

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

7 4. Reinsurance, except as otherwise provided in NRS
8 689A.470 to 689A.740, inclusive, *and section 92 of this act*, and
9 689C.610 to 689C.940, inclusive, relating to the program of
10 reinsurance.

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

13 689A.04033 1. A policy of health insurance must provide
14 coverage for medical treatment which a policyholder or subscriber
15 receives as part of a clinical trial or study if:

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

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

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

23 (2) A cooperative group;

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

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

27 (5) The United States Department of Defense;

28 (c) In the case of:

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

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

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

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

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



1 (g) The policyholder or subscriber has signed, before
2 participating in the clinical trial or study, a statement of consent
3 indicating that the policyholder or subscriber has been informed of,
4 without limitation:

5 (1) The procedure to be undertaken;

6 (2) Alternative methods of treatment; and

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

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

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

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

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

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

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

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

37 ➤ Except as otherwise provided in NRS 689A.04036, the services
38 provided pursuant to paragraphs (b), (c), (e) and (f) must be covered
39 only if the services are provided by a provider with whom the
40 insurer has contracted for such services. If the insurer has not
41 contracted for the provision of such services, the insurer shall pay
42 the provider the rate of reimbursement that is paid to other providers
43 with whom the insurer has contracted for similar services and the
44 provider shall accept that rate of reimbursement as payment in full.



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

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

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

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

14 (c) Health care services that are specifically excluded from
15 coverage under the policyholder's or subscriber's policy of health
16 insurance, regardless of whether such services are provided under
17 the clinical trial or study.

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

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

24 (f) Any expenses incurred by a person who accompanies the
25 policyholder or subscriber during the clinical trial or study.

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

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

31 5. An insurer who delivers or issues for delivery a policy of
32 health insurance specified in subsection 1 may require copies of the
33 approval or certification issued pursuant to paragraph (b) of
34 subsection 1, the statement of consent signed by the policyholder or
35 subscriber, protocols for the clinical trial or study and any other
36 materials related to the scope of the clinical trial or study relevant to
37 the coverage of medical treatment pursuant to this section.

38 6. An insurer who delivers or issues for delivery a policy
39 specified in subsection 1 shall:

40 (a) Include in ~~the~~ *any* disclosure ~~required pursuant to NRS~~
41 ~~689A.390~~ *of the coverage provided by the policy* notice to each
42 policyholder and subscriber under the policy of the availability of
43 the benefits required by this section.



1 (b) Provide the coverage required by this section subject to the
2 same deductible, copayment, coinsurance and other such conditions
3 for coverage that are required under the policy.

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

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

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

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

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

19 (b) Any adverse or unanticipated outcome arising out of a
20 policyholder's or subscriber's participation in a clinical trial or study
21 described in this section.

22 9. As used in this section:

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

27 (1) The Clinical Trials Cooperative Group Program; and

28 (2) The Community Clinical Oncology Program.

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

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

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

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

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



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

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

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

9 (c) "Provider of health care" means:

10 (1) A hospital; or

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

12 NRS.

13 **Sec. 95.** NRS 689A.0427 is hereby amended to read as
14 follows:

15 689A.0427 1. No policy of health insurance that provides
16 coverage for hospital, medical or surgical expenses may be
17 delivered or issued for delivery in this state unless the policy
18 includes coverage for the management and treatment of diabetes,
19 including, without limitation, coverage for the self-management of
20 diabetes.

21 2. An insurer who delivers or issues for delivery a policy
22 specified in subsection 1:

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

27 (b) Shall provide the coverage required by this section subject to
28 the same deductible, copayment, coinsurance and other such
29 conditions for coverage that are required under the policy.

30 3. A policy of health insurance subject to the provisions of this
31 chapter that is delivered, issued for delivery or renewed on or after
32 January 1, 1998, has the legal effect of including the coverage
33 required by this section, and any provision of the policy that
34 conflicts with this section is void.

35 4. As used in this section:

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

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

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



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

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

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

10 **Sec. 96.** NRS 689A.470 is hereby amended to read as follows:
11 689A.470 As used in NRS 689A.470 to 689A.740, inclusive,
12 *and section 92 of this act*, unless the context otherwise requires, the
13 words and terms defined in NRS 689A.475 to 689A.600, inclusive,
14 have the meanings ascribed to them in those sections.

15 **Sec. 97.** NRS 689A.615 is hereby amended to read as follows:
16 689A.615 For the purposes of NRS 689A.470 to 689A.740,
17 inclusive ~~†~~, *and section 92 of this act*:

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

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

30 **Sec. 98.** NRS 689A.630 is hereby amended to read as follows:
31 689A.630 1. Except as otherwise provided in this section,
32 coverage under an individual health benefit plan must be renewed
33 by the individual carrier that issued the plan, at the option of the
34 individual, unless:

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

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

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



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

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

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

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

24 2. An individual carrier may discontinue ~~{the issuance and~~
25 ~~renewal of a form of}~~ a product ~~{of a health benefit plan if the~~
26 ~~Commissioner finds that the form of the product offered by the~~
27 ~~individual carrier is obsolete and is being replaced with comparable~~
28 ~~coverage. A form of a product of a health benefit plan may be~~
29 ~~discontinued by the individual carrier}~~ pursuant to this subsection
30 only if:

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

37 (b) The individual carrier notifies each person covered by the
38 discontinued ~~{insurance, the Commissioner and the chief regulatory~~
39 ~~officer for insurance in each state in which a person covered by the~~
40 ~~discontinued insurance is known to reside}~~ **product** of the decision
41 of the individual carrier to discontinue offering ~~{the form of}~~
42 the product. The notice must be made to persons covered by the
43 discontinued ~~{insurance}~~ **product** at least ~~{180}~~ **90** days before the
44 date on which the individual carrier will discontinue offering ~~{the~~
45 ~~form of}~~ the product.



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

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

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

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

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

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

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

28 5. If an individual carrier does business in only one geographic
29 service area of this state, the provisions of this section apply only to
30 the operations of the individual carrier in that service area.

31 **Sec. 99.** NRS 689A.700 is hereby amended to read as follows:

32 689A.700 The Commissioner may adopt regulations ~~to carry~~
33 ~~out the provisions of this section and NRS 689A.690 and~~ to ensure
34 that the practices used by individual carriers relating to the
35 establishment of rates are consistent with the purposes of NRS
36 689A.470 to 689A.740, inclusive ~~+~~, **and section 92 of this act.**

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

39 689A.715 1. An employee welfare benefit plan for providing
40 benefits for employees of more than one employer under which
41 individual health insurance coverage is provided must comply with
42 the provisions of NRS 679B.139 and 689A.470 to 689A.740,
43 inclusive, **and section 92 of this act**, and the regulations adopted by
44 the Commissioner pursuant thereto.



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

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

8 689A.725 For the purposes of NRS 689A.470 to 689A.740,
9 inclusive, *and section 92 of this act*, a plan for coverage of a bona
10 fide association must:

11 1. Conform with *any regulations adopted pursuant to* NRS
12 ~~689A.690 and~~ 689A.700 concerning rates.

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

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

18 689A.740 The Commissioner shall adopt regulations as
19 necessary to carry out the provisions of NRS 689A.470 to
20 689A.740, inclusive ~~H~~, *and section 92 of this act*.

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

23 689A.745 1. Except as otherwise provided in subsection 4,
24 each insurer that issues a policy of health insurance in this State
25 shall establish a system for resolving any complaints of an insured
26 concerning health care services covered under the policy. The
27 system must be approved by the Commissioner . ~~in consultation~~
28 ~~with the State Board of Health.~~

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

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

39 4. Each insurer that issues a policy of health insurance in this
40 State that provides, delivers, arranges for, pays for or reimburses
41 any cost of health care services through managed care shall provide
42 a system for resolving any complaints of an insured concerning
43 those health care services that complies with the provisions of NRS
44 695G.200 to 695G.310, inclusive.



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

3 689A.750 1. Each insurer that issues a policy of health
4 insurance in this State shall submit to the Commissioner ~~and the~~
5 ~~State Board of Health~~ an annual report regarding its system for
6 resolving complaints established pursuant to subsection 1 of NRS
7 689A.745 on a form prescribed by the Commissioner ~~in~~
8 ~~consultation with the State Board of Health~~ which includes, without
9 limitation:

10 (a) A description of the procedures used for resolving any
11 complaints of an insured;

12 (b) The total number of complaints and appeals handled through
13 the system for resolving complaints since the last report and a
14 compilation of the causes underlying the complaints filed;

15 (c) The current status of each complaint and appeal filed; and

16 (d) The average amount of time that was needed to resolve a
17 complaint and an appeal, if any.

18 2. Each insurer shall maintain records of complaints filed with
19 it which concern something other than health care services and shall
20 submit to the Commissioner a report summarizing such complaints
21 at such times and in such format as the Commissioner may require.

22 **Sec. 105.** NRS 689B.0285 is hereby amended to read as
23 follows:

24 689B.0285 1. Except as otherwise provided in subsection 4,
25 each insurer that issues a policy of group health insurance in this
26 State shall establish a system for resolving any complaints of an
27 insured concerning health care services covered under the policy.
28 The system must be approved by the Commissioner . ~~in~~
29 ~~consultation with the State Board of Health.~~

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

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

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



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

3 689B.029 1. Each insurer that issues a policy of group health
4 insurance in this State shall submit to the Commissioner ~~and the~~
5 ~~State Board of Health~~ an annual report regarding its system for
6 resolving complaints established pursuant to subsection 1 of NRS
7 689B.0285 on a form prescribed by the Commissioner ~~in~~
8 ~~consultation with the State Board of Health~~ which includes, without
9 limitation:

10 (a) A description of the procedures used for resolving any
11 complaints of an insured;

12 (b) The total number of complaints and appeals handled through
13 the system for resolving complaints since the last report and a
14 compilation of the causes underlying the complaints filed;

15 (c) The current status of each complaint and appeal filed; and

16 (d) The average amount of time that was needed to resolve a
17 complaint and an appeal, if any.

18 2. Each insurer shall maintain records of complaints filed with
19 it which concern something other than health care services and shall
20 submit to the Commissioner a report summarizing such complaints
21 at such times and in such format as the Commissioner may require.

22 **Sec. 107.** NRS 689B.0306 is hereby amended to read as
23 follows:

24 689B.0306 1. A policy of group health insurance must
25 provide coverage for medical treatment which a person insured
26 under the group policy receives as part of a clinical trial or study if:

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

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

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

34 (2) A cooperative group;

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

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

38 (5) The United States Department of Defense;

39 (c) In the case of:

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

44 (2) A Phase II, Phase III or Phase IV study or clinical trial
45 for the treatment of cancer or chronic fatigue syndrome, the medical



1 treatment is provided by a provider of health care and the facility
2 and personnel for the clinical trial or study have the experience and
3 training to provide the treatment in a capable manner;

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

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

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

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

14 (1) The procedure to be undertaken;

15 (2) Alternative methods of treatment; and

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

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

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

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

32 (c) The cost of any routine health care services that would
33 otherwise be covered under the policy of group health insurance for
34 an insured participating in a Phase I clinical trial or study.

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

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

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

44 ➤ Except as otherwise provided in NRS 689B.0303, the services
45 provided pursuant to paragraphs (b), (c), (e) and (f) must be covered



1 only if the services are provided by a provider with whom the
2 insurer has contracted for such services. If the insurer has not
3 contracted for the provision of such services, the insurer shall pay
4 the provider the rate of reimbursement that is paid to other providers
5 with whom the insurer has contracted for similar services and the
6 provider shall accept that rate of reimbursement as payment in full.

7 3. Particular medical treatment described in subsection 2 and
8 provided to a person insured under the group policy is not required
9 to be covered pursuant to this section if that particular medical
10 treatment is provided by the sponsor of the clinical trial or study free
11 of charge to the person insured under the group policy.

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

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

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

20 (c) Health care services that are specifically excluded from
21 coverage under the insured's policy of group health insurance,
22 regardless of whether such services are provided under the clinical
23 trial or study.

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

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

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

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

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

37 5. An insurer who delivers or issues for delivery a policy of
38 group health insurance specified in subsection 1 may require copies
39 of the approval or certification issued pursuant to paragraph (b) of
40 subsection 1, the statement of consent signed by the insured,
41 protocols for the clinical trial or study and any other materials
42 related to the scope of the clinical trial or study relevant to the
43 coverage of medical treatment pursuant to this section.

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



1 (a) Include in ~~the~~ any disclosure ~~required pursuant to NRS~~
2 ~~689B.027~~ *of the coverage provided by the policy* notice to each
3 group policyholder of the availability of the benefits required by this
4 section.

5 (b) Provide the coverage required by this section subject to the
6 same deductible, copayment, coinsurance and other such conditions
7 for coverage that are required under the policy.

8 7. A policy of group health insurance subject to the provisions
9 of this chapter that is delivered, issued for delivery or renewed on or
10 after January 1, 2006, has the legal effect of including the coverage
11 required by this section, and any provision of the policy that
12 conflicts with this section is void.

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

16 (a) Any injury to the insured caused by:

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

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

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

27 9. As used in this section:

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

32 (1) The Clinical Trials Cooperative Group Program; and

33 (2) The Community Clinical Oncology Program.

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

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

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

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



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

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

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

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

13 (c) "Provider of health care" means:

14 (1) A hospital; or

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

16 NRS.

17 **Sec. 108.** NRS 689B.0357 is hereby amended to read as
18 follows:

19 689B.0357 1. No group policy of health insurance that
20 provides coverage for hospital, medical or surgical expenses may be
21 delivered or issued for delivery in this state unless the policy
22 includes coverage for the management and treatment of diabetes,
23 including, without limitation, coverage for the self-management of
24 diabetes.

25 2. An insurer who delivers or issues for delivery a policy
26 specified in subsection 1:

27 (a) Shall include in ~~the~~ *any* disclosure ~~required pursuant to~~
28 ~~NRS 689B.0271~~ *of the coverage provided by the policy* notice to
29 each policyholder and subscriber under the policy of the availability
30 of the benefits required by this section.

31 (b) Shall provide the coverage required by this section subject to
32 the same deductible, copayment, coinsurance and other such
33 conditions for coverage that are required under the policy.

34 3. A policy subject to the provisions of this chapter that is
35 delivered, issued for delivery or renewed on or after January 1,
36 1998, has the legal effect of including the coverage required by this
37 section, and any provision of the policy that conflicts with this
38 section is void.

39 4. As used in this section:

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

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



1 (1) The training and education provided to the employee or
2 member of the insured group after the employee or member is
3 initially diagnosed with diabetes which is medically necessary for
4 the care and management of diabetes, including, without limitation,
5 counseling in nutrition and the proper use of equipment and supplies
6 for the treatment of diabetes;

7 (2) Training and education which is medically necessary as a
8 result of a subsequent diagnosis that indicates a significant change
9 in the symptoms or condition of the employee or member of the
10 insured group and which requires modification of his or her program
11 of self-management of diabetes; and

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

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

16 **Sec. 109.** NRS 689B.061 is hereby amended to read as
17 follows:

18 689B.061 A policy of group health insurance which offers a
19 difference of payment between preferred providers of health care
20 and providers of health care who are not preferred:

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

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

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

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



1 ~~15.1~~ 4. Must require the insurer to process a claim of a provider
2 of health care who is not preferred not later than 30 working days
3 after the date on which proof of the claim is received.

4 **Sec. 110.** NRS 689B.560 is hereby amended to read as
5 follows:

6 689B.560 1. Except as otherwise provided in this section,
7 coverage under a policy of group health insurance must be renewed
8 by the carrier at the option of the plan sponsor, unless:

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

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

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

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

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

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

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

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

41 (a) The carrier notifies the Commissioner ~~and the chief~~
42 ~~regulatory officer in each state in which it is licensed~~ of its decision
43 pursuant to this subsection to discontinue ~~the issuance and renewal~~
44 ~~of the form of~~ the product at least 60 days before the ~~individual~~



1 carrier notifies the *affected employers and* persons covered ~~by the~~
2 ~~discontinued insurance~~ pursuant to paragraph (b).

3 (b) The carrier notifies each *affected employer and* person
4 covered ~~by the discontinued insurance and the Commissioner and~~
5 ~~the chief regulatory officer in each state in which such a person is~~
6 ~~known to reside~~ of the decision of the carrier to discontinue
7 ~~offering the form of~~ the product. The notice must be made at least
8 ~~180~~ 90 days before the date on which the carrier will discontinue
9 offering ~~the form of~~ the product.

10 (c) The carrier offers to each ~~person covered by the~~
11 ~~discontinued insurance~~ *affected employer* the option to purchase
12 any other health benefit plan currently offered by the carrier to
13 ~~large~~ groups in this state.

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

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

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

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

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

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

39 5. If the carrier does business in only one geographic service
40 area of this state, the provisions of this section apply only to the
41 operations of the carrier in that service area.

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



1 **Sec. 111.** NRS 689C.111 is hereby amended to read as
2 follows:

3 689C.111 ~~1. If an employer was not in existence throughout~~
4 ~~the entire preceding calendar year, the determination of whether the~~
5 ~~employer is a small or large employer must be based on the average~~
6 ~~number of employees reasonably expected to be employed on~~
7 ~~business days in the current calendar year.~~

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

15 ~~3.1~~ An employee leasing company which has more than 50
16 employees, including leased employees at client locations, and
17 which sponsors a fully insured health benefit plan for those
18 employees shall be deemed to be a large employer for the purposes
19 of this chapter.

20 **Sec. 112.** NRS 689C.310 is hereby amended to read as
21 follows:

22 689C.310 1. Except as otherwise provided in subsections 2
23 and 3, a carrier shall renew a health benefit plan at the option of the
24 small employer who purchased the plan.

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

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

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

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

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

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

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

42 3. A carrier may require a small employer to exclude a
43 particular employee or a dependent of the particular employee from
44 coverage under a health benefit plan as a condition to renewal of the
45 plan if the employee or dependent of the employee commits fraud



1 upon the carrier or misrepresents a material fact which affects his or
2 her coverage under the plan.

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

11 5. A carrier may discontinue ~~the issuance and renewal of a~~
12 ~~form of~~ a product ~~of a health benefit plan~~ offered to small
13 employers ~~pursuant to this chapter if the Commissioner finds that~~
14 ~~the form of the product offered by the carrier is obsolete and is~~
15 ~~being replaced with comparable coverage. A form of a product of a~~
16 ~~health benefit plan may be discontinued by a carrier~~ pursuant to this
17 subsection only if:

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

24 (b) The carrier notifies each affected small employer ~~and the~~
25 ~~Commissioner and the chief regulatory officer for insurance in each~~
26 ~~state in which any affected small employer is located or eligible~~
27 ~~employee resides~~ of the decision of the carrier to discontinue
28 ~~offering the form of~~ the product. The notice must be made at least
29 ~~180~~ 90 days before the date on which the carrier will discontinue
30 offering ~~the form of~~ the product.

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

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

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



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

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

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

9 7. If a carrier does business in only one geographic service area
10 of this state, the provisions of this section apply only to the
11 operations of the carrier in that service area.

12 **Sec. 113.** NRS 689C.350 is hereby amended to read as
13 follows:

14 689C.350 A health benefit plan which offers a difference of
15 payment between preferred providers of health care and providers of
16 health care who are not preferred:

17 1. Must require that the deductible and payment for
18 coinsurance paid by the insured to a preferred provider of health
19 care be applied to the negotiated reduced rates of that provider.

20 2. ~~Must include for providers of health care who are not~~
21 ~~preferred a provision establishing the point at which an insured's~~
22 ~~payment for coinsurance is no longer required to be paid if such a~~
23 ~~provision is included for preferred providers of health care. Such~~
24 ~~provisions must be based on a plan year. The point at which an~~
25 ~~insured's payment for coinsurance is no longer required to be paid~~
26 ~~for providers of health care who are not preferred must not be~~
27 ~~greater than twice the amount for preferred providers of health care,~~
28 ~~regardless of the method of payment.~~

29 ~~3.~~ Must provide that if there is a particular service which a
30 preferred provider of health care does not provide and the provider
31 of health care who is treating the insured requests the service and
32 the insurer determines that the use of the service is necessary for the
33 health of the insured, the service shall be deemed to be provided by
34 the preferred provider of health care.

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

37 689C.470 1. Except as otherwise provided in NRS 689C.360
38 to 689C.600, inclusive, a carrier shall renew a contract as to all
39 insured small employers that are members of a voluntary purchasing
40 group and their employees and dependents at the request of the
41 purchaser unless:

42 (a) Required premiums are not paid;

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

45 (c) Provisions of the contract are breached;



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

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

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

13 2. A carrier may discontinue ~~issuance and renewal of a form~~
14 ~~of~~ a product ~~of a health benefit plan~~ offered to a small employer
15 or purchasers pursuant to NRS 689C.360 to 689C.600, inclusive, ~~if~~
16 ~~the Commissioner finds that the form of the product offered by the~~
17 ~~carrier is obsolete and is being replaced with comparable coverage.~~
18 ~~A form of a product of a health benefit plan may be discontinued by~~
19 ~~a carrier pursuant to this subsection~~ only if:

20 (a) The carrier notifies the Commissioner ~~and the chief~~
21 ~~regulatory officer for insurance in each state in which it is licensed~~
22 of its decision pursuant to this subsection to discontinue ~~offering~~
23 ~~and renewing the form of~~ the product at least 60 days before the
24 carrier notifies the affected small employers and purchasers
25 pursuant to paragraph (b).

26 (b) The carrier notifies each affected small employer and
27 purchaser ~~, and the Commissioner and the chief regulatory officer~~
28 ~~for insurance in each state in which any affected small employer is~~
29 ~~located or employee resides,~~ of the decision of the carrier to
30 discontinue ~~offering the form of~~ the product. The notice must be
31 made at least ~~180~~ 90 days before the date on which the carrier will
32 discontinue offering ~~the form of~~ the product.

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

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

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



* A B 8 3 R 2 *

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

4 (b) The membership of that small employer or the purchaser in
5 the association ceases; and

6 (c) The coverage is terminated pursuant to this subsection
7 uniformly without regard to any health status-related factor relating
8 to the small employer or the purchaser or his or her dependent.

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

11 689C.520 1. Before the issuance of a certificate of
12 registration, each voluntary purchasing group shall, to the
13 satisfaction of the Commissioner:

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

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

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

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

32 690B.200 As used in NRS 690B.200 to ~~690B.370,~~ **690B.360,**
33 inclusive, unless the context otherwise requires, the words and terms
34 defined in NRS 690B.210 to 690B.240, inclusive, have the
35 meanings ascribed to them in those sections.

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

38 690B.250 Except as more is required in NRS 630.3067 and
39 633.526:

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



1 more than \$5,000, giving the name ~~{and address}~~ of the claimant and
2 the practitioner and the circumstances of the case.

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

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

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

16 690B.260 1. Each insurer which issues a policy of insurance
17 covering the liability of a physician licensed under chapter 630 of
18 NRS or an osteopathic physician licensed under chapter 633 of NRS
19 for a breach of his or her professional duty toward a patient shall,
20 within 45 days after the end of a calendar quarter, submit a report to
21 the Commissioner concerning each claim that was closed during that
22 calendar quarter under such a policy of insurance issued by the
23 insurer and any change during that calendar quarter to any claim
24 under such a policy of insurance issued by the insurer that was
25 closed during a previous calendar quarter. The report must include,
26 without limitation:

27 (a) The name ~~{and address}~~ of the claimant and the insured
28 under each policy;

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

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

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

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

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

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

44 690B.350 1. *The requirements of this section apply only if,*
45 *after a hearing convened at the discretion of the Commissioner,*



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

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

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

20 ~~12~~ 4. If an insurer intends to cancel, terminate or otherwise
21 not renew a specific policy of professional liability insurance that it
22 has issued to a practitioner who is practicing in one or more of the
23 essential medical specialties designated by the Commissioner:

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

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

30 ~~13~~ 5. If an insurer intends to cancel, terminate or otherwise
31 not renew all policies of professional liability insurance that it has
32 issued to practitioners who are practicing in one or more of the
33 essential medical specialties designated by the Commissioner:

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

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

41 ~~14. On or before April 1 of each year, the Commissioner shall:~~
42 ~~—(a) Determine whether there are any medical specialties in this~~
43 ~~State which are essential as a matter of public policy and which~~
44 ~~must be protected pursuant to this section from certain adverse~~
45 ~~actions relating to professional liability insurance that may impair~~



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

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

8 ~~—5.} 6.~~ The Commissioner may adopt any regulations that are
9 necessary to carry out the provisions of this section.

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

14 ~~—(a) Emergency medicine.~~

15 ~~—(b) Neurosurgery.~~

16 ~~—(c) Obstetrics and gynecology.~~

17 ~~—(d) Orthopedic surgery.~~

18 ~~—(e) Pediatrics.~~

19 ~~—(f) Trauma surgery.}~~

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

22 690B.360 1. The Commissioner ~~{shall}~~ *may* collect all
23 information which is pertinent to monitoring whether an insurer that
24 issues professional liability insurance for a practitioner licensed
25 pursuant to chapter 630, 631, 632 or 633 of NRS is complying with
26 the applicable standards for rates established in NRS 686B.010 to
27 686B.1799, inclusive ~~{}~~, *and sections 35 to 39, inclusive, of this*
28 *act.* Such information ~~{must}~~ *may* include, without limitation:

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

31 (b) Information relating to loss ratios;

32 (c) Information reported pursuant to NRS ~~{690B.250;}~~
33 *690B.260;* and

34 (d) Information reported pursuant to NRS 679B.430 and
35 679B.440.

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

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

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



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

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

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

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

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

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

18 ~~(b) Prepare~~

19 **5. If the Commissioner convenes a hearing pursuant to**
20 **subsection 1 of NRS 690B.350 and determines that the market for**
21 **professional liability insurance issued to any class, type or**
22 **specialty of practitioner licensed pursuant to chapter 630, 631 or**
23 **633 of NRS is not competitive and that such insurance is**
24 **unavailable or unaffordable for a substantial number of such**
25 **practitioners, the Commissioner shall prepare** and submit a report
26 of the Commissioner's findings and recommendations to the
27 Director of the Legislative Counsel Bureau for transmittal to
28 members of the Legislature. ~~on or before November 15 of each~~
29 ~~year.~~

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

33 **Sec. 122. "Controlling person" means a person who**
34 **qualifies as a controlling person of a provider pursuant to section**
35 **123 of this act.**

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

38 **1. Is an officer of the provider; or**

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

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



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

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

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

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

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

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

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

24 690C.010 As used in this chapter, unless the context otherwise
25 requires, the words and terms defined in NRS 690C.020 to
26 690C.080, inclusive, *and section 122 of this act*, have the meanings
27 ascribed to them in those sections.

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

30 690C.100 1. The provisions of this title do not apply to:

31 (a) A warranty;

32 (b) A maintenance agreement;

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

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

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

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



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

4 3. As used in this section:

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

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

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

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

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

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

18 690C.160 1. A provider who wishes to issue, sell or offer for
19 sale service contracts in this state must submit to the Commissioner:

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

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

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

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

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

30 ***(f) The following information for each controlling person:***

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

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

34 ***(II) Insolvent or adjudged bankrupt;***

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

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

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

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



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

5 (a) An application on a form prescribed by the Commissioner ~~to~~
6 ~~it~~;

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

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

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

13 (2) *For a controlling person who has not previously*
14 *submitted the information required by paragraph (f) of subsection*
15 *1 to the Commissioner.*

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

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

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

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

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

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

31 690C.170 1. To be issued a certificate of registration, a
32 provider must comply with one of the following ~~to~~:

33 ~~1.1~~ *to provide for financial security:*

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

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

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



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

3 ~~12-1~~ (b) Maintain a reserve account *in this State* and deposit
4 with the Commissioner security as provided in this subsection. The
5 reserve account must contain at all times an amount of money equal
6 to at least 40 percent of the unearned gross consideration received
7 by the provider for any unexpired service contracts. *The reserve*
8 *account must be kept separate from the operating accounts of the*
9 *provider and must be clearly identified as the “(Provider’s Name)*
10 *Nevada Service Contracts Funded Reserve Account.”* The
11 Commissioner may examine the reserve account at any time. The
12 provider shall also deposit with the Commissioner security in an
13 amount that is equal to \$25,000 or 10 percent of the unearned gross
14 consideration received by the provider for any unexpired service
15 contracts, whichever is greater. The security must be:

16 ~~11-a~~ (1) A surety bond issued by a surety company authorized
17 to do business in this State;

18 ~~11-b~~ (2) Securities of the type eligible for deposit pursuant to
19 NRS 682B.030;

20 ~~11-c~~ (3) Cash;

21 ~~11-d~~ (4) An irrevocable letter of credit issued by a financial
22 institution approved by the Commissioner; or

23 ~~11-e~~ (5) In any other form prescribed by the Commissioner.

24 ~~13-1~~ (c) Maintain, or be a subsidiary of a parent company that
25 maintains, a net worth or stockholders’ equity of at least
26 \$100,000,000. Upon request, a provider shall provide to the
27 Commissioner a copy of the most recent Form 10-K report or Form
28 20-F report filed by the provider or parent company of the provider
29 with the Securities and Exchange Commission within the previous
30 year. If the provider or parent company is not required to file those
31 reports with the Securities and Exchange Commission, the provider
32 shall provide to the Commissioner a copy of the most recently
33 audited financial statements of the provider or parent company. If
34 the net worth or stockholders’ equity of the parent company of the
35 provider is used to comply with the requirements of this subsection,
36 the parent company must guarantee to carry out the duties of the
37 provider under any service contract issued or sold by the provider.

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

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

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



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

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

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

14 690C.240 1. A provider ~~{who, whether directly or through a~~
15 ~~vehicle dealer licensed pursuant to NRS 482.325, enters into a~~
16 ~~vehicle service contract with a buyer}~~ shall, within 30 days after
17 ceasing doing business in this State, notify ~~{any buyer who~~
18 ~~purchased such a contract}~~ *the Commissioner and each holder of*
19 *an unexpired service contract* in writing of the fact that the provider
20 has ceased doing business in this State . ~~{if the specified period of~~
21 ~~the vehicle service contract has not yet expired.}~~

22 2. The provisions of this section do not:

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

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

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

27 ~~{3. As used in this section:~~

28 ~~—(a) “Buyer” means the buyer of a vehicle service contract.~~

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

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

42 691C.340 ~~{~~ *H. The Commissioner shall, by regulation,*
43 *establish reasonable rates as described in this chapter and in*
44 *accordance with the standards established in NRS 686B.050 and*
45 *686B.060. The rates must be reasonable in relation to the benefits*



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

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

- 7 ~~[(a)]~~ 1. Actual and expected loss experience;
- 8 ~~[(b)]~~ 2. General and administrative expenses;
- 9 ~~[(c)]~~ 3. Loss settlement and adjustment expenses;
- 10 ~~[(d)]~~ 4. Reasonable creditor compensation;
- 11 ~~[(e)]~~ 5. The manner in which premiums are charged;
- 12 ~~[(f)]~~ 6. Other acquisition costs;
- 13 ~~[(g)]~~ 7. Reserves;
- 14 ~~[(h)]~~ 8. Taxes;
- 15 ~~[(i)]~~ 9. Regulatory license fees and fund assessments;
- 16 ~~[(j)]~~ 10. Reasonable insurer profit; and
- 17 ~~[(k)]~~ 11. Other relevant data consistent with generally

18 accepted actuarial standards.

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

21 691C.390 1. Each individual policy or certificate of
22 insurance must provide for a refund of unearned premiums if the
23 credit personal property insurance is cancelled before the scheduled
24 date of termination of the insurance.

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

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

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

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

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



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

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

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

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

23 3. *As used in this section:*

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

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

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

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

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

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

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

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

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

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

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



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

3 695B.150 *1.* A corporation organized under this chapter shall
4 be deemed to be insolvent if ~~fits~~ :

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

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

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

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

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

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

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

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

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



1 **679B.370, inclusive, at the request of any party to the proceedings**
2 **whose interests are substantially affected.**

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

5 695B.185 A group contract for hospital, medical or dental
6 services which offers a difference of payment between preferred
7 providers of health care and providers of health care who are not
8 preferred:

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

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

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

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

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

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

37 ~~—7.†~~ Must provide that if there is a particular service which a
38 preferred provider of health care does not provide and the provider
39 of health care who is treating the insured determines that the use of
40 the service is necessary for the health of the insured, the service
41 shall be deemed to be provided by the preferred provider of health
42 care.

43 ~~†8.†~~ 7. Must require the corporation to process a claim of a
44 provider of health care who is not preferred not later than 30
45 working days after the date on which proof of the claim is received.



* A B 8 3 R 2 *

1 **Sec. 135.** NRS 695B.1903 is hereby amended to read as
2 follows:

3 695B.1903 1. A policy of health insurance issued by a
4 medical services corporation must provide coverage for medical
5 treatment which a person insured under the policy receives as part of
6 a clinical trial or study if:

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

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

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

14 (2) A cooperative group;

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

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

18 (5) The United States Department of Defense;

19 (c) In the case of:

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

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

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

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

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

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

39 (1) The procedure to be undertaken;

40 (2) Alternative methods of treatment; and

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

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



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

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

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

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

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

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

24 ➤ Except as otherwise provided in NRS 695B.1901, the services
25 provided pursuant to paragraphs (b), (c), (e) and (f) must be covered
26 only if the services are provided by a provider with whom the
27 medical services corporation has contracted for such services. If the
28 medical services corporation has not contracted for the provision of
29 such services, the medical services corporation shall pay the
30 provider the rate of reimbursement that is paid to other providers
31 with whom the medical services corporation has contracted for
32 similar services and the provider shall accept that rate of
33 reimbursement as payment in full.

34 3. Particular medical treatment described in subsection 2 and
35 provided to a person insured under the policy is not required to be
36 covered pursuant to this section if that particular medical treatment
37 is provided by the sponsor of the clinical trial or study free of charge
38 to the person insured under the policy.

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

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



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

4 (c) Health care services that are specifically excluded from
5 coverage under the insured's policy of health insurance, regardless
6 of whether such services are provided under the clinical trial or
7 study.

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

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

14 (f) Any expenses incurred by a person who accompanies the
15 insured during the trial or study.

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

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

21 5. A medical services corporation that delivers or issues for
22 delivery a policy of health insurance specified in subsection 1 may
23 require copies of the approval or certification issued pursuant to
24 paragraph (b) of subsection 1, the statement of consent signed by the
25 insured, protocols for the clinical trial or study and any other
26 materials related to the scope of the clinical trial or study relevant to
27 the coverage of medical treatment pursuant to this section.

28 6. A medical services corporation that delivers or issues for
29 delivery a policy of health insurance specified in subsection 1 shall:

30 (a) Include in ~~the~~ *any* disclosure ~~required pursuant to NRS~~
31 ~~695B.172~~ *of the coverage provided by the policy* notice to each
32 person insured under the policy of the availability of the benefits
33 required by this section.

34 (b) Provide the coverage required by this section subject to the
35 same deductible, copayment, coinsurance and other such conditions
36 for coverage that are required under the policy.

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

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

45 (a) Any injury to the insured caused by:



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

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

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

11 9. As used in this section:

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

16 (1) The Clinical Trials Cooperative Group Program; and

17 (2) The Community Clinical Oncology Program.

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

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

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

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

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

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

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

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

42 (c) "Provider of health care" means:

43 (1) A hospital; or

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

45 NRS.



1 **Sec. 136.** NRS 695B.1927 is hereby amended to read as
2 follows:

3 695B.1927 1. No contract for hospital or medical service that
4 provides coverage for hospital, medical or surgical expenses may be
5 delivered or issued for delivery in this state unless the contract
6 includes coverage for the management and treatment of diabetes,
7 including, without limitation, coverage for the self-management of
8 diabetes.

9 2. An insurer who delivers or issues for delivery a contract
10 specified in subsection 1:

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

15 (b) Shall provide the coverage required by this section subject to
16 the same deductible, copayment, coinsurance and other such
17 conditions for coverage that are required under the contract.

18 3. A contract for hospital or medical service subject to the
19 provisions of this chapter that is delivered, issued for delivery or
20 renewed on or after January 1, 1998, has the legal effect of
21 including the coverage required by this section, and any provision of
22 the contract that conflicts with this section is void.

23 4. As used in this section:

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

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

29 (1) The training and education provided to a person covered
30 under the contract after the person is initially diagnosed with
31 diabetes which is medically necessary for the care and management
32 of diabetes, including, without limitation, counseling in nutrition
33 and the proper use of equipment and supplies for the treatment of
34 diabetes;

35 (2) Training and education which is medically necessary as a
36 result of a subsequent diagnosis that indicates a significant change
37 in the symptoms or condition of the person covered under the
38 contract and which requires modification of the person's program of
39 self-management of diabetes; and

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

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



1 **Sec. 137.** NRS 695B.290 is hereby amended to read as
2 follows:

3 695B.290 Any agent of a nonprofit hospital or medical or
4 dental service corporation who acts as such in the solicitation,
5 negotiation, procurement or making of a hospital service or medical
6 or dental care contract shall be qualified, examined and licensed in
7 the same manner and pay the same fees as provided for ~~health~~
8 ~~insurance agents~~ *a producer of insurance* in NRS 680B.010 (fee
9 schedule), chapter 683A of NRS and, in addition to any other fee or
10 charge, all applicable fees required pursuant to NRS 680C.110.

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

13 695B.320 *1.* Nonprofit hospital and medical or dental service
14 corporations are subject to the provisions of this chapter, and to the
15 provisions of chapters 679A and 679B of NRS, NRS 686A.010 to
16 686A.315, inclusive, 687B.010 to 687B.040, inclusive, 687B.070 to
17 687B.140, inclusive, 687B.150, 687B.160, 687B.180, 687B.200
18 to 687B.255, inclusive, 687B.270, 687B.310 to 687B.380, inclusive,
19 687B.410, 687B.420, 687B.430, 687B.500 and chapters *692B,*
20 *692C , 693A* and 696B of NRS, to the extent applicable and not in
21 conflict with the express provisions of this chapter.

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

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

27 695B.380 *1.* Except as otherwise provided in subsection 4,
28 each insurer that issues a contract for hospital or medical services in
29 this State shall establish a system for resolving any complaints of an
30 insured concerning health care services covered under the policy.
31 The system must be approved by the Commissioner . ~~##~~
32 ~~consultation with the State Board of Health.~~

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

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

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



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

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

7 695B.390 1. Each insurer that issues a contract for hospital or
8 medical services in this State shall submit to the Commissioner ~~and~~
9 ~~the State Board of Health~~ an annual report regarding its system for
10 resolving complaints established pursuant to subsection 1 of NRS
11 695B.380 on a form prescribed by the Commissioner ~~in~~
12 ~~consultation with the State Board of Health~~ which includes, without
13 limitation:

14 (a) A description of the procedures used for resolving any
15 complaints of an insured;

16 (b) The total number of complaints and appeals handled through
17 the system for resolving complaints since the last report and a
18 compilation of the causes underlying the complaints filed;

19 (c) The current status of each complaint and appeal filed; and

20 (d) The average amount of time that was needed to resolve a
21 complaint and an appeal, if any.

22 2. Each insurer shall maintain records of complaints filed with
23 it which concern something other than health care services and shall
24 submit to the Commissioner a report summarizing such complaints
25 at such times and in such format as the Commissioner may require.

26 **Sec. 141.** Chapter 695C of NRS is hereby amended by adding
27 thereto the provisions set forth as sections 142 to 146, inclusive, of
28 this act.

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

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

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



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

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

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

13 *3. As used in this section:*

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

24 6. *An order or decision of the Commissioner under this*
25 *section is subject to review in accordance with NRS 679B.310 to*
26 *679B.370, inclusive, at the request of any party to the proceedings*
27 *whose interests are substantially affected.*

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

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

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



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

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

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

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

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

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

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

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

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

32 2. *The Commissioner may adopt regulations to:*

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

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

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



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

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

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

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

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

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

22 **(a) If an enrollee is liable to a provider for health care services**
23 *provided pursuant to and covered by the applicable health care*
24 *plan, that liability shall be deemed to be a claim of the enrollee for*
25 *distribution of the general assets of the health maintenance*
26 *organization.*

27 **(b) A provider under contract with the health maintenance**
28 *organization who is obligated by law or contract to hold an*
29 *enrollee harmless from liability for health care services provided*
30 *pursuant to and covered by the applicable health care plan shall*
31 *be deemed to have a priority for distribution of the general assets*
32 *of the health maintenance organization immediately following*
33 *that of an enrollee as described in this section and immediately*
34 *preceding any other priority for distribution which, pursuant to*
35 *this section and chapter 696B of NRS, would follow that of an*
36 *enrollee.*

37 **Sec. 147. NRS 695C.055 is hereby amended to read as**
38 *follows:*

39 **695C.055 1. The provisions of NRS 449.465, 679A.200,**
40 *679B.700, subsections 6 and 7 of NRS 680A.270, subsections 2, 4,*
41 *18, 19 and 32 of NRS 680B.010, NRS 680B.020 to 680B.060,*
42 *inclusive, chapter 686A of NRS, NRS 687B.500 and ~~chapter~~*
43 *chapters 692C and 695G of NRS apply to a health maintenance*
44 *organization.*



1 2. For the purposes of subsection 1, unless the context requires
2 that a provision apply only to insurers, any reference in those
3 sections to "insurer" must be replaced by "health maintenance
4 organization."

5 **Sec. 148.** NRS 695C.080 is hereby amended to read as
6 follows:

7 695C.080 1. The Commissioner shall determine whether the
8 applicant for a certificate of authority, with respect to health care
9 services to be furnished:

10 (a) Has demonstrated the willingness and ability to ensure that
11 such health care services will be provided in a manner to ensure
12 both availability and accessibility of adequate personnel and
13 facilities and in a manner enhancing availability, accessibility and
14 continuity of service;

15 (b) Has organizational arrangements, established in accordance
16 with regulations promulgated by the Commissioner ; ~~and in~~
17 ~~consultation with the State Board of Health;~~ and

18 (c) Has a procedure established in accordance with regulations
19 of the Commissioner to develop, compile, evaluate and report
20 statistics relating to the cost of its operations, the pattern of
21 utilization of its services, the availability and accessibility of its
22 services and such other matters as may be reasonably required by
23 the Commissioner.

24 2. Within 90 days of receipt of the application for issuance of a
25 certificate of authority, the Commissioner shall certify whether the
26 proposed health maintenance organization meets the requirements of
27 subsection 1. If the Commissioner certifies that the health
28 maintenance organization does not meet such requirements, it shall
29 specify in what respects it is deficient.

30 **Sec. 149.** NRS 695C.310 is hereby amended to read as
31 follows:

32 695C.310 1. The Commissioner shall make an examination
33 of the affairs of any health maintenance organization and providers
34 with whom such organization has contracts, agreements or other
35 arrangements pursuant to its health care plan as often as the
36 Commissioner deems it necessary for the protection of the interests
37 of the people of this State ~~[An examination must be made]~~ , *but* not
38 less frequently than once every 3 years.

39 2. The Commissioner shall make an examination concerning
40 ~~the quality of health care services of any health maintenance~~
41 ~~organization and providers with whom such organization has~~
42 ~~contracts, agreements or other arrangements pursuant to its health~~
43 ~~care plan] any compliance program used by a health maintenance~~
44 *organization and any report, as determined to be appropriate by*
45 *the Commissioner, regarding the health maintenance organization*



1 *produced by an organization which examines best practices in the*
2 *insurance industry. The Commissioner shall make such an*
3 *examination* as often as ~~the~~ *the Commissioner* deems it necessary
4 for the protection of the interests of the people of this State ~~[-An~~
5 ~~examination must be made]~~, *but* not less frequently than once every
6 3 years.

7 3. ~~Every~~ *In making an examination pursuant to subsection*
8 *1 or 2, the Commissioner:*

9 (a) *Shall determine whether the health maintenance*
10 *organization is in compliance with this Code, including, without*
11 *limitation, whether any relationship or transaction between the*
12 *health maintenance organization and any another health*
13 *maintenance organization is in compliance with this Code; and*

14 (b) *May examine any account, record, document or*
15 *transaction of any health maintenance organization or any*
16 *provider which relates to:*

17 (1) *Compliance with this Code by the health maintenance*
18 *organization which is the subject of the examination;*

19 (2) *Any relationship or transaction between the health*
20 *maintenance organization which is the subject of the examination*
21 *and any other health maintenance organization; or*

22 (3) *Any relationship or transaction between the health*
23 *maintenance organization which is the subject of the examination*
24 *and any provider.*

25 4. *Except as otherwise provided in this subsection, for the*
26 *purposes of an examination pursuant to subsection 1 or 2, each*
27 *health maintenance organization and provider shall, upon the*
28 *request of the Commissioner or an examiner designated by the*
29 *Commissioner, submit its books and records relating to ~~the~~ any*
30 *applicable health care plan to ~~an examination made pursuant to~~*
31 *subsection 1 or 2 and in every way facilitate the examination.] the*
32 *Commissioner or the examiner, as applicable.* Medical records of
33 natural persons and records of physicians providing service pursuant
34 to a contract ~~to the~~ *with a* health maintenance organization are not
35 subject to such examination, although the records, *except privileged*
36 *medical information*, are subject to subpoena upon a showing of
37 good cause. For the purpose of examinations, the Commissioner
38 may administer oaths to, and examine the officers and agents of
39 ~~the~~ *a* health maintenance organization and the principals of ~~such~~
40 providers concerning their business.

41 ~~4.~~ 5. The expenses of examinations pursuant to this section
42 must be assessed against the *health maintenance* organization being
43 examined and remitted to the Commissioner.

44 ~~5.~~ 6. In lieu of ~~such~~ *an* examination ~~it~~ *pursuant to this*
45 *section*, the Commissioner may accept the report of an examination



1 made by the insurance commissioner ~~for the state board of health~~ of
2 another state ~~H~~ *or an applicable regulatory agency of another*
3 *state.*

4 **Sec. 150.** NRS 695C.330 is hereby amended to read as
5 follows:

6 695C.330 1. The Commissioner may suspend or revoke any
7 certificate of authority issued to a health maintenance organization
8 pursuant to the provisions of this chapter if the Commissioner finds
9 that any of the following conditions exist:

10 (a) The health maintenance organization is operating
11 significantly in contravention of its basic organizational document,
12 its health care plan or in a manner contrary to that described in and
13 reasonably inferred from any other information submitted pursuant
14 to NRS 695C.060, 695C.070 and 695C.140, unless any amendments
15 to those submissions have been filed with and approved by the
16 Commissioner;

17 (b) The health maintenance organization issues evidence of
18 coverage or uses a schedule of charges for health care services
19 which do not comply with the requirements of NRS 695C.1691 to
20 695C.200, inclusive, or 695C.207;

21 (c) The health care plan does not furnish comprehensive health
22 care services as provided for in NRS 695C.060;

23 (d) The Commissioner certifies that the health maintenance
24 organization:

25 (1) Does not meet the requirements of subsection 1 of NRS
26 695C.080; or

27 (2) Is unable to fulfill its obligations to furnish health care
28 services as required under its health care plan;

29 (e) The health maintenance organization is no longer financially
30 responsible and may reasonably be expected to be unable to meet its
31 obligations to enrollees or prospective enrollees;

32 (f) The health maintenance organization has failed to put into
33 effect a mechanism affording the enrollees an opportunity to
34 participate in matters relating to the content of programs pursuant to
35 NRS 695C.110;

36 (g) The health maintenance organization has failed to put into
37 effect the system required by NRS 695C.260 for:

38 (1) Resolving complaints in a manner reasonably to dispose
39 of valid complaints; and

40 (2) Conducting external reviews of adverse determinations
41 that comply with the provisions of NRS 695G.241 to 695G.310,
42 inclusive;

43 (h) The health maintenance organization or any person on its
44 behalf has advertised or merchandised its services in an untrue,
45 misrepresentative, misleading, deceptive or unfair manner;



1 (i) The continued operation of the health maintenance
2 organization would be hazardous to its enrollees **† or creditors or**
3 **to the general public;**

4 (j) The health maintenance organization fails to provide the
5 coverage required by NRS 695C.1691; or

6 (k) The health maintenance organization has otherwise failed to
7 comply substantially with the provisions of this chapter.

8 2. A certificate of authority must be suspended or revoked only
9 after compliance with the requirements of NRS 695C.340.

10 3. If the certificate of authority of a health maintenance
11 organization is suspended, the health maintenance organization shall
12 not, during the period of that suspension, enroll any additional
13 groups or new individual contracts, unless those groups or persons
14 were contracted for before the date of suspension.

15 4. If the certificate of authority of a health maintenance
16 organization is revoked, the organization shall proceed, immediately
17 following the effective date of the order of revocation, to wind up its
18 affairs and shall conduct no further business except as may be
19 essential to the orderly conclusion of the affairs of the organization.
20 It shall engage in no further advertising or solicitation of any kind.
21 The Commissioner may, by written order, permit such further
22 operation of the organization as the Commissioner may find to be in
23 the best interest of enrollees to the end that enrollees are afforded
24 the greatest practical opportunity to obtain continuing coverage for
25 health care.

26 **Sec. 151.** Chapter 695D of NRS is hereby amended by adding
27 thereto the provisions set forth as sections 152 and 153 of this act.

28 **Sec. 152. 1. *The Commissioner may adopt regulations to***
29 ***define when an organization for dental care is considered to be in***
30 ***a hazardous financial condition and to set forth the standards to***
31 ***be considered by the Commissioner in determining whether the***
32 ***continued operation of an organization for dental care transacting***
33 ***business in this State may be considered to be hazardous to its***
34 ***members or creditors or to the general public.***

35 ***2. If the Commissioner determines after a hearing that any***
36 ***organization for dental care is in a hazardous financial condition,***
37 ***the Commissioner may, instead of suspending or revoking the***
38 ***certificate of authority of the organization, limit the certificate of***
39 ***authority as the Commissioner deems reasonably necessary to***
40 ***correct, eliminate or remedy any conduct, condition or ground***
41 ***that is deemed to be a cause of the hazardous financial condition.***

42 ***3. An order or decision of the Commissioner under this***
43 ***section is subject to review in accordance with NRS 679B.310 to***
44 ***679B.370, inclusive, at the request of any party to the proceedings***
45 ***whose interests are substantially affected.***



1 **Sec. 153.** *Each organization for dental care which receives a*
2 *certificate of authority shall maintain a capital account with a net*
3 *worth of not less than \$500,000 unless a lesser amount is*
4 *permitted in writing by the Commissioner. The account must not*
5 *be obligated for any accrued liabilities and must consist of cash,*
6 *securities or a combination thereof which is acceptable to the*
7 *Commissioner.*

8 **Sec. 154.** NRS 695D.095 is hereby amended to read as
9 follows:

10 695D.095 *1.* An organization for dental care is not exempt
11 from the provisions of NRS 679B.700. If an organization is an
12 admitted health insurer, as that term is defined in NRS 449.450, it is
13 not exempt from the fees imposed pursuant to NRS 449.465.

14 *2. For the purposes of this section and the provisions set forth*
15 *in subsection 1, an organization for dental care is included in the*
16 *meaning of the term "insurer."*

17 **Sec. 155.** NRS 695D.170 is hereby amended to read as
18 follows:

19 695D.170 1. ~~Before~~ *Except as otherwise provided in this*
20 *section, before* a certificate of authority may be issued to an
21 organization for dental care:

22 (a) The officers responsible for operating the organization must
23 file with the Commissioner a collective fidelity bond for
24 \$1,000,000; and

25 (b) The organization must file with the Commissioner a surety
26 bond in the sum of ~~\$250,000~~ *\$500,000* or deposit with the
27 Commissioner cash or securities acceptable to the Commissioner in
28 the sum of ~~\$250,000~~ *\$500,000*,

29 ↳ to guarantee the organization's performance pursuant to this
30 chapter.

31 2. If the bond is furnished in:

32 (a) Cash, the Commissioner shall deposit the money in the State
33 Treasury for credit to the Fund for Bonds of Organizations for
34 Dental Care which is hereby created as a trust fund.

35 (b) Negotiable securities, the principal must be placed without
36 restriction at the disposal of the Commissioner, but any income
37 must inure to the benefit of the organization.

38 3. The Commissioner may reduce the *required amount of the*
39 *organization's surety* bond or deposit:

40 (a) To \$125,000, if the obligations assumed by the organization
41 under the plan can be satisfied for less than \$125,000.

42 (b) To any amount if the organization demonstrates that it has
43 commitments of money from federal, state or municipal
44 governments or their political subdivisions or other comparable



1 resources which are sufficient to ensure the ability of the
2 organization to satisfy its obligations.

3 4. *The Commissioner may increase the required amount of*
4 *the organization's surety bond or deposit to any amount the*
5 *Commissioner determines to be appropriate pursuant to*
6 *subsection 5 if the Commissioner determines that the current level*
7 *of the surety bond or deposit is insufficient to provide protection to*
8 *the members in the event of:*

9 (a) *Insolvency; or*

10 (b) *A determination by the Commissioner that the organization*
11 *is in a hazardous financial condition.*

12 5. *When determining the appropriate amount of an increase*
13 *pursuant to subsection 4, the Commissioner must base his or her*
14 *determination on the type, volume and nature of premiums written*
15 *and premiums assumed by the organization.*

16 6. *The amount of the organization's surety bond or deposit*
17 *required pursuant to this section:*

18 (a) *Is in addition to any reserve required by this chapter and*
19 *any reserve established by the organization according to good*
20 *business and accounting practices for incurred but unreported*
21 *claims and other similar claims;*

22 (b) *May increase the amount of net worth required pursuant to*
23 *this chapter; and*

24 (c) *May increase the amount of risk-based capital required*
25 *pursuant to NRS 681B.550.*

26 7. Any final judgment against the organization which is unpaid
27 is a lien on the *surety* bond or deposit and is subject to execution 30
28 days after entry of the judgment. Any *surety* bond or deposit which
29 is reduced by this lien must be increased by the organization to the
30 amount required by this section within 90 days after the judgment is
31 paid.

32 ~~151~~ 8. If an organization is dissolved, liquidated or otherwise
33 terminated:

34 (a) That amount of the *surety* bond or deposit which is
35 necessary to satisfy the outstanding obligations of the organization
36 may not be withdrawn for at least 3 years after the certificate of
37 authority has been terminated.

38 (b) Any balance remaining after money has been withheld to
39 pay the organization's debts and liens must be paid to the
40 organization by the Commissioner no later than 90 days after the
41 certificate of authority has been terminated.

42 **Sec. 156.** Chapter 695F of NRS is hereby amended by adding
43 thereto a new section to read as follows:

44 1. *The Commissioner may adopt regulations to define when a*
45 *prepaid limited health service organization is considered to be in a*



1 *hazardous financial condition and to set forth the standards to be*
2 *considered by the Commissioner in determining whether the*
3 *continued operation of a prepaid limited health service*
4 *organization transacting business in this State may be considered*
5 *to be hazardous to its enrollees or creditors or to the general*
6 *public.*

7 2. *If the Commissioner determines after a hearing that any*
8 *prepaid limited health service organization is in a hazardous*
9 *financial condition, the Commissioner may, instead of suspending*
10 *or revoking the prepaid limited health service organization's*
11 *certificate of authority, limit the certificate of authority of the*
12 *prepaid limited health service organization as the Commissioner*
13 *deems reasonably necessary to correct, eliminate or remedy any*
14 *conduct, condition or ground that is deemed to be a cause of the*
15 *hazardous financial condition.*

16 3. *An order or decision of the Commissioner under this*
17 *section is subject to review in accordance with NRS 679B.310 to*
18 *679B.370, inclusive, at the request of any party to the proceedings*
19 *whose interests are substantially affected.*

20 **Sec. 157.** NRS 695F.090 is hereby amended to read as
21 follows:

22 695F.090 1. Prepaid limited health service organizations are
23 subject to the provisions of this chapter and to the following
24 provisions, to the extent reasonably applicable:

25 ~~111~~ (a) NRS 687B.310 to 687B.420, inclusive, concerning
26 cancellation and nonrenewal of policies.

27 ~~121~~ (b) NRS 687B.122 to 687B.128, inclusive, concerning
28 readability of policies.

29 ~~131~~ (c) The requirements of NRS 679B.152.

30 ~~141~~ (d) The fees imposed pursuant to NRS 449.465.

31 ~~151~~ (e) NRS 686A.010 to 686A.310, inclusive, concerning
32 trade practices and frauds.

33 ~~161~~ (f) The assessment imposed pursuant to NRS 679B.700.

34 ~~171~~ (g) Chapter 683A of NRS.

35 ~~181~~ (h) To the extent applicable, the provisions of NRS
36 689B.340 to 689B.580, inclusive, and chapter 689C of NRS relating
37 to the portability and availability of health insurance.

38 ~~191~~ (i) NRS 689A.035, 689A.0463, 689A.410, 689A.413 and
39 689A.415.

40 ~~101~~ (j) NRS 680B.025 to 680B.039, inclusive, concerning
41 premium tax, premium tax rate, annual report and estimated
42 quarterly tax payments. For the purposes of this subsection, unless
43 the context otherwise requires that a section apply only to insurers,
44 any reference in those sections to "insurer" must be replaced by a
45 reference to "prepaid limited health service organization."



~~111~~ (k) Chapter 692C of NRS, concerning holding companies.

~~112~~ (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:*

~~111~~ (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.

~~112~~ (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.*



1 **Sec. 159.** NRS 695G.130 is hereby amended to read as
2 follows:

3 695G.130 1. In addition to any other report which is required
4 to be filed with the Commissioner, each managed care organization
5 shall file with the Commissioner, ~~on or before March 1 of each~~
6 ~~year,~~ *with its annual filing made pursuant to NRS 686B.070 of*
7 *forms and rates relating to policies of insurance for individuals*
8 *and small employer groups,* a report regarding its methods for
9 reviewing the quality of health care services provided to its insureds.

10 ~~2. Each managed care organization shall include in its report~~
11 ~~the criteria, data, benchmarks or studies used to:~~

12 ~~—(a) Assess the nature, scope, quality and accessibility of health~~
13 ~~care services provided to insureds; or~~

14 ~~—(b) Determine any reduction or modification of the provision of~~
15 ~~health care services to insureds.~~

16 ~~3. Except as already required to be filed with the~~
17 ~~Commissioner, if the managed care organization is not owned and~~
18 ~~operated by a public entity and has more than 100 insureds, the~~
19 ~~report filed pursuant to subsection 1 must include:~~

20 ~~—(a) A copy of all of its quarterly and annual financial reports;~~

21 ~~—(b) A statement of any financial interest it has in any other~~
22 ~~business which is related to health care that is greater than 5 percent~~
23 ~~of that business or \$5,000, whichever is less; and~~

24 ~~—(c) A description of each complaint filed with or against it that~~
25 ~~resulted in arbitration, a lawsuit or other legal proceeding, unless~~
26 ~~disclosure is prohibited by law or a court order.~~

27 ~~4.] The report must be submitted on a form prescribed by the~~
28 ~~Commissioner.~~

29 2. A report filed pursuant to this section must be made
30 available for public inspection within a reasonable time after it is
31 received by the Commissioner.

32 3. *As used in this section, “small employer” has the meaning*
33 *ascribed to it in NRS 689C.095.*

34 **Sec. 160.** NRS 695G.200 is hereby amended to read as
35 follows:

36 695G.200 1. Each managed care organization shall establish
37 a system for resolving complaints of an insured concerning:

38 (a) Payment or reimbursement for covered health care services;

39 (b) Availability, delivery or quality of covered health care
40 services, including, without limitation, an adverse determination
41 made pursuant to utilization review; or

42 (c) The terms and conditions of a health care plan.

43 ➔ The system must be approved by the Commissioner . ~~in~~
44 ~~consultation with the State Board of Health.]~~



1 2. If an insured makes an oral complaint, a managed care
2 organization shall inform the insured that if the insured is not
3 satisfied with the resolution of the complaint, the insured must file
4 the complaint in writing to receive further review of the complaint.

5 3. Each managed care organization shall:

6 (a) Upon request, assign an employee of the managed care
7 organization to assist an insured or other person in filing a complaint
8 or appealing a decision of the review board;

9 (b) Authorize an insured who appeals a decision of the review
10 board to appear before the review board to present testimony at a
11 hearing concerning the appeal; and

12 (c) Authorize an insured to introduce any documentation into
13 evidence at a hearing of a review board and require an insured to
14 provide the documentation required by the health care plan of the
15 insured to the review board not later than 5 business days before a
16 hearing of the review board.

17 4. The Commissioner may examine the system for resolving
18 complaints established pursuant to this section at such times as
19 ~~either~~ *the Commissioner* deems necessary or appropriate.

20 **Sec. 161.** NRS 695G.220 is hereby amended to read as
21 follows:

22 695G.220 1. Each managed care organization shall submit to
23 the Commissioner an annual report regarding its system for
24 resolving complaints established pursuant to NRS 695G.200 on a
25 form prescribed by the Commissioner ~~in consultation with the State~~
26 ~~Board of Health~~ which includes, without limitation:

27 (a) A description of the procedures used for resolving
28 complaints of an insured;

29 (b) The total number of complaints and appeals handled through
30 the system for resolving complaints since the last report and a
31 compilation of the causes underlying the complaints filed;

32 (c) The current status of each complaint and appeal filed; and

33 (d) The average amount of time that was needed to resolve a
34 complaint and an appeal, if any.

35 2. Each managed care organization shall maintain records of
36 complaints filed with it which concern something other than health
37 care services and shall submit to the Commissioner a report
38 summarizing such complaints at such times and in such format as
39 the Commissioner may require.

40 **Sec. 162.** (Deleted by amendment.)

41 **Sec. 163.** NRS 239.010 is hereby amended to read as follows:

42 239.010 1. Except as otherwise provided in this section and
43 NRS 1.4683, 1.4687, 1A.110, 41.071, 49.095, 62D.420, 62D.440,
44 62E.516, 62E.620, 62H.025, 62H.030, 62H.170, 62H.220, 62H.320,
45 75A.100, 75A.150, 76.160, 78.152, 80.113, 81.850, 82.183, 86.246,



1 86.54615, 87.515, 87.5413, 87A.200, 87A.580, 87A.640, 88.3355,
2 88.5927, 88.6067, 88A.345, 88A.7345, 89.045, 89.251, 90.730,
3 91.160, 116.757, 116A.270, 116B.880, 118B.026, 119.260,
4 119.265, 119.267, 119.280, 119A.280, 119A.653, 119B.370,
5 119B.382, 120A.690, 125.130, 125B.140, 126.141, 126.161,
6 126.163, 126.730, 127.007, 127.057, 127.130, 127.140, 127.2817,
7 130.312, 130.712, 136.050, 159.044, 172.075, 172.245, 176.015,
8 176.0625, 176.09129, 176.156, 176A.630, 178.39801, 178.4715,
9 178.5691, 179.495, 179A.070, 179A.165, 179A.450, 179D.160,
10 200.3771, 200.3772, 200.5095, 200.604, 202.3662, 205.4651,
11 209.392, 209.3925, 209.419, 209.521, 211A.140, 213.010, 213.040,
12 213.095, 213.131, 217.105, 217.110, 217.464, 217.475, 218A.350,
13 218E.625, 218F.150, 218G.130, 218G.240, 218G.350, 228.270,
14 228.450, 228.495, 228.570, 231.069, 231.1473, 233.190, 237.300,
15 239.0105, 239.0113, 239B.030, 239B.040, 239B.050, 239C.140,
16 239C.210, 239C.230, 239C.250, 239C.270, 240.007, 241.020,
17 241.030, 241.039, 242.105, 244.264, 244.335, 250.087, 250.130,
18 250.140, 250.150, 268.095, 268.490, 268.910, 271A.105, 281.195,
19 281A.350, 281A.440, 281A.550, 284.4068, 286.110, 287.0438,
20 289.025, 289.080, 289.387, 289.830, 293.5002, 293.503, 293.558,
21 293B.135, 293D.510, 331.110, 332.061, 332.351, 333.333, 333.335,
22 338.070, 338.1379, 338.16925, 338.1725, 338.1727, 348.420,
23 349.597, 349.775, 353.205, 353A.049, 353A.085, 353A.100,
24 353C.240, 360.240, 360.247, 360.255, 360.755, 361.044, 361.610,
25 365.138, 366.160, 368A.180, 372A.080, 378.290, 378.300, 379.008,
26 385A.830, 385B.100, 387.626, 387.631, 388.1455, 388.259,
27 388.501, 388.503, 388.513, 388.750, 391.035, 392.029, 392.147,
28 392.264, 392.271, 392.850, 394.167, 394.1698, 394.447, 394.460,
29 394.465, 396.3295, 396.405, 396.525, 396.535, 398.403, 408.3885,
30 408.3886, 408.3888, 408.5484, 412.153, 416.070, 422.2749,
31 422.305, 422A.342, 422A.350, 425.400, 427A.1236, 427A.872,
32 432.205, 432B.175, 432B.280, 432B.290, 432B.407, 432B.430,
33 432B.560, 433.534, 433A.360, 439.840, 439B.420, 440.170,
34 441A.195, 441A.220, 441A.230, 442.330, 442.395, 445A.665,
35 445B.570, 449.209, 449.245, 449.720, 450.140, 453.164, 453.720,
36 453A.610, 453A.700, 458.055, 458.280, 459.050, 459.3866,
37 459.555, 459.7056, 459.846, 463.120, 463.15993, 463.240,
38 463.3403, 463.3407, 463.790, 467.1005, 480.365, 481.063, 482.170,
39 482.5536, 483.340, 483.363, 483.575, 483.659, 483.800, 484E.070,
40 485.316, 503.452, 522.040, 534A.031, 561.285, 571.160, 584.583,
41 584.655, 587.877, 598.0964, 598.098, 598A.110, 599B.090,
42 603.070, 603A.210, 604A.710, 612.265, 616B.012, 616B.015,
43 616B.315, 616B.350, 618.341, 618.425, 622.310, 623.131,
44 623A.137, 624.110, 624.265, 624.327, 625.425, 625A.185, 628.418,
45 628B.230, 628B.760, 629.047, 629.069, 630.133, 630.30665,



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1 630.336, 630A.555, 631.368, 632.121, 632.125, 632.405, 633.283,
2 633.301, 633.524, 634.055, 634.214, 634A.185, 635.158, 636.107,
3 637.085, 637B.288, 638.087, 638.089, 639.2485, 639.570, 640.075,
4 640A.220, 640B.730, 640C.400, 640C.745, 640C.760, 640D.190,
5 640E.340, 641.090, 641A.191, 641B.170, 641C.760, 642.524,
6 643.189, 644.446, 645.180, 645.625, 645A.050, 645A.082,
7 645B.060, 645B.092, 645C.220, 645C.225, 645D.130, 645D.135,
8 645E.300, 645E.375, 645G.510, 645H.320, 645H.330, 647.0945,
9 647.0947, 648.033, 648.197, 649.065, 649.067, 652.228, 654.110,
10 656.105, 661.115, 665.130, 665.133, 669.275, 669.285, 669A.310,
11 671.170, 673.430, 675.380, 676A.340, 676A.370, 677.243,
12 679B.122, 679B.152, 679B.159, 679B.190, 679B.285, 679B.690,
13 680A.270, 681A.440, 681B.260, 681B.410, 681B.540, 683A.0873,
14 685A.077, 686A.289, 686B.170, 686C.306, 687A.110, 687A.115,
15 687C.010, 688C.230, 688C.480, 688C.490, 692A.117, 692C.190,
16 692C.3536, 692C.3538, 692C.354, 692C.420, 693A.480, 693A.615,
17 696B.550, 703.196, 704B.320, 704B.325, 706.1725, 706A.230,
18 710.159, 711.600, **and sections 8 and 92 of this act**, sections 35, 38
19 and 41 of chapter 478, Statutes of Nevada 2011 and section 2 of
20 chapter 391, Statutes of Nevada 2013 and unless otherwise declared
21 by law to be confidential, all public books and public records of a
22 governmental entity must be open at all times during office hours to
23 inspection by any person, and may be fully copied or an abstract or
24 memorandum may be prepared from those public books and public
25 records. Any such copies, abstracts or memoranda may be used to
26 supply the general public with copies, abstracts or memoranda of the
27 records or may be used in any other way to the advantage of the
28 governmental entity or of the general public. This section does not
29 supersede or in any manner affect the federal laws governing
30 copyrights or enlarge, diminish or affect in any other manner the
31 rights of a person in any written book or record which is
32 copyrighted pursuant to federal law.

33 2. A governmental entity may not reject a book or record
34 which is copyrighted solely because it is copyrighted.

35 3. A governmental entity that has legal custody or control of a
36 public book or record shall not deny a request made pursuant to
37 subsection 1 to inspect or copy or receive a copy of a public book or
38 record on the basis that the requested public book or record contains
39 information that is confidential if the governmental entity can
40 redact, delete, conceal or separate the confidential information from
41 the information included in the public book or record that is not
42 otherwise confidential.

43 4. A person may request a copy of a public record in any
44 medium in which the public record is readily available. An officer,



1 employee or agent of a governmental entity who has legal custody
2 or control of a public record:

3 (a) Shall not refuse to provide a copy of that public record in a
4 readily available medium because the officer, employee or agent has
5 already prepared or would prefer to provide the copy in a different
6 medium.

7 (b) Except as otherwise provided in NRS 239.030, shall, upon
8 request, prepare the copy of the public record and shall not require
9 the person who has requested the copy to prepare the copy himself
10 or herself.

11 **Sec. 164.** NRS 266.355 is hereby amended to read as follows:

12 266.355 1. Except as otherwise provided in subsections 3, 4
13 and 5, the city council may:

14 (a) Except as otherwise provided in NRS 268.0881 to 268.0888,
15 inclusive, 598D.150 and 640C.100, regulate all businesses, trades
16 and professions.

17 (b) Except as otherwise provided in NRS 576.128, fix, impose
18 and collect a license tax for revenue upon all businesses, trades and
19 professions.

20 2. The city council may establish any equitable standard to be
21 used in fixing license taxes required to be collected pursuant to this
22 section.

23 3. The city council may license insurance ~~agents, brokers,~~
24 analysts, adjusters and managing general agents *and producers of*
25 *insurance* within the limitations and under the conditions prescribed
26 in NRS 680B.020.

27 4. A city council shall not require that a person who is licensed
28 as a contractor pursuant to chapter 624 of NRS obtain more than one
29 license to engage in the business of contracting or pay more than
30 one license tax related to engaging in the business of contracting,
31 regardless of the number of classifications or subclassifications of
32 licensing for which the person is licensed pursuant to chapter 624 of
33 NRS.

34 5. The city council shall not require a person to obtain a license
35 or pay a license tax on the sole basis that the person is a
36 professional. As used in this subsection, "professional" means a
37 person who:

38 (a) Holds a license, certificate, registration, permit or similar
39 type of authorization issued by a regulatory body as defined in NRS
40 622.060, or who is regulated pursuant to the Nevada Supreme Court
41 Rules; and

42 (b) Practices his or her profession for any type of compensation
43 as an employee.



1 **Sec. 165.** NRS 269.170 is hereby amended to read as follows:
2 269.170 1. Except as otherwise provided in subsection 5 and
3 NRS 576.128, 598D.150 and 640C.100, the town board or board of
4 county commissioners may, in any unincorporated town:

5 (a) Fix and collect a license tax on, and regulate, having due
6 regard to the amount of business done by each person so licensed,
7 and all places of business and amusement so licensed, as follows:

8 (1) Artisans, artists, assayers, auctioneers, bakers, banks and
9 bankers, barbers, boilermakers, cellars and places where soft drinks
10 are kept or sold, clothes cleaners, foundries, laundries, lumberyards,
11 manufacturers of soap, soda, borax or glue, markets, newspaper
12 publishers, pawnbrokers, funeral directors and wood and coal
13 dealers.

14 (2) Bootmakers, cobblers, dressmakers, milliners,
15 shoemakers and tailors.

16 (3) Boardinghouses, hotels, lodging houses, restaurants and
17 refreshment saloons.

18 (4) Barrooms, gaming, manufacturers of liquors and other
19 beverages, and saloons.

20 (5) Billiard tables, bowling alleys, caravans, circuses,
21 concerts and other exhibitions, dance houses, melodeons,
22 menageries, shooting galleries, skating rinks and theaters.

23 (6) Corrals, hay yards, livery and sale stables and wagon
24 yards.

25 (7) Electric light companies, illuminating gas companies,
26 power companies, telegraph companies, telephone companies and
27 water companies.

28 (8) Carts, drays, express companies, freight companies, job
29 wagons, omnibuses and stages.

30 (9) Brokers, commission merchants, factors, general agents,
31 mercantile agents, merchants, traders and stockbrokers.

32 (10) Drummers, hawkers, peddlers and solicitors.

33 (11) Insurance ~~agents, brokers,~~ analysts, adjusters and
34 managing general agents *and producers of insurance* within the
35 limitations and under the conditions prescribed in NRS 680B.020.

36 (b) Fix and collect a license tax upon all professions, trades or
37 business within the town not specified in paragraph (a).

38 2. No license to engage in business as a seller of tangible
39 personal property may be granted unless the applicant for the license
40 presents written evidence that:

41 (a) The Department of Taxation has issued or will issue a permit
42 for this activity, and this evidence clearly identifies the business by
43 name; or

44 (b) Another regulatory agency of the State has issued or will
45 issue a license required for this activity.



1 3. Any license tax levied for the purposes of NRS 244A.597 to
2 244A.655, inclusive, constitutes a lien upon the real and personal
3 property of the business upon which the tax was levied until the tax
4 is paid. The lien must be enforced in the same manner as liens for ad
5 valorem taxes on real and personal property. The town board or
6 other governing body of the unincorporated town may delegate the
7 power to enforce such liens to the county fair and recreation board.

8 4. The governing body or the county fair and recreation board
9 may agree with the Department of Taxation for the continuing
10 exchange of information concerning taxpayers.

11 5. The town board or board of county commissioners shall not
12 require a person to obtain a license or pay a license tax on the sole
13 basis that the person is a professional. As used in this subsection,
14 "professional" means a person who:

15 (a) Holds a license, certificate, registration, permit or similar
16 type of authorization issued by a regulatory body as defined in NRS
17 622.060, or who is regulated pursuant to the Nevada Supreme Court
18 Rules; and

19 (b) Practices his or her profession for any type of compensation
20 as an employee.

21 **Sec. 166.** NRS 616A.330 is hereby amended to read as
22 follows:

23 616A.330 "Tangible net worth" means the value of all the
24 assets, minus the value of all the liabilities, of *a self-insured*
25 *employer or* an association of self-insured private employers ~~for of a~~
26 ~~member of such an association~~ except:

27 1. Goodwill or excess cost over the fair market value of assets.

28 2. Any other items listed in the assets that are deemed
29 unacceptable by the Commissioner because they cannot be justified
30 or because they do not directly support the ability of the *self-insured*
31 *employer or* association ~~for the member~~ to pay a claim.

32 **Sec. 166.3.** NRS 616B.386 is hereby amended to read as
33 follows:

34 616B.386 1. If an employer wishes to become a member of
35 an association of self-insured public or private employers, the
36 employer must:

37 (a) Submit an application for membership to the board of
38 trustees or third-party administrator of the association; and

39 (b) Enter into an indemnity agreement as required by
40 NRS 616B.353.

41 2. The membership of the applicant becomes effective when
42 each member of the association approves the application or on a
43 later date specified by the association. The application for
44 membership and the action taken on the application must be
45 maintained as permanent records of the board of trustees.



1 3. Each member who is a member of an association during the
2 12 months immediately following the formation of the association
3 must:

4 (a) Have a tangible net worth of at least \$500,000; or

5 (b) Have had a reported payroll for the previous 12 months
6 which would have resulted in a manual premium of at least \$15,000,
7 calculated in accordance with a manual prepared pursuant to
8 subsection 4 of NRS 686B.1765.

9 4. An employer who seeks to become a member of the
10 association after the 12 months immediately following the formation
11 of the association must meet the requirement set forth in paragraph
12 (a) or (b) of subsection 3 unless the Commissioner adjusts the
13 requirement for membership in the association after conducting an
14 annual review of the actuarial solvency of the association pursuant
15 to subsection 1 of NRS 616B.353.

16 5. An association of self-insured private employers may apply
17 to the Commissioner for authority to determine the amount of
18 tangible net worth and manual premium that an employer must have
19 to become a member of the association. The Commissioner shall
20 approve the application if the association:

21 (a) Has been certified to act as an association for at least the 3
22 consecutive years immediately preceding the date on which the
23 association filed the application with the Commissioner;

24 (b) Has, as determined by the Commissioner, either:

25 (1) A combined tangible net worth of all members in the
26 association of at least \$5,000,000; or

27 (2) Combined net cash flows from operating activities plus
28 net cash flows from financing activities of all members in the
29 association of five times the average of claims paid for each of the
30 last 3 years or \$7,500,000, whichever is less;

31 (c) Has at least 15 members; and

32 (d) Has not been required to meet informally with the
33 Commissioner pursuant to subsection 1 of NRS 616B.431 during
34 the 18-month period immediately preceding the date on which the
35 association filed the application with the Commissioner or, if the
36 association has been required to attend such a meeting during that
37 period, has not had its certificate withdrawn before the date on
38 which the association filed the application.

39 6. An association of self-insured private employers may apply
40 to the Commissioner for authority to determine the documentation
41 demonstrating solvency that an employer must provide to become a
42 member of the association. The Commissioner shall approve the
43 application if the association:



1 (a) Has been certified to act as an association for at least the 3
2 consecutive years immediately preceding the date on which the
3 association filed the application with the Commissioner;

4 (b) Has, as determined by the Commissioner, either:

5 (1) A combined tangible net worth of all members in the
6 association of at least \$5,000,000; or

7 (2) Combined net cash flows from operating activities plus
8 net cash flows from financing activities of all members in the
9 association of five times the average of claims paid for each of the
10 last 3 years or \$7,500,000, whichever is less; and

11 (c) Has at least 15 members.

12 7. The Commissioner may withdraw approval of an application
13 submitted pursuant to subsection 5 or 6 if the Commissioner
14 determines the association has ceased to comply with any of the
15 requirements set forth in subsection 5 or 6, as applicable.

16 8. A member of an association *of self-insured public or*
17 *private employers* may terminate his or her membership at any time.
18 To terminate his or her membership, a member must submit to the
19 association's administrator a notice of intent to withdraw from the
20 association at least 120 days before the effective date of withdrawal.
21 The notice of intent to withdraw ~~must include a statement~~
22 ~~indicating~~ *shall be deemed rescinded if the member does not*
23 *provide to the association before the expiration of the 120-day*
24 *period proof* that the member has:

25 (a) Been certified as a self-insured employer pursuant to
26 NRS 616B.312;

27 (b) Become a member of another association of self-insured
28 public or private employers; or

29 (c) Become insured by a private carrier.

30 9. The members of an association may cancel the membership
31 of any member of the association in accordance with the bylaws of
32 the association.

33 10. The association shall:

34 (a) Within 30 days after the addition of an employer to the
35 membership of the association, notify the Commissioner of the
36 addition and:

37 (1) If the association has not received authority from the
38 Commissioner pursuant to subsection 5 or 6, as applicable, provide
39 to the Commissioner all information and assurances for the new
40 member that were required from each of the original members of the
41 association upon its organization; or

42 (2) If the association has received authority from the
43 Commissioner pursuant to subsection 5 or 6, as applicable, provide
44 to the Commissioner evidence that is satisfactory to the
45 Commissioner that the new member is a member or associate



1 member of the bona fide trade association as required pursuant to
2 paragraph (a) of subsection 2 of NRS 616B.350, a copy of the
3 indemnity agreement that jointly and severally binds the new
4 member, the other members of the association and the association
5 that is required to be executed pursuant to paragraph (a) of
6 subsection 1 of NRS 616B.353 and any other information the
7 Commissioner may reasonably require to determine whether the
8 amount of security deposited with the Commissioner pursuant to
9 paragraph (d) or (e) of subsection 1 of NRS 616B.353 is sufficient,
10 but such information must not exceed the information required to be
11 provided to the Commissioner pursuant to subparagraph (1);

12 (b) Notify the Commissioner and the Administrator of the
13 termination or cancellation of the membership of any member of the
14 association within 10 days after the termination or cancellation; and

15 (c) At the expense of the member whose membership is
16 terminated or cancelled, maintain coverage for that member for 60
17 days after notice is given pursuant to paragraph (b), unless the
18 association first receives notice from the Administrator that the
19 member has:

20 (1) Been certified as a self-insured employer pursuant to
21 NRS 616B.312;

22 (2) Become a member of another association of self-insured
23 public or private employers; or

24 (3) Become insured by a private carrier.

25 11. If a member of an association changes his or her name or
26 form of organization, the member remains liable for any obligations
27 incurred or any responsibilities imposed pursuant to chapters 616A
28 to 617, inclusive, of NRS under the member's former name or form
29 of organization.

30 12. An association is liable for the payment of any
31 compensation required to be paid by a member of the association
32 pursuant to chapters 616A to 616D, inclusive, or chapter 617 of
33 NRS during the member's period of membership. The insolvency or
34 bankruptcy of a member does not relieve the association of liability
35 for the payment of the compensation.

36 **Sec. 166.5.** 1. The provisions of NRS 689A.630, as amended
37 by section 98 of this act, apply to any discontinuation of a product
38 that occurs on or after the effective date of section 98 of this act.

39 2. The provisions of NRS 689B.560, as amended by section
40 110 of this act, apply to any discontinuation of a product offered to
41 employers that occurs on or after the effective date of section 110 of
42 this act.

43 3. The provisions of NRS 689C.310, as amended by section
44 112 of this act, apply to any discontinuation of a product offered to



1 small employers that occurs on or after the effective date of section
2 112 of this act.

3 4. The provisions of NRS 689C.470, as amended by section
4 114 of this act, apply to any discontinuation of a product offered to a
5 small employer or purchasers pursuant to NRS 689C.360 to
6 689C.600, inclusive, that occurs on or after the effective date of
7 section 114 of this act.

8 **Sec. 167.** The provisions of subsection 1 of NRS 218D.380 do
9 not apply to any provision of this act which adds or revises a
10 requirement to submit a report to the Legislature.

11 **Sec. 168.** NRS 680A.290, 689A.390, 689A.400, 689A.690,
12 689B.027, 689B.028, 689C.270, 689C.280, 689C.330, 689C.440,
13 689C.450, 690B.370, 695B.172, 695B.174 and 695F.215 are hereby
14 repealed.

15 **Sec. 169.** 1. Sections 98, 110, 112 and 114 of this act
16 become effective upon passage and approval.

17 2. This section and sections 1 to 97, inclusive, 99 to 109,
18 inclusive, 111, 113, 115 to 152, inclusive, 154, 156, 157 and 159 to
19 168, inclusive, of this act become effective:

20 (a) Upon passage and approval for the purpose of adopting
21 regulations and performing any other preparatory administrative
22 tasks that are necessary to carry out the provisions of this act; and

23 (b) On July 1, 2017, for all other purposes.

24 3. Sections 153, 155 and 158 of this act become effective:

25 (a) Upon passage and approval for the purpose of adopting
26 regulations and performing any other preparatory administrative acts
27 that are necessary to carry out the provisions of this act; and

28 (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.



