

Assembly Bill No. 293—Assemblymen Nolan, Beers, Brower, de Braga, Chowning, Evans, Leslie, Hettrick, Cegavske, Gustavson and Angle

CHAPTER.....

AN ACT relating to insurance; providing for the revision of the provisions governing parity for insurance benefits for the treatment of conditions relating to mental health; exempting certain group health coverage provided by public agencies from certain provisions governing required benefits; making various changes concerning the notice required to be provided to an insured when an insurer denies coverage of a health care service; requiring a managed care organization to provide coverage for medically necessary emergency services provided to an insured at any hospital; and providing other matters properly relating thereto.

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

Section 1. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. Notwithstanding any provision of this Title to the contrary, a policy of health insurance issued or delivered for issuance in this state pursuant to this chapter must provide coverage for the treatment of conditions relating to mental health and must not establish any rate, term or condition that places a greater financial burden on the insured person for access to treatment for conditions relating to mental health than for access to treatment for conditions relating to physical health. Any limits required under the policy of health insurance for deductibles and out-of-pocket expenses must be comprehensive for coverage of both conditions relating to mental health and conditions relating to physical health.

2. A policy of health insurance that does not otherwise provide for managed care, or that does not provide for the same degree of managed care for all health conditions, may provide coverage for the treatment of conditions relating to mental health through a managed care organization if the managed care organization is in compliance with regulations adopted by the commissioner which ensure that the system for delivery of the treatment for conditions relating to mental health does not diminish or negate the purpose of this section. The regulations adopted by the commissioner must ensure that:

- (a) Timely and appropriate access to care is available;*
- (b) The distribution of providers of health care who provide services relating to mental health is adequate to serve the needs of persons in this state, considering the quality, location and area of specialization of such providers; and*
- (c) Administrative or clinical protocols do not reduce access to medically necessary treatment for the insured person.*

3. A policy of health insurance shall be deemed to be in compliance with this section if the policy provides to the insured person at least one

option for treatment of conditions relating to mental health which has rates, terms and conditions that impose no greater financial burden on the insured person than that imposed for treatment of conditions relating to the physical health of the insured person. The commissioner may disapprove any policy of health insurance if he determines that the policy is inconsistent with this section.

4. Benefits provided pursuant to this section by a policy of health insurance for conditions relating to mental health must be paid in the same manner as benefits for any other illness covered by the policy.

5. Benefits for conditions relating to mental health are not required by this section if the treatment for the condition relating to mental health is not provided:

(a) By a person who is licensed or certified to provide treatment for conditions relating to mental health; or

(b) In a mental health facility or institution designated as a division facility pursuant to NRS 433.233, or in a medical or other facility licensed by the state board of health pursuant to chapter 449 of NRS that provides programs for the treatment of conditions relating to mental health, and pursuant to an individualized written plan developed for the insured person.

6. The provisions of this section must not be construed to:

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

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

(c) Affect any existing policy of health insurance until its date of renewal or, if the policy of health insurance is governed by a collective bargaining agreement or employment contract, until the expiration of that agreement or contract.

7. As used in this section:

(a) "Condition relating to mental health" means a condition or disorder involving mental illness that falls within any of the diagnostic categories listed in the section on mental disorders in the "International Classification of Diseases," published by the United States Department of Health and Human Services.

(b) "Managed care" has the meaning ascribed to it in NRS 695G.040.

(c) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

(d) "Rate, term or condition" means any lifetime or annual limit on payments, any requirement concerning deductibles, copayments, coinsurance or other forms of cost sharing, any limit on out-of-pocket costs or on visits to a provider of treatment, and any other financial component of health insurance coverage that affects the insured person.

Sec. 2. NRS 689A.040 is hereby amended to read as follows:

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

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

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

Sec. 3. NRS 689A.755 is hereby amended to read as follows:

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

- (a) At the time he receives his evidence of coverage;
- (b) Any time that the insurer denies coverage of a health care service or limits coverage of a health care service to an insured; and
- (c) Any other time deemed necessary by the commissioner.

2. Any time that an insurer denies coverage of a health care service to an insured, *including, without limitation, denying a claim relating to a policy of health insurance pursuant to NRS 689A.410*, it shall notify the insured in writing *within 10 working days after it denies coverage of the health care service* of:

- (a) The reason for denying coverage of the service;
- (b) The criteria by which the insurer determines whether to authorize or deny coverage of the health care service; and
- (c) His right to file a written complaint ~~and~~ *and the procedure for filing such a complaint*.

