

SENATE BILL NO. 356—SENATOR TOWNSEND

MARCH 10, 1999

Referred to Committee on Commerce and Labor

SUMMARY—Makes various changes relating to required benefits for health insurance.
(BDR 57-682)

FISCAL NOTE: Effect on Local Government: Yes.
Effect on the State or on Industrial Insurance: Yes.

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

AN ACT relating to insurance; providing in skeleton form 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; and providing other matters properly relating thereto.

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

- 1 **Section 1.** Chapter 689A of NRS is hereby amended by adding thereto
2 a new section to read as follows:
3 1. *Notwithstanding any provision of this Title to the contrary, a*
4 *policy of health insurance issued or delivered for issuance in this state*
5 *pursuant to this chapter must provide coverage for the treatment of*
6 *conditions relating to mental health and must not establish any rate, term*
7 *or condition that places a greater financial burden on the insured person*
8 *for access to treatment for conditions relating to mental health than for*
9 *access to treatment for conditions relating to physical health. Any limits*
10 *required under the policy of health insurance for deductibles and out-of-*
11 *pocket expenses must be comprehensive for coverage of both conditions*
12 *relating to mental health and conditions relating to physical health.*
13 2. *A policy of health insurance that does not otherwise provide for*
14 *managed care, or that does not provide for the same degree of managed*
15 *care for all health conditions, may provide coverage for the treatment of*
16 *conditions relating to mental health through a managed care*
17 *organization if the managed care organization is in compliance with*

1 regulations adopted by the commissioner which ensure that the system
2 for delivery of the treatment for conditions relating to mental health does
3 not diminish or negate the purpose of this section. The regulations
4 adopted by the commissioner must ensure that:

5 (a) Timely and appropriate access to care is available;
6 (b) The distribution of providers of health care who provide services
7 relating to mental health is adequate to serve the needs of persons in this
8 state, considering the quality, location and area of specialization of such
9 providers; and

10 (c) Administrative or clinical protocols do not reduce access to
11 medically necessary treatment for the insured person.

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

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

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

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

28 (b) In a mental health facility or institution designated as a division
29 facility pursuant to NRS 433.233, or in a medical or other facility
30 licensed by the state board of health pursuant to chapter 449 of NRS that
31 provides programs for the treatment of conditions relating to mental
32 health, and pursuant to an individualized written plan developed for the
33 insured person. A nonprofit hospital or medical service corporation may
34 require a mental health facility or a person who is licensed or certified to
35 provide treatment for conditions relating to mental health to enter into a
36 contract as a condition of providing benefits in accordance with this
37 section.

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

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

41 (b) Supersede any provision of federal law, any federal or state policy
42 relating to Medicaid, or the terms and conditions imposed on any
43 Medicaid waiver granted to this state with respect to the provision of

1 *services to persons with conditions relating to mental health or substance*
2 *abuse.*

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

7 *7. As used in this section:*

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

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

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

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

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

22 689A.040 1. Except as *otherwise* provided in subsections 2 and 3,
23 each such policy delivered or issued for delivery to any person in this state
24 must contain the provisions specified in NRS 689A.050 to 689A.170,
25 inclusive, *and section 1 of this act*, in the words in which the provisions
26 appear, except that the insurer may, at its option, substitute for one or more
27 of the provisions corresponding provisions of different wording approved
28 by the commissioner which are in each instance not less favorable in any
29 respect to the insured or the beneficiary. Each such provision must be
30 preceded individually by the applicable caption shown, or, at the option of
31 the insurer, by such appropriate individual or group captions or subcaptions
32 as the commissioner may approve.

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

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

1 **Sec. 3.** Chapter 689B of NRS is hereby amended by adding thereto a
2 new section to read as follows:

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

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

23 ***(a) Timely and appropriate access to care is available;***

24 ***(b) The distribution of providers of health care who provide services***
25 ***relating to mental health is adequate to serve the needs of persons in this***
26 ***state, considering the quality, location and area of specialization of such***
27 ***providers; and***

28 ***(c) Administrative or clinical protocols do not reduce access to***
29 ***medically necessary treatment for the insured person.***

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

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

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

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

3 (b) In a mental health facility or institution designated as a division
4 facility pursuant to NRS 433.233, or in a medical or other facility
5 licensed by the state board of health pursuant to chapter 449 of NRS that
6 provides programs for the treatment of conditions relating to mental
7 health, and pursuant to an individualized written plan developed for the
8 insured person. A nonprofit hospital or medical service corporation may
9 require a mental health facility or a person who is licensed or certified to
10 provide treatment for conditions relating to mental health to enter into a
11 contract as a condition of providing benefits in accordance with this
12 section.

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

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

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

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

25 7. As used in this section:

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

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

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

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

39 **Sec. 4.** NRS 689B.030 is hereby amended to read as follows:

40 689B.030 Each group health insurance policy must contain in
41 substance the following provisions:

42 1. A provision that, in the absence of fraud, all statements made by
43 applicants or the policyholders or by an insured person are representations

1 and not warranties, and that no statement made for the purpose of effecting
2 insurance voids the insurance or reduces its benefits unless the statement is
3 contained in a written instrument signed by the policyholder or the insured
4 person, a copy of which has been furnished to him or his beneficiary.

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

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

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

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

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

22 ***7. A provision for benefits for expenses incurred for the treatment of***
23 ***conditions relating to mental health, as provided in section 3 of this act.***

24 **Sec. 5.** NRS 689B.340 is hereby amended to read as follows:

25 689B.340 As used in NRS 689B.340 to ~~[689B.600,]~~ **689B.590,**
26 inclusive, unless the context otherwise requires, the words and terms
27 defined in NRS 689B.350 to 689B.460, inclusive, have the meanings
28 ascribed to them in those sections.

29 **Sec. 6.** Chapter 689C of NRS is hereby amended by adding thereto a
30 new section to read as follows:

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

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

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

7 (a) Timely and appropriate access to care is available;

8 (b) The distribution of providers of health care who provide services
9 relating to mental health is adequate to serve the needs of persons in this
10 state, considering the quality, location and area of specialization of such
11 providers; and

12 (c) Administrative or clinical protocols do not reduce access to
13 medically necessary treatment for the insured person.

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

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

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

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

30 (b) In a mental health facility or institution designated as a division
31 facility pursuant to NRS 433.233, or in a medical or other facility
32 licensed by the state board of health pursuant to chapter 449 of NRS that
33 provides programs for the treatment of conditions relating to mental
34 health, and pursuant to an individualized written plan developed for the
35 insured person. A nonprofit hospital or medical service corporation may
36 require a mental health facility or a person who is licensed or certified to
37 provide treatment for conditions relating to mental health to enter into a
38 contract as a condition of providing benefits in accordance with this
39 section.

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

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

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

6 *(c) Affect any existing health benefit plan until its date of renewal or,*
7 *if the health benefit plan is governed by a collective bargaining*
8 *agreement or employment contract, until the expiration of that*
9 *agreement or contract.*

10 **7. As used in this section:**

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

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

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

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

24 **Sec. 7.** NRS 689C.155 is hereby amended to read as follows:

25 689C.155 The commissioner may adopt regulations to carry out the
26 provisions of *section 6 of this act and* NRS 689C.107 to 689C.145,
27 inclusive, 689C.156 to 689C.159, inclusive, 689C.165, 689C.183,
28 689C.187, 689C.191 to 689C.198, inclusive, 689C.203, 689C.207,
29 689C.265, 689C.283, 689C.287, 689C.325, 689C.342 to 689C.348,
30 inclusive, 689C.355 and 689C.610 to 689C.980, inclusive, and to ensure
31 that rating practices used by carriers serving small employers are consistent
32 with those sections, including regulations that:

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

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

40 **Sec. 8.** NRS 689C.156 is hereby amended to read as follows:

41 689C.156 1. As a condition of transacting business in this state with
42 small employers, a carrier shall actively market to a small employer each
43 health benefit plan which is actively marketed in this state by the carrier to

1 any small employer in this state. The health insurance plans marketed
2 pursuant to this section by the carrier must include, without limitation, a
3 basic health benefit plan and a standard health benefit plan. A carrier shall
4 be deemed to be actively marketing a health benefit plan when it makes
5 available any of its plans to a small employer that is not currently receiving
6 coverage under a health benefit plan issued by that carrier.

7 2. A carrier shall issue to a small employer any health benefit plan
8 marketed in accordance with this section if the eligible small employer
9 applies for the plan and agrees to make the required premium payments and
10 satisfy the other reasonable provisions of the health benefit plan that are not
11 inconsistent with NRS 689C.015 to 689C.355, inclusive, **and section 6 of**
12 **this act**, and **NRS** 689C.610 to 689C.980, inclusive, except that a carrier is
13 not required to issue a health benefit plan to a self-employed person who is
14 covered by, or is eligible for coverage under, a health benefit plan offered
15 by another employer.

16 **Sec. 9.** NRS 695B.180 is hereby amended to read as follows:

17 695B.180 A contract for hospital, medical or dental services must not
18 be entered into between a corporation proposing to furnish or provide any
19 one or more of the services authorized under this chapter and a subscriber:

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

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

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

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

31 5. Except for group contracts and blanket contracts issued under NRS
32 695B.220, unless the exceptions of the contract are printed with greater
33 prominence than the benefits to which they apply.

34 6. Except for group contracts and blanket contracts issued under NRS
35 695B.230, unless, if any portion of the contract purports, by reason of the
36 circumstances under which an illness, injury or disablement is incurred to
37 reduce any service to less than that provided for the same illness, injury or
38 disablement incurred under ordinary circumstances, that portion is printed
39 in boldface type and with greater prominence than any other text of the
40 contract.

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

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

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

5 (b) *Conditions relating to mental health, as provided in section 3 of*
6 *this act.*

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

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

11
12 This contract does not restrict or interfere with the right of any
13 person entitled to service and care in a hospital to select the
14 contracting hospital or to make a free choice of his attending
15 physician, who must be the holder of a valid and unrevoked
16 physician's license and a member of, or acceptable to, the attending
17 staff and board of directors of the hospital in which the services are to
18 be provided.

19 **Sec. 10.** NRS 695C.170 is hereby amended to read as follows:

20 695C.170 1. Every enrollee residing in this state is entitled to
21 evidence of coverage under a health care plan. If the enrollee obtains
22 coverage under a health care plan through an insurance policy, whether by
23 option or otherwise, the insurer shall issue the evidence of coverage.
24 Otherwise, the health maintenance organization shall issue the evidence of
25 coverage.

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

30 3. An evidence of coverage:

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

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

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

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

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

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

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

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

8 (II) *Conditions relating to mental health, as provided in section 3*
9 *of this act.*

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

12 4. A copy of the form of the evidence of coverage to be used in this
13 state and any amendment thereto is subject to the requirements for filing
14 and approval of subsection 2 unless it is subject to the jurisdiction of the
15 commissioner under the laws governing health insurance, in which event
16 the provisions for filing and approval of those laws apply. To the extent
17 that such provisions do not apply to the requirements in subsection 3, such
18 provisions are amended to incorporate the requirements of subsection 3 in
19 approving or disapproving an evidence of coverage required by subsection
20 2.

21 **Sec. 11.** NRS 287.010 is hereby amended to read as follows:

22 287.010 1. The governing body of any county, school district,
23 municipal corporation, political subdivision, public corporation or other
24 public agency of the State of Nevada may:

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

31 (b) Purchase group policies of life, accident or health insurance, or any
32 combination thereof, for the benefit of such officers and employees, and the
33 dependents of such officers and employees, as have authorized the
34 purchase, from insurance companies authorized to transact the business of
35 such insurance in the State of Nevada, and, where necessary, deduct from
36 the compensation of officers and employees the premiums upon insurance
37 and pay the deductions upon the premiums.

38 (c) Provide group life, accident or health coverage through a self-
39 insurance reserve fund and, where necessary, deduct contributions to the
40 maintenance of the fund from the compensation of officers and employees
41 and pay the deductions into the fund. The money accumulated for this
42 purpose through deductions from the compensation of officers and
43 employees and contributions of the governing body must be maintained as

1 an internal service fund as defined by NRS 354.543. The money must be
2 deposited in a state or national bank authorized to transact business in the
3 State of Nevada. Any independent administrator of a fund created under
4 this section is subject to the licensing requirements of chapter 683A of
5 NRS, and must be a resident of this state. Any contract with an independent
6 administrator must be approved by the commissioner of insurance as to the
7 reasonableness of administrative charges in relation to contributions
8 collected and benefits provided. The provisions of NRS 689B.030 to
9 689B.050, inclusive, apply to coverage provided pursuant to this paragraph
10 ~~H~~, *except that the provisions of section 3 of this act do not apply to such*
11 *coverage.*

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

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

23 **Sec. 12.** NRS 689B.600 is hereby repealed.

24 **Sec. 13.** This act becomes effective on July 1, 1999.

TEXT OF REPEALED SECTION

689B.600 Insurance for groups of 51 persons or more which offers medical and surgical benