

Assembly Bill No. 470—Assemblymen Goldwater and Buckley

CHAPTER.....

AN ACT relating to industrial insurance; prohibiting organizations for managed care that provide medical and health care services to injured employees from engaging in certain practices that restrict the actions of a provider of health care; requiring a response to a request for prior authorization for medical treatment to be issued within a certain number of days; allowing an injured employee whose employer's insurer has entered into a contract with an organization for managed care or providers of health care to change treating physicians or chiropractors under certain circumstances; requiring that a test of an injured employee for the presence of alcohol or a controlled substance be performed by a laboratory that is licensed by the health division of the department of human resources; allowing hearing officers and appeals officers to refer an injured employee to a physician or chiropractor competent to determine the necessity of certain medical treatment; revising the provisions governing the filing of rates for industrial insurance with the commissioner of insurance; 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 616B of NRS is hereby amended by adding thereto the provisions set forth as sections 2, 3 and 4 of this act.

Sec. 2. *An organization for managed care shall not restrict or interfere with any communication between a provider of health care and an injured employee regarding any information that the provider of health care determines is relevant to the health care of the injured employee.*

Sec. 3. *An organization for managed care shall not terminate a contract with, demote, refuse to contract with or refuse to compensate a provider of health care solely because the provider, in good faith:*

- 1. Advocates in private or in public on behalf of an injured employee;*
- 2. Assists an injured employee in seeking reconsideration of a determination by the organization for managed care to deny coverage for a medical or health care service; or*
- 3. Reports a violation of law to an appropriate authority.*

Sec. 4. 1. *An organization for managed care shall not offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay specific medically necessary medical or health care services to an injured employee.*

2. The provisions of this section do not prohibit an arrangement for payment between an organization for managed care and a provider of health care that uses financial incentives, if the arrangement is designed to provide an incentive to the provider of health care to use medical and health care services effectively and consistently in the best interest of the treatment of the injured employee.

Sec. 5. NRS 616B.515 is hereby amended to read as follows:

616B.515 1. Except as otherwise provided in NRS 616B.518, the manager may enter into a contract or contracts with one or more organizations for managed care, including health maintenance organizations, to provide comprehensive medical and health care services to injured employees whose employers are insured by the system for injuries and diseases that are compensable under chapters 616A to 617, inclusive, of NRS. The contract or contracts must be awarded pursuant to reasonable competitive bidding procedures as established by the manager.

2. After the selection of an organization for managed care, the bids received by the manager and the records related to the bidding are subject to review by any member of the public upon request.

3. An organization for managed care or a health maintenance organization ~~{shall}~~ *chosen pursuant to this section:*

(a) Shall not discriminate against or exclude a provider of health care from participation in the organization's proposed plan for providing medical and health care services because of race, creed, sex, national origin, age or disability.

(b) Shall comply with the provisions of sections 2, 3 and 4 of this act.

Sec. 6. NRS 616B.527 is hereby amended to read as follows:

616B.527 A self-insured employer, an association of self-insured public or private employers or a private carrier may:

1. Enter into a contract or contracts with one or more organizations for managed care to provide comprehensive medical and health care services to employees for injuries and diseases that are compensable pursuant to chapters 616A to 617, inclusive, of NRS.

2. Enter into a contract or contracts with providers of health care, including, without limitation, physicians who provide primary care, specialists, pharmacies, physical therapists, radiologists, nurses, diagnostic facilities, laboratories, hospitals and facilities that provide treatment to outpatients, to provide medical and health care services to employees for injuries and diseases that are compensable pursuant to chapters 616A to 617, inclusive, of NRS.

3. Use the services of an organization for managed care that has entered into a contract with the manager pursuant to NRS 616B.515, but is not required to use such services.

4. Require employees to obtain medical and health care services for their industrial injuries from those organizations and persons with whom the self-insured employer, association or private carrier has contracted pursuant to subsections 1 and 2, or as the self-insured employer, association or private carrier otherwise prescribes.

5. Require employees to obtain the approval of the self-insured employer, association or private carrier before obtaining medical and health care services for their industrial injuries from a provider of health care who has not been previously approved by the self-insured employer, association or private carrier.

6. An organization for managed care with whom a self-insured employer, association of self-insured public or private employers or a private carrier has contracted pursuant to this section shall comply with the provisions of sections 2, 3 and 4 of this act.

Sec. 7. Chapter 616C of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer, organization for managed care or third-party administrator shall respond to a written request for prior authorization for:

- (a) Treatment;**
- (b) Diagnostic testing; or**
- (c) Consultation,**

within 5 working days after receiving the written request.

2. If the insurer, organization for managed care or third-party administrator fails to respond to such a request within 5 working days, authorization shall be deemed to be given. The insurer, organization for managed care or third-party administrator may subsequently deny authorization.

3. If the insurer, organization for managed care or third-party administrator subsequently denies a request for authorization submitted by a provider of health care for additional visits or treatments, it shall pay for the additional visits or treatments actually provided to the injured employee, up to the number of treatments for which payment is requested by the provider of health care before the denial of authorization is received by the provider.

Sec. 8. NRS 616C.090 is hereby amended to read as follows:

616C.090 1. The administrator shall establish a panel of physicians and chiropractors who have demonstrated special competence and interest in industrial health to treat injured employees under chapters 616A to 616D, inclusive, or chapter 617 of NRS. Every employer whose insurer has not entered into a contract with an organization for managed care **or with providers of health care services** pursuant to NRS 616B.515 **or 616B.527** shall maintain a list of those physicians and chiropractors on the panel who are reasonably accessible to his employees.

2. An injured employee whose **employer's** insurer has not entered into a contract with an organization for managed care **or with providers of health care services pursuant to NRS 616B.515 or 616B.527** may choose his treating physician or chiropractor from the panel of physicians and chiropractors. If the injured employee is not satisfied with the first physician or chiropractor he so chooses, he may make an alternative choice of physician or chiropractor from the panel if the choice is made within 90 days after his injury. The insurer shall notify the first physician or chiropractor in writing. The notice must be postmarked within 3 working days after the insurer receives knowledge of the change. The first physician or chiropractor must be reimbursed only for the services he rendered to the injured employee up to and including the date of notification. Any further

change is subject to the approval of the insurer, which must be granted or denied within 10 days after a written request for such a change is received from the injured employee. If no action is taken on the request within 10 days, the request shall be deemed granted. Any request for a change of physician or chiropractor must include the name of the new physician or chiropractor chosen by the injured employee.

3. An injured employee ~~employed or residing in any county in this state~~ whose **employer's** insurer has entered into a contract with an organization for managed care **or with providers of health care services pursuant to NRS 616B.515 or 616B.527** must choose his treating physician or chiropractor pursuant to the terms of that contract. ***If the injured employee is not satisfied with the first physician or chiropractor he so chooses, he may make an alternative choice of physician or chiropractor pursuant to the terms of the contract if the choice is made within 90 days after his injury.*** If the **injured** employee, after choosing his treating physician or chiropractor, moves to a county which is not served by the organization for managed care **or providers of health care named in the contract** and the insurer determines that it is impractical for the **injured** employee to continue treatment with the physician or chiropractor, the **injured** employee must choose a treating physician or chiropractor who has agreed to the terms of that contract unless the insurer authorizes the **injured** employee to choose another physician or chiropractor.

4. Except when emergency medical care is required and except as otherwise provided in NRS 616C.055, the insurer is not responsible for any charges for medical treatment or other accident benefits furnished or ordered by any physician, chiropractor or other person selected by the **injured** employee in disregard of the provisions of this section or for any compensation for any aggravation of the **injured** employee's injury attributable to improper treatments by such physician, chiropractor or other person.

5. The administrator may order necessary changes in a panel of physicians and chiropractors and shall suspend or remove any physician or chiropractor from a panel for good cause shown.

6. An injured employee may receive treatment by more than one physician or chiropractor if the insurer provides written authorization for such treatment.

Sec. 8.5. NRS 616C.230 is hereby amended to read as follows:

616C.230 1. Compensation is not payable pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS for an injury:

- (a) Caused by the employee's willful intention to injure himself.
- (b) Caused by the employee's willful intention to injure another.
- (c) Proximately caused by the employee's intoxication. If the employee was intoxicated at the time of his injury, intoxication must be presumed to be a proximate cause unless rebutted by evidence to the contrary.

(d) Proximately caused by the employee's use of a controlled substance. If the employee had any amount of a controlled substance in his system at the time of his injury for which the employee did not have a current and lawful prescription issued in his name, the controlled substance must be presumed to be a proximate cause unless rebutted by evidence to the contrary.

2. For the purposes of paragraphs (c) and (d) of subsection 1:

(a) The affidavit or declaration of an expert or other person described in NRS 50.315 is admissible to prove the existence of any alcohol or the existence, quantity or identity of a controlled substance in an employee's system. If the affidavit or declaration is to be so used, it must be submitted in the manner prescribed in NRS 616C.355.

(b) When an examination requested or ordered includes testing for the use of alcohol or a controlled substance, ~~it~~:

~~—(1) If the laboratory that conducts the testing is located in a county whose population is 100,000 or more and the testing is of urine, the laboratory must be certified for forensic testing of urine for drugs by the College of American Pathologists or a successor organization or by the federal Department of Health and Human Services; and~~

~~—(2) Any such testing of breath for alcohol must be performed pursuant to the regulations of the federal Department of Transportation.]~~ **licensed pursuant to the provisions of chapter 652 of NRS.**

3. No compensation is payable for the death, disability or treatment of an employee if his death is caused by, or insofar as his disability is aggravated, caused or continued by, an unreasonable refusal or neglect to submit to or to follow any competent and reasonable surgical treatment or medical aid.

4. If any employee persists in an unsanitary or injurious practice that imperils or retards his recovery, or refuses to submit to such medical or surgical treatment as is necessary to promote his recovery, his compensation may be reduced or suspended.

5. An injured employee's compensation, other than accident benefits, must be suspended if:

(a) A physician or chiropractor determines that the employee is unable to undergo treatment, testing or examination for the industrial injury solely because of a condition or injury that did not arise out of and in the course of his employment; and

(b) It is within the ability of the employee to correct the nonindustrial condition or injury.

The compensation must be suspended until the injured employee is able to resume treatment, testing or examination for the industrial injury. The insurer may elect to pay for the treatment of the nonindustrial condition or injury.

Sec. 9. NRS 616C.305 is hereby amended to read as follows:

616C.305 1. Except as otherwise provided in subsection 3, any person who is aggrieved by a ~~{decision}~~ **final determination** concerning accident benefits made by an organization for managed care which has contracted with an insurer must, within 14 days of the ~~{decision}~~ **determination** and before requesting a resolution of the dispute pursuant to NRS 616C.345 to 616C.385, inclusive, appeal that ~~{decision}~~ **determination** in accordance with the procedure for resolving complaints established by the organization for managed care.

2. The procedure for resolving complaints established by the organization for managed care must be informal and must include, but is not limited to, a review of the appeal by a qualified physician or chiropractor who did not make or otherwise participate in making the ~~{decision.}~~ **determination.**

3. If a person appeals a final determination pursuant to a procedure for resolving complaints established by an organization for managed care and the dispute is not resolved within 14 days after it is submitted, he may request a resolution of the dispute pursuant to NRS 616C.345 to 616C.385, inclusive.

Sec. 10. NRS 616C.330 is hereby amended to read as follows:

616C.330 1. The hearing officer shall:

(a) Within 5 days after receiving a request for a hearing, set the hearing for a date and time within 30 days after his receipt of the request;

(b) Give notice by mail or by personal service to all interested parties to the hearing at least 15 days before the date and time scheduled; and

(c) Conduct hearings expeditiously and informally.

2. The notice must include a statement that the injured employee may be represented by a private attorney or seek assistance and advice from the Nevada attorney for injured workers.

3. If necessary to resolve a medical question concerning an injured employee's condition ~~{ } or to determine the necessity of treatment for which authorization for payment has been denied,~~ the hearing officer may refer the employee to a physician or chiropractor ~~{chosen by the hearing officer.}~~ **of his choice who has demonstrated special competence to treat the particular medical condition of the employee.** If the medical question concerns the rating of a permanent disability, the hearing officer may refer the employee to a rating physician or chiropractor. The rating physician or chiropractor must be selected in rotation from the list of qualified physicians and chiropractors maintained by the administrator pursuant to subsection 2 of NRS 616C.490, unless the insurer and injured employee otherwise agree to a rating physician or chiropractor. The insurer shall pay the costs of any medical examination requested by the hearing officer.

4. The hearing officer may allow or forbid the presence of a court reporter and the use of a tape recorder in a hearing.

5. The hearing officer shall render his decision within 15 days after:

(a) The hearing; o

r

(b) He receives a copy of the report from the medical examination he requested.

6. The hearing officer shall render his decision in the most efficient format developed by the chief of the hearings division of the department of administration.