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

Sec. 4. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. Notwithstanding any provision of this Title to the contrary, a policy of group health insurance issued or delivered for issuance in this state pursuant to this chapter must provide coverage for the treatment of conditions relating to mental health and must not establish any rate, term or condition that places a greater financial burden on the insured person for access to treatment for conditions relating to mental health than for access to treatment for conditions relating to physical health. Any limits required under the policy of group health insurance for deductibles and out-of-pocket expenses must be comprehensive for coverage of both conditions relating to mental health and conditions relating to physical health.

2. A policy of group health insurance that does not otherwise provide for managed care, or that does not provide for the same degree of managed care for all health conditions, may provide coverage for the treatment of conditions relating to mental health through a managed care organization if the managed care organization is in compliance with regulations adopted by the commissioner which ensure that the system for delivery of the treatment for conditions relating to mental health does not diminish or negate the purpose of this section. The regulations adopted by the commissioner must ensure that:

- (a) Timely and appropriate access to care is available;*
- (b) The distribution of providers of health care who provide services relating to mental health is adequate to serve the needs of persons in this state, considering the quality, location and area of specialization of such providers; and*
- (c) Administrative or clinical protocols do not reduce access to medically necessary treatment for the insured person.*

3. A policy of group health insurance shall be deemed to be in compliance with this section if the policy provides to the insured person at least one option for treatment of conditions relating to mental health which has rates, terms and conditions that impose no greater financial burden on the insured person than that imposed for treatment of conditions relating to the physical health of the insured person. The commissioner may disapprove any policy of group health insurance if he determines that the policy is inconsistent with this section.

4. Benefits provided pursuant to this section by a policy of group health insurance for conditions relating to mental health must be paid in the same manner as benefits for any other illness covered by the policy.

5. Benefits for conditions relating to mental health are not required by this section if the treatment for the condition relating to mental health is not provided:

- (a) By a person who is licensed or certified to provide treatment for conditions relating to mental health; or*

(b) In a mental health facility or institution designated as a division facility pursuant to NRS 433.233, or in a medical or other facility licensed by the state board of health pursuant to chapter 449 of NRS that provides programs for the treatment of conditions relating to mental health, and pursuant to an individualized written plan developed for the insured person.

6. The provisions of this section must not be construed to:

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

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

(c) Affect any existing policy of group health insurance until its date of renewal or, if the policy of group health insurance is governed by a collective bargaining agreement or employment contract, until the expiration of that agreement or contract.

7. As used in this section:

(a) "Condition relating to mental health" means a condition or disorder involving mental illness that falls within any of the diagnostic categories listed in the section on mental disorders in the "International Classification of Diseases," published by the United States Department of Health and Human Services.

(b) "Managed care" has the meaning ascribed to it in NRS 695G.040.

(c) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

(d) "Rate, term or condition" means any lifetime or annual limit on payments, any requirement concerning deductibles, copayments, coinsurance or other forms of cost sharing, any limit on out-of-pocket costs or on visits to a provider of treatment, and any other financial component of health insurance coverage that affects the insured person.

Sec. 5. NRS 689B.0295 is hereby amended to read as follows:

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

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

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

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

2. Any time that an insurer denies coverage of a health care service , *including, without limitation, denying a claim relating to a policy of group health insurance or blanket insurance pursuant to NRS 689B.255,*

to an insured it shall notify the insured in writing *within 10 working days after it denies coverage of the health care service* of:

- (a) The reason for denying coverage of the service;
- (b) The criteria by which the insurer determines whether to authorize or deny coverage of the health care service; and
- (c) His right to file a written complaint ~~[-]~~ *and the procedure for filing such a complaint.*

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

Sec. 6. NRS 689B.030 is hereby amended to read as follows:

689B.030 Each group health insurance policy must contain in substance the following provisions:

1. A provision that, in the absence of fraud, all statements made by applicants or the policyholders or by an insured person are representations and not warranties, and that no statement made for the purpose of effecting insurance voids the insurance or reduces its benefits unless the statement is contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to him or his beneficiary.

2. A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of that employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one statement need be issued for each family.

3. A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

4. A provision for benefits for ~~[expense]~~ *expenses* arising from care at home or health supportive services if the care or service was prescribed by a physician and would have been covered by the policy if performed in a medical facility or facility for the dependent as defined in chapter 449 of NRS.

5. A provision for benefits ~~[payable]~~ for expenses incurred for the treatment of the abuse of alcohol or drugs, as provided in NRS 689B.036.

6. A provision for benefits for expenses arising from hospice care.

7. A provision for benefits for expenses incurred for the treatment of conditions relating to mental health, as provided in section 4 of this act.

Sec. 7. NRS 689B.340 is hereby amended to read as follows:

689B.340 As used in NRS 689B.340 to ~~[689B.600,]~~ *689B.590*, inclusive, unless the context otherwise requires, the words and terms defined in NRS 689B.350 to 689B.460, inclusive, have the meanings ascribed to them in those sections.

Sec. 8. NRS 689B.410 is hereby amended to read as follows:

689B.410 1. "Health benefit plan" means a policy, contract, certificate or agreement offered by a carrier to provide for, arrange for *the*

payment of, pay for or reimburse any of the costs of health care services. Except as otherwise provided in this section, the term includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis.

2. The term does not include:

- (a) Coverage that is only for accident or disability income insurance, or any combination thereof;
- (b) Coverage issued as a supplement to liability insurance;
- (c) Liability insurance, including general liability insurance and automobile liability insurance;
- (d) Workers' compensation or similar insurance;
- (e) Coverage for medical payments under a policy of automobile insurance;
- (f) Credit insurance;
- (g) Coverage for on-site medical clinics; and
- (h) Other similar insurance coverage specified in federal regulations issued pursuant to *the Health Insurance Portability and Accountability Act of 1996*, Public Law 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

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

- (a) Limited-scope dental or vision benefits;
- (b) Benefits for long-term care, nursing home care, home health care or community-based care, or any combination thereof; and
- (c) Such other similar benefits as are specified in any federal regulations adopted pursuant to *the Health Insurance Portability and Accountability Act of 1996*, Public Law 104-191.

4. For the purposes of NRS 689B.340 to ~~689B.600,~~ 689B.590, inclusive, if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and such benefits are paid for a claim without regard to whether benefits are provided for such a claim under any group health plan maintained by the same plan sponsor, the term does not include:

- (a) Coverage that is only for a specified disease or illness; and
- (b) Hospital indemnity or other fixed indemnity insurance.

5. For the purposes of NRS 689B.340 to ~~689B.600,~~ 689B.590, inclusive, if offered as a separate policy, certificate or contract of insurance, the term does not include:

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

(b) Coverage supplemental to the coverage provided pursuant to ~~chapter 55 of Title 10, United States Code~~ (*the* Civilian Health and

Medical Program of Uniformed Services ~~[(CHAMPUS)];~~, **CHAMPUS**, **10 U.S.C. §§ 1071 et seq.**; and

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

Sec. 9. NRS 689B.470 is hereby amended to read as follows:

689B.470 For the purposes of NRS 689B.340 to ~~[689B.600,]~~ **689B.590**, inclusive:

1. Any plan, fund or program which would not be, but for section 2721(e) of the Public Health Service Act, **42 U.S.C. § 300gg-21(e)**, as amended by Public Law 104-191, as that section existed on July 16, 1997, an employee welfare benefit plan and which is established or maintained by a partnership to the extent that the plan, fund or program provides medical care, including items and services paid for as medical care, to current or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement, or otherwise, must be treated, subject to the provisions of subsection 2, as an employee welfare benefit plan that is a group health plan.

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

Sec. 10. NRS 689B.480 is hereby amended to read as follows:

689B.480 1. In determining the applicable creditable coverage of a person for the purposes of NRS 689B.340 to ~~[689B.600,]~~ **689B.590**, inclusive, a period of creditable coverage must not be included if, after the expiration of that period but before the enrollment date, there was a 63-day period during all of which the person was not covered under any creditable coverage. To establish a period of creditable coverage, a person must present any certificates of coverage provided to him in accordance with NRS 689B.490 and such other evidence of coverage as required by regulations adopted by the commissioner. For the purposes of this subsection, any waiting period for coverage or an affiliation period must not be considered in determining the applicable period of creditable coverage.

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

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

- (a) Included prominently in any disclosure statement concerning the health benefit plan; and
- (b) Provided to each person at the time of enrollment in the health benefit plan.

Sec. 11. NRS 689B.580 is hereby amended to read as follows:

689B.580 1. A plan sponsor of a governmental plan that is a group health plan to which the provisions of NRS 689B.340 to ~~689B.600,~~ **689B.590**, inclusive, otherwise apply may elect to exclude the governmental plan from compliance with those sections. Such an election:

- (a) Must be made in such a form and in such a manner as the commissioner prescribes by regulation.
- (b) Is effective for a single specified year of the plan or, if the plan is provided pursuant to a collective bargaining agreement, for the term of that agreement.
- (c) May be extended by subsequent elections.
- (d) Excludes the governmental plan from those provisions in this chapter that apply only to group health plans.

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

- (a) Annually and at the time of enrollment, notify the enrollees in the plan of the election and the consequences of the election; and
- (b) Provide certification and disclosure of creditable coverage under the plan with respect to those enrollees pursuant to NRS 689B.490.

3. As used in this section, "governmental plan" has the meaning ascribed to in section 3(32) of the Employee Retirement Income Security Act of 1974, **29 U.S.C. § 1002(32)**, as that section existed on July 16, 1997.

Sec. 12. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. Notwithstanding any provision of this Title to the contrary, a health benefit plan issued or delivered for issuance in this state pursuant to this chapter must provide coverage for the treatment of conditions relating to mental health and must not establish any rate, term or condition that places a greater financial burden on the insured person for access to treatment for conditions relating to mental health than for access to treatment for conditions relating to physical health. Any limits required under the health benefit plan for deductibles and out-of-pocket expenses must be comprehensive for coverage of both conditions relating to mental health and conditions relating to physical health.

2. A health benefit plan that does not otherwise provide for managed care, or that does not provide for the same degree of managed care for all health conditions, may provide coverage for the treatment of

conditions relating to mental health through a managed care organization if the managed care organization is in compliance with regulations adopted by the commissioner which ensure that the system for delivery of the treatment for conditions relating to mental health does not diminish or negate the purpose of this section. The regulations adopted by the commissioner must ensure that:

- (a) Timely and appropriate access to care is available;
- (b) The distribution of providers of health care who provide services relating to mental health is adequate to serve the needs of persons in this state, considering the quality, location and area of specialization of such providers; and
- (c) Administrative or clinical protocols do not reduce access to medically necessary treatment for the insured person.

3. A health benefit plan shall be deemed to be in compliance with this section if the health benefit plan provides to the insured person at least one option for treatment of conditions relating to mental health which has rates, terms and conditions that impose no greater financial burden on the insured person than that imposed for treatment of conditions relating to the physical health of the insured person. The commissioner may disapprove any health benefit plan if he determines that the plan is inconsistent with this section.

4. Benefits provided pursuant to this section by a health benefit plan for conditions relating to mental health must be paid in the same manner as benefits for any other illness covered by the health benefit plan.

5. Benefits for conditions relating to mental health are not required by this section if the treatment for the condition relating to mental health is not provided:

- (a) By a person who is licensed or certified to provide treatment for conditions relating to mental health; or
- (b) In a mental health facility or institution designated as a division facility pursuant to NRS 433.233, or in a medical or other facility licensed by the state board of health pursuant to chapter 449 of NRS that provides programs for the treatment of conditions relating to mental health, and pursuant to an individualized written plan developed for the insured person.

6. The provisions of this section must not be construed to:

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

(c) Affect any existing health benefit plan until its date of renewal or, if the health benefit plan is governed by a collective bargaining

agreement or employment contract, until the expiration of that agreement or contract.

7. As used in this section:

(a) "Condition relating to mental health" means a condition or disorder involving mental illness that falls within any of the diagnostic categories listed in the section on mental disorders in the "International Classification of Diseases," published by the United States Department of Health and Human Services.

(b) "Managed care" has the meaning ascribed to it in NRS 695G.040.

(c) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

(d) "Rate, term or condition" means any lifetime or annual limit on payments, any requirement concerning deductibles, copayments, coinsurance or other forms of cost sharing, any limit on out-of-pocket costs or on visits to a provider of treatment, and any other financial component of health insurance coverage that affects the insured person.

Sec. 13. NRS 689C.155 is hereby amended to read as follows:

689C.155 The commissioner may adopt regulations to carry out the provisions of *section 12 of this act and* NRS 689C.107 to 689C.145, inclusive, 689C.156 to 689C.159, inclusive, 689C.165, 689C.183, 689C.187, 689C.191 to 689C.198, inclusive, 689C.203, 689C.207, 689C.265, 689C.283, 689C.287, 689C.325, 689C.342 to 689C.348, inclusive, 689C.355 and 689C.610 to 689C.980, inclusive, and to ensure that rating practices used by carriers serving small employers are consistent with those sections, including regulations that:

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

2. Prescribe the manner in which characteristics may be used by such carriers.

Sec. 14. NRS 689C.156 is hereby amended to read as follows:

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

2. A carrier shall issue to a small employer any health benefit plan marketed in accordance with this section if the eligible small employer applies for the plan and agrees to make the required premium payments and satisfy the other reasonable provisions of the health benefit plan that are not

inconsistent with NRS 689C.015 to 689C.355, inclusive, *and section 12 of this act*, and NRS 689C.610 to 689C.980, inclusive, except that a carrier is not required to issue a health benefit plan to a self-employed person who is covered by, or is eligible for coverage under, a health benefit plan offered by another employer.

Sec. 15. NRS 695A.152 is hereby amended to read as follows:

695A.152 1. To the extent reasonably applicable, a fraternal benefit society shall comply with the provisions of NRS 689B.340 to ~~698B.600,~~ **689B.590**, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance offered by the society to its members. If there is a conflict between the provisions of this chapter and the provisions of NRS 689B.340 to ~~698B.600,~~ **689B.590**, inclusive, and chapter 689C of NRS, the provisions of NRS 689B.340 to ~~698B.600,~~ **689B.590**, inclusive, and chapter 689C of NRS control.

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

Sec. 16. NRS 695A.159 is hereby amended to read as follows:

695A.159 1. If a person:

(a) Adopts a dependent child; or

(b) Assumes and retains a legal obligation for the total or partial support of a dependent child in anticipation of adopting the child, while the person is eligible for group coverage under a certificate for health benefits, the society issuing that certificate shall not restrict the coverage, in accordance with NRS 689B.340 to ~~689B.600,~~ **689B.590**, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance, of the child solely because of a preexisting condition the child has at the time he would otherwise become eligible for coverage pursuant to that policy.

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

Sec. 17. NRS 695B.180 is hereby amended to read as follows:

695B.180 A contract for hospital, medical or dental services must not be entered into between a corporation proposing to furnish or provide any one or more of the services authorized under this chapter and a subscriber:

1. Unless the entire consideration therefor is expressed in the contract.

2. Unless the times at which the benefits or services to the subscriber take effect and terminate are stated in a portion of the contract above the evidence of its execution.

3. If the contract purports to entitle more than one person to benefits or services, except for family contracts issued under NRS 695B.190, group contracts issued under NRS 695B.200, and blanket contracts issued under NRS 695B.220.

4. Unless every printed portion and any endorsement or attached papers are plainly printed in type of which the face is not smaller than 10 points.

5. Except for group contracts and blanket contracts issued under NRS 695B.220, unless the exceptions of the contract are printed with greater prominence than the benefits to which they apply.

6. Except for group contracts and blanket contracts issued under NRS 695B.230, unless, if any portion of the contract purports, by reason of the circumstances under which an illness, injury or disablement is incurred to reduce any service to less than that provided for the same illness, injury or disablement incurred under ordinary circumstances, that portion is printed in boldface type and with greater prominence than any other text of the contract.

7. If the contract contains any provisions purporting to make any portion of the charter, constitution or bylaws of a nonprofit corporation a part of the contract unless that portion is set forth in full in the contract.

8. Unless the contract, if it is a group contract, contains a provision for benefits payable for expenses incurred for the treatment of ~~the~~ :

(a) *The* abuse of alcohol or drugs, as provided in NRS 695B.194 ~~H~~ ;
and

(b) *Conditions relating to mental health, as provided in section 4 of this act.*

9. Unless the contract provides benefits for expenses incurred for hospice care.

10. Unless the contract for service in a hospital contains in blackface type, not less than 10 points, the following provisions:

This contract does not restrict or interfere with the right of any person entitled to service and care in a hospital to select the contracting hospital or to make a free choice of his attending physician, who must be the holder of a valid and unrevoked physician's license and a member of, or acceptable to, the attending staff and board of directors of the hospital in which the services are to be provided.

Sec. 18. NRS 695B.187 is hereby amended to read as follows:

695B.187 Except as otherwise provided by the provisions of NRS 689B.340 to ~~689B.600,~~ **689B.590**, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance:

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

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

(b) Except as otherwise provided in subsection 2, provide benefits which are at least as extensive as the benefits provided by the previous policy or coverage, except that the benefits may be reduced or excluded to

the extent that such a reduction or exclusion was permissible under the terms of the previous policy or coverage, if that contract is issued within 60 days after the date on which the previous policy or coverage was discontinued.

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

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

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

Sec. 19. NRS 695B.189 is hereby amended to read as follows:

695B.189 A group contract issued by a corporation under the provisions of this chapter must contain a provision which permits the continuation of coverage pursuant to the provisions of NRS 689B.245 to 689B.249, inclusive, and 689B.340 to ~~689B.600,~~ **689B.590**, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance.

Sec. 20. NRS 695B.192 is hereby amended to read as follows:

695B.192 1. No hospital, medical or dental service contract issued by a corporation pursuant to the provisions of this chapter may contain any exclusion, reduction or other limitation of coverage relating to complications of pregnancy, unless the provision applies generally to all benefits payable under the contract and complies with the provisions of NRS 689B.340 to NRS ~~689B.600,~~ **689B.590**, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance.

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

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

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

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

Sec. 21. NRS 695B.251 is hereby amended to read as follows:

695B.251 1. Except as otherwise provided in the provisions of this section, NRS 689B.340 to ~~689B.600,~~ 689B.590, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance, all group subscriber contracts delivered or issued for delivery in this state providing for hospital, surgical or major medical coverage, or any combination of these coverages, on a service basis or an expense-incurred basis, or both, must contain a provision that the employee or member is entitled to have issued to him a subscriber contract of health coverage when the employee or member is no longer covered by the group subscriber contract.

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

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

Sec. 22. NRS 695B.318 is hereby amended to read as follows:

695B.318 1. Nonprofit hospital, medical or dental service corporations are subject to the provisions of NRS 689B.340 to ~~689B.600,~~ 689B.590, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance offered by such organizations. If there is a conflict between the provisions of this chapter and the provisions of NRS 689B.340 to ~~689B.600,~~ 689B.590, inclusive, and chapter 689C of NRS, the provisions of NRS 689B.340 to ~~689B.600,~~ 689B.590, inclusive, and chapter 689C of NRS control.

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

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

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

Sec. 23. NRS 695B.400 is hereby amended to read as follows:

695B.400 1. Following approval by the commissioner, each insurer that issues a contract for hospital or medical services in this state shall provide written notice to an insured, in clear and comprehensible language that is understandable to an ordinary layperson, explaining the right of the insured to file a written complaint. Such notice must be provided to an insured:

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

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

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

2. Any time that an ~~insured~~ **insurer** denies coverage of a health care service to a beneficiary or subscriber, **including, without limitation, denying a claim relating to a contract for dental, hospital or medical services pursuant to NRS 695B.2505**, it shall notify the beneficiary or subscriber in writing **within 10 working days after it denies coverage of the health care service** of:

(a) The reason for denying coverage of the service;

(b) The criteria by which the insurer determines whether to authorize or deny coverage of the health care service; and

(c) His right to file a written complaint ~~[-]~~ **and the procedure for filing such a complaint.**

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

Sec. 24. NRS 695C.057 is hereby amended to read as follows:

695C.057 1. A health maintenance organization is subject to the provisions of NRS 689B.340 to ~~689B.600,]~~ **689B.590**, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance offered by such organizations. If there is a conflict between the provisions of this chapter and the provisions of NRS 689B.340 to ~~689B.600,]~~ **689B.590**, inclusive, and chapter 689C of NRS, the provisions of NRS 689B.340 to ~~689B.600,]~~ **689B.590**, inclusive, and chapter 689C of NRS control.

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

Sec. 25. NRS 695C.170 is hereby amended to read as follows:

695C.170 1. Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy, whether by option or otherwise, the insurer shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

2. Evidence of coverage or amendment thereto must not be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment thereto has been filed with and approved by the commissioner.

3. An evidence of coverage

:

(a) Must not contain any provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, which encourage misrepresentation or which are untrue, misleading or deceptive as defined in subsection 1 of NRS 695C.300; and

(b) Must contain a clear and complete statement, if a contract, or a reasonably complete summary if a certificate, of:

(1) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;

(2) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

(3) Where and in what manner the services may be obtained;

(4) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay; and

(5) A provision for benefits payable for expenses incurred for the treatment of ~~the~~ :

(I) The abuse of alcohol or drugs, as provided in NRS 695C.174 ~~H~~ ; and

(II) Conditions relating to mental health, as provided in section 4 of this act.

Any subsequent change may be evidenced in a separate document issued to the enrollee.

4. A copy of the form of the evidence of coverage to be used in this state and any amendment thereto is subject to the requirements for filing and approval of subsection 2 unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance, in which event the provisions for filing and approval of those laws apply. To the extent that such provisions do not apply to the requirements in subsection 3, such provisions are amended to incorporate the requirements of subsection 3 in approving or disapproving an evidence of coverage required by subsection 2.

Sec. 26. NRS 695C.1705 is hereby amended to read as follows:

695C.1705 Except as otherwise provided in the provisions of NRS 689B.340 to ~~[689B.600,]~~ **689B.590**, inclusive, and chapter 689C of NRS relating to the portability and accountability of health insurance:

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

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

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

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

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

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

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

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

Sec. 27. NRS 695C.1707 is hereby amended to read as follows:

695C.1707 Any policy of group insurance to which an enrollee is entitled under a health care plan provided by a health maintenance organization must contain a provision which permits the continuation of coverage pursuant to the provisions of NRS 689B.245 to 689B.249, inclusive, NRS 689B.340 to ~~689B.600,~~ 689B.590, inclusive, and chapter 689C of NRS relating to the portability and accountability of health insurance.

Sec. 28. NRS 695C.172 is hereby amended to read as follows:

695C.172 1. No health maintenance organization may issue evidence of coverage under a health care plan to any enrollee in this state if it contains any exclusion, reduction or other limitation of coverage relating to complications of pregnancy unless the provision applies generally to all benefits payable under the policy and complies with the provisions of NRS 689B.340 to ~~689B.600,~~ 689B.590, inclusive, and chapter 689C of NRS relating to the portability and accountability of health insurance.

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

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

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

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

Sec. 29. NRS 695F.090 is hereby amended to read as follows:

695F.090 Prepaid limited health service organizations are subject to the provisions of this chapter and to the following provisions, to the extent reasonably applicable:

1. NRS 687B.310 to 687B.420, inclusive, concerning cancellation and nonrenewal of policies.

2. NRS 687B.122 to 687B.128, inclusive, concerning readability of policies.

3. The requirements of NRS 679B.152.

4. The fees imposed pursuant to NRS 449.465.

5. NRS 686A.010 to 686A.310, inclusive, concerning trade practices and frauds.

6. The assessment imposed pursuant to subsection 3 of NRS 679B.158.

7. Chapter 683A of NRS.

8. To the extent applicable, the provisions of NRS 689B.340 to ~~689B.600,~~ **689B.590**, inclusive, and chapter 689C of NRS relating to the portability and availability of health insurance.

9. NRS 689A.413.

10. NRS 680B.025 to 680B.039, inclusive, concerning premium tax, premium tax rate, annual report and estimated quarterly tax payments. For the purposes of this subsection, unless the context otherwise requires that a section apply only to insurers, any reference in those sections to "insurer" must be replaced by a reference to "prepaid limited health service organization."

11. Chapter 692C of NRS, concerning holding companies.

Sec. 30. NRS 695G.230 is hereby amended to read as follows:

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

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

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

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

2. Any time that a managed care organization denies coverage of a health care service to an insured, **including, without limitation, a health**

maintenance organization that denies a claim related to a health care plan pursuant to NRS 695C.185, it shall notify the insured in writing within 10 working days after it denies coverage of the health care service

of:

- (a) The reason for denying coverage of the service;
- (b) The criteria by which the managed care organization or insurer determines whether to authorize or deny coverage of the health care service; and
- (c) His right to file a written complaint ~~and~~ ***and the procedure for filing such a complaint.***

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

Sec. 31. NRS 695G.170 is hereby amended to read as follows:

695G.170 1. Each managed care organization shall provide coverage for medically necessary emergency services ~~and~~ ***provided at any hospital.***

2. A managed care organization shall not require prior authorization for medically necessary emergency services.

3. As used in this section, “medically necessary emergency services” means health care services that are provided to an insured by a provider of health care after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:

- (a) Serious jeopardy to the health of an insured;
- (b) Serious jeopardy to the health of an unborn child;
- (c) Serious impairment of a bodily function; or
- (d) Serious dysfunction of any bodily organ or part.

4. A health care plan subject to the provisions of this section that is delivered, issued for delivery or renewed on or after October 1, ~~1997,~~ ***1999,*** has the legal effect of including the coverage required by this section, and any provision of the plan or the renewal which is in conflict with this section is void.

Sec. 32. NRS 287.010 is hereby amended to read as follows:

287.010 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other public agency of the State of Nevada may:

(a) Adopt and carry into effect a system of group life, accident or health insurance, or any combination thereof, for the benefit of its officers and employees, and the dependents of officers and employees who elect to accept the insurance and who, where necessary, have authorized the governing body to make deductions from their compensation for the payment of premiums on the insurance.

(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of

such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this state. Any contract with an independent administrator must be approved by the commissioner of insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 689B.030 to 689B.050, inclusive, apply to coverage provided pursuant to this paragraph ~~4~~, *except that the provisions of section 4 of this act do not apply to such coverage.*

(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation, political subdivision, public corporation or other public agency of the State of Nevada.

2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.

Sec. 33. NRS 287.045 is hereby amended to read as follows:

287.045 1. Except as otherwise provided in this section, every officer or employee of the state is eligible to participate in the program on the first day of the month following the completion of 90 days of full-time employment.

2. Professional employees of the University and Community College System of Nevada who have annual employment contracts are eligible to participate in the program on:

(a) The effective dates of their respective employment contracts, if those dates are on the first day of a month; or

(b) The first day of the month following the effective dates of their respective employment contracts, if those dates are not on the first day of a month.

3. Every officer or employee who is employed by a participating public agency on a permanent and full-time basis on the date the agency enters

into an agreement to participate in the state's group insurance program, and every officer or employee who commences his employment after that date is eligible to participate in the program on the first day of the month following the completion of 90 days of full-time employment.

4. Every senator and assemblyman is eligible to participate in the program on the first day of the month following the 90th day after his initial term of office begins.

5. An officer or employee of the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other public agency of the State of Nevada who retires under the conditions set forth in NRS 286.510 or 286.620 and was not participating in the state's group insurance program at the time of his retirement is eligible to participate in the program 30 days after notice of the selection to participate is given pursuant to NRS 287.023 or 287.0235. The committee on benefits shall make a separate accounting for these retired persons. For the first year following enrollment, the rates charged must be the full actuarial costs determined by the actuary based upon the expected claims experience with these retired persons. The claims experience of these retired persons must not be commingled with the retired persons who were members of the state's program before their retirement, nor with active employees of the state. After the first year following enrollment, the rates charged must be the full actuarial costs determined by the actuary based upon the past claims experience of these retired persons since enrolling.

6. Notwithstanding the provisions of subsections 1, 3 and 4, if the committee on benefits does not, pursuant to NRS 689B.580, elect to exclude the program from compliance with NRS 689B.340 to ~~689B.600,~~ **689B.590**, inclusive, and if the coverage under the program is provided by a health maintenance organization authorized to transact insurance in this state pursuant to chapter 695C of NRS, any affiliation period imposed by the program may not exceed the statutory limit for an affiliation period set forth in NRS 689B.500.

Sec. 34. NRS 689B.600 is hereby repealed.

Sec. 35. 1. This section and sections 1, 2, 4, 6 to 22, inclusive, 24 to 29, inclusive, 32, 33 and 34 of this act become effective on July 1, 1999.

2. Sections 3, 5, 23, 30 and 31 of this act become effective on October 1, 1999.

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