7. The hearing officer shall give notice of his decision to each party by mail. He shall include with the notice of his decision the necessary forms for appealing from the decision.

8. Except as otherwise provided in NRS 616C.380, the decision of the hearing officer is not stayed if an appeal from that decision is taken unless an application for a stay is submitted by a party. If such an application is submitted, the decision is automatically stayed until a determination is made on the application. A determination on the application must be made within 30 days after the filing of the application. If, after reviewing the application, a stay is not granted by the hearing officer or an appeals officer, the decision must be complied with within 10 days after the refusal to grant a stay.

Sec. 11. NRS 616C.345 is hereby amended to read as follows:

616C.345 1. Any party aggrieved by a decision of the hearing officer relating to a claim for compensation may appeal from the decision by filing a notice of appeal with an appeals officer within 30 days after the date of the decision.

2. If a dispute is required to be submitted to a procedure for resolving complaints pursuant to NRS 616C.305 and:

(a) A final ~~{decision}~~ **determination** was rendered pursuant to that procedure; or

(b) The dispute was not resolved pursuant to that procedure within 14 days after it was submitted, any party to the dispute may file a notice of appeal within 70 days after the date on which the final ~~{decision}~~ **determination** was mailed to the employee, or his dependent, or the unanswered request for resolution was submitted. Failure to render a written ~~{decision}~~ **determination** within 30 days after receipt of such a request shall be deemed by the appeals officer to be a denial of the request.

3. Except as otherwise provided in NRS 616C.380, the filing of a notice of appeal does not automatically stay the enforcement of the decision of a hearing officer or a ~~{decision}~~ **determination** rendered pursuant to NRS 616C.305. The appeals officer may order a stay, when appropriate, upon the application of a party. If such an application is submitted, the decision is automatically stayed until a determination is made concerning the application. A determination on the application must be made within 30 days after the filing of the application. If a stay is not granted by the officer after reviewing the application, the decision must be complied with within 10 days after the date of the refusal to grant a stay.

4. Except as otherwise provided in this subsection, the appeals officer shall, within 10 days after receiving a notice of appeal pursuant to this section or a contested claim pursuant to subsection 5 of NRS 616C.315, schedule a hearing on the merits of the appeal or contested claim for a date and time within 90 days after his receipt of the notice and give notice by mail or by personal service to all parties to the matter and their attorneys or agents at least 30 days before the date and time scheduled. A request to schedule the hearing for a date and time which is:

(a) Within 60 days after the receipt of the notice of appeal or contested claim; or

(b) More than 90 days after the receipt of the notice or claim, may be submitted to the appeals officer only if all parties to the appeal or contested claim agree to the request.

5. An appeal or contested claim may be continued upon written stipulation of all parties, or upon good cause shown.

6. Failure to file a notice of appeal within the period specified in subsection 1 or 2 may be excused if the party aggrieved shows by a preponderance of the evidence that he did not receive the notice of the ~~{decision}~~ **determination** and the forms necessary to appeal the ~~{decision}~~ **determination**. The claimant, employer or insurer shall notify the hearing officer of a change of address.

Sec. 12. NRS 616C.360 is hereby amended to read as follows:

616C.360 1. A stenographic or electronic record must be kept of the hearing before the appeals officer and the rules of evidence applicable to contested cases under chapter 233B of NRS apply to the hearing.

2. The appeals officer must hear any matter raised before him on its merits, including new evidence bearing on the matter.

3. If necessary to resolve a medical question concerning an injured employee's condition ~~{}~~ **or to determine the necessity of treatment for which authorization for payment has been denied**, the appeals officer may refer the employee to a physician or chiropractor ~~{chosen by the appeals officer}~~ **of his choice who has demonstrated special competence to treat the particular medical condition of the employee**. If the medical question concerns the rating of a permanent disability, the appeals officer may refer the employee to a rating physician or chiropractor. The rating physician or chiropractor must be selected in rotation from the list of qualified physicians or chiropractors maintained by the administrator pursuant to subsection 2 of NRS 616C.490, unless the insurer and the injured employee otherwise agree to a rating physician or chiropractor. The insurer shall pay the costs of any examination requested by the appeals officer.

4. Any party to the appeal or the appeals officer may order a transcript of the record of the hearing at any time before the seventh day after the hearing. The transcript must be filed within 30 days after the date of the order unless the appeals officer otherwise orders.

5. The appeals officer shall render his decision

:

- (a) If a transcript is ordered within 7 days after the hearing, within 30 days after the transcript is filed; or
- (b) If a transcript has not been ordered, within 30 days after the date of the hearing.

6. The appeals officer may affirm, modify or reverse any decision made by the hearing officer and issue any necessary and proper order to give effect to his decision.

Sec. 13. Chapter 686B of NRS is hereby amended by adding thereto a new section to read as follows:

“Prospective loss cost” means the portion of a rate that is based on historical aggregate losses and loss adjustment expenses which are adjusted to their ultimate value and projected to a future point in time. Except as otherwise provided in this section, the term does not include provisions for expenses or profit.

Sec. 14. NRS 686B.1751 is hereby amended to read as follows:

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

Sec. 15. NRS 686B.1765 is hereby amended to read as follows:

686B.1765 The advisory organization may:

1. Develop statistical plans including definitions for the classification of risks.
2. Collect statistical data from its members and subscribers or any other reliable source.
3. Prepare and distribute data on ~~the basic premium rate or rates, adjusted for expected changes in reported losses and for trends in losses, according to its statistical plan.~~ ***prospective loss costs.***
4. Prepare and distribute manuals of rules and schedules for rating which do not permit calculating the final rates without using information other than the information in the manual.
5. Distribute any information filed with the commissioner which is open to public inspection.
6. Conduct research and collect statistics to discover, identify and classify information on the causes and prevention of losses.
7. Prepare and file forms and endorsements for policies and consult with its members, subscribers and any other knowledgeable persons on their use.
8. Collect, compile and distribute information on the past and current premiums charged by individual insurers if the information is available for public inspection.
9. Conduct research and collect information to determine what effect changes in benefits to injured employees pursuant to chapters 616A to 617, inclusive, of NRS will have on ~~the basic premium rate or rates.~~ ***prospective loss costs.***

10. Prepare and distribute rules and rating values for the uniform plan for rating experience.

11. Calculate and provide to the insurer the modification of premiums based on the individual employer's losses.

12. Assist an individual insurer to develop rates, supplementary rate information or other supporting information if authorized to do so by the insurer.

Sec. 16. NRS 686B.177 is hereby amended to read as follows:

686B.177 1. The advisory organization shall file with the commissioner a copy of every basic premium rate, the portion of the rate that is allowable for expenses as determined by the advisory organization, every manual of rating rules, every rating schedule and every change, amendment or modification to them which is proposed for use in this state at least 60 days before they are distributed to the organization's members, subscribers or other persons. The rates shall be deemed to be approved unless they are disapproved by the commissioner within 60 days after they are filed.

2. The commissioner shall report any changes in rates or in the uniform plan for rating experience, the uniform statistical plan or the uniform system of classification, when approved, to the director of the legislative counsel bureau.

3. The rates filed by the advisory organization and approved by the commissioner apply to every insurer. In no case may an insurer's rate be less than the approved rate by more than the following percentages:

(a) For the period beginning on July 1, 1999, and ending on June 30, 2000, no variance.

(b) For the period beginning on July 1, 2000, and ending on June 30, 2001, no more than a ~~5~~ 15 percent variance.

~~[(c) For the period beginning on July 1, 2001, and ending on June 30, 2002, no more than a 10 percent variance.]~~

~~[(d) For the period beginning on July 1, 2002, and ending on June 30, 2003, no more than a 15 percent variance.]~~

Sec. 17. NRS 686B.177 is hereby amended to read as follows:

686B.177 1. The advisory organization shall file with the commissioner a copy of every ~~basic premium rate,~~ prospective loss cost, every manual of rating rules, every rating schedule and every change, amendment or modification to them which is proposed for use in this state at least 60 days before they are distributed to the organization's members, subscribers or other persons. The rates shall be deemed to be approved unless they are disapproved by the commissioner within 60 days after they are filed.

2. The commissioner shall report any changes in rates or in the uniform plan for rating experience, the uniform statistical plan or the uniform system of classification, when approved, to the director of the legislative counsel bureau.

Sec. 18. NRS 686B.1775 is hereby amended to read as follows:

686B.1775 1. ~~{If the interaction among insurers and employers is presumed or found to be competitive, each}~~ **Each** insurer shall file with the commissioner all the rates , ~~{and}~~ supplementary rate information, **supporting data, and changes and amendments thereof**, except any information filed by the advisory organization, which the insurer intends to use in this state. ~~{The insurer shall file the rates and supplementary rate information}~~ **An insurer may adopt by reference any supplementary rate information or supporting data that has been previously filed by that insurer and approved by the commissioner. The filing must indicate the date the rates will become effective. An insurer may file its rates pursuant to this subsection by filing:**

(a) **Final rates; or**

(b) **A multiplier and, if used by an insurer, a premium charged to each policy of industrial insurance regardless of the size of the policy which, when applied to the prospective loss costs filed by the advisory organization pursuant to NRS 686B.177, will result in final rates.**

2. **Each insurer shall file the rates, supplementary rate information and supporting data pursuant to subsection 1:**

(a) **Except as otherwise provided in subsection 4, if the interaction among insurers and employers is presumed or found to be competitive,** not later than 15 days ~~{after}~~ **before** the date the rates become effective.

~~{An insurer may adopt by reference, with or without a deviation, the rates or supplementary rate information filed by any other insurer.~~

~~—2.}~~ (b) **If the commissioner has issued a finding that the interaction is not competitive,** ~~{each insurer shall file with the commissioner all the rates and supplementary rate information, except for the information filed by the advisory organization, at least}~~ **not later than** 60 days before the rates become effective.

3. **If the information supplied by an insurer pursuant to** ~~{this}~~ subsection 1 is insufficient, the commissioner shall notify the insurer and ~~{the information shall be deemed to be filed when}~~ **require the insurer to provide additional information. The filing must not be deemed complete or available for use by the insurer and review by the commissioner must not commence until** all the information requested by the commissioner is received by him.

~~{3.}~~ **If the requested information is not received by the commissioner within 60 days after its request, the filing may be disapproved without further review.**

4. **If, after notice to the insurer and a hearing, the commissioner finds that an insurer's rates require supervision because of the insurer's financial condition or because of rating practices which are unfairly discriminatory, the commissioner shall order the insurer to file its rates, supplementary rate information , supporting data and any other information required by the commissioner, at least 60 days before they become effective.**

~~[4.]~~ 5. For any filing made by an insurer pursuant to this section, the commissioner may authorize an earlier effective date for the rates upon a written request from the insurer.

~~[5.—Every]~~

6. *Except as otherwise provided in subsection 1, every* rate filed by an insurer must be filed in the form and manner prescribed by the commissioner.

7. *As used in this section, “supporting data” means:*

(a) *The experience and judgment of the insurer and of other insurers or of the advisory organization, if relied upon by the insurer;*

(b) *The interpretation of any statistical data relied upon by the insurer;*

(c) *A description of the actuarial and statistical methods employed in setting the rates; and*

(d) *Any other relevant matters required by the commissioner.*

Sec. 19. NRS 686B.1777 is hereby amended to read as follows:

686B.1777 1. If the commissioner finds that:

(a) The interaction among insurers is not competitive;

(b) The rates filed by insurers whose interaction is competitive are inadequate or unfairly discriminatory; or

(c) The rates violate the provisions of this chapter,
the commissioner may require the insurers to file information supporting their existing rates. Before the commissioner may disapprove those rates, he shall notify the insurers and hold a hearing on the rates and the supplementary rate information.

2. The commissioner may disapprove any rate ~~[which must be filed before it becomes effective]~~ without a hearing. Any insurer whose rates are disapproved in this manner may request in writing and within 30 days after the disapproval that the commissioner conduct a hearing on the matter.

Sec. 20. NRS 686B.1779 is hereby amended to read as follows:

686B.1779 1. The commissioner may disapprove a rate filed by an insurer ~~;~~

~~—(a) At any time after the rate becomes effective; or~~

~~—(b) At] at any time . [before the rate becomes effective.]~~

2. The commissioner shall disapprove a rate if:

(a) An insurer has failed to meet the requirements for filing a rate pursuant to this chapter or the regulations of the commissioner; or

(b) The rate is inadequate, excessive or unfairly discriminatory.

Sec. 21. NRS 686B.1779 is hereby amended to read as follows:

686B.1779 1. The commissioner may disapprove a rate filed by an insurer ~~;~~

~~—(a) At any time after the rate becomes effective; or~~

~~—(b) At] at any time . [before the rate becomes effective if the insurer is required to file its rates before they become effective.]~~

2. The commissioner shall disapprove a rate if

:

- (a) An insurer has failed to meet the requirements for filing a rate pursuant to this chapter or the regulations of the commissioner;
- (b) The rate is inadequate or unfairly discriminatory and the interaction among insurers and employers is competitive; or
- (c) A rate is inadequate, excessive or unfairly discriminatory and the commissioner has found and issued an order that the interaction among the insurers and employers is not competitive.

Sec. 22. NRS 686B.1784 is hereby amended to read as follows:

686B.1784 1. The commissioner may examine any insurer, advisory organization or plan for apportioned risks whenever he determines that such an examination is necessary.

2. The reasonable cost of an examination must be paid by the *insurer or other* person examined upon presentation by the commissioner of an accounting of those costs pursuant to NRS 679B.290.

3. In lieu of an examination, the commissioner may accept the report of an examination made by the agency of another state that regulates insurance.

Sec. 23. NRS 686B.1793 is hereby amended to read as follows:

686B.1793 1. ~~[A]~~ *An insurer or other* person who violates any provision of NRS 686B.1751 to 686B.1799, inclusive, *and section 13 of this act* shall, upon the order of the commissioner, pay an administrative fine not to exceed \$1,000 for each violation and not to exceed \$10,000 for each willful violation. These administrative fines are in addition to any other penalty provided by law. Any insurer using a rate before it has been filed with the commissioner as required by NRS 686B.1775, shall be deemed to have committed a separate violation for each day the insurer failed to file the rate.

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

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

Sec. 24. Section 197 of chapter 580, Statutes of Nevada 1995, as amended by chapter 410, Statutes of Nevada 1997, at page 1456, is hereby amended to read as follows:

Sec. 197. 1. This section and sections 25 to 36, inclusive, 44, 86, 119, 127, 128, 186.5, 188, 194, 195 and 196 of this act become effective upon passage and approval.

2. Section 68 of this act becomes effective at 12:01 a.m. on July 1, 1995.

3. Section 161 of this act becomes effective on July 1, ~~[2003.]~~ *2001.*

4. The remaining sections of this act become effective:
 - (a) Upon passage and approval for the purposes of:
 - (1) The adoption of regulations by the commissioner of insurance and the administrator of the division of industrial relations of the department of business and industry.
 - (2) The qualification of private carriers to sell industrial insurance.
 - (3) The designation of a licensed advisory organization by the commissioner and the initial filing of classifications of risk, the uniform plan for rating experience and the uniform statistical plan, by that organization.
 - (4) The inspection of the records of the system, the Nevada industrial commission and the administrator with respect to the self-insured employers, by the commissioner and the advisory organization.
 - (5) The filing, by private carriers and the system, of rates to be used by them.
 - (b) For all other purposes on July 1, 1999.

5. Section 145 of this act expires by limitation on July 1, 2001.

Sec. 25. Section 81 of chapter 410, Statutes of Nevada 1997, as amended by section 36 of Senate Bill No. 453 of this session, is hereby amended to read as follows:

Sec. 81. 1. This section and sections 3 to 10, inclusive, 12, 13, 15, 15.5, 16, 17, 20, 21, 22, 27, 28, 35, 40.5, 41, 42, 61, 62, 62.5, 63, 65, 67, 70, 72, 74, 76, 78, 79 and 80 of this act become effective on July 1, 1997.

2. Section 14 of this act becomes effective at 12:01 a.m. on July 1, 1997.

3. Sections 1, 11, 26, 36, 37, 38, 39, 43, 45, 46, 49, 51, 52, 53, 54, 58 and 59 of this act become effective on January 1, 1998.

4. Section 50 of this act becomes effective at 12:01 a.m. on January 1, 1998.

5. Sections 18, 23, 40, 48, 57, 60, 77 and 77.5 of this act become effective on July 1, 1999.

6. Sections 64, 66, 68, 71, 73 and 75 of this act become effective on July 1, ~~2003.~~ **2001.**

Sec. 26. 1. This section and sections 14, 16, 20, 22, 23, 24 and 25 of this act become effective at 12:01 a.m. on July 1, 1999.

2. Sections 1 to 7, inclusive, and 9 to 12, inclusive, of this act become effective on October 1, 1999.

3. Sections 8 and 8.5 of this act become effective at 12:01 a.m. on October 1, 1999.

4. Section 13, 15, 17, 18, 19 and 21 of this act become effective at 12:01 a.m. on July 1, 2001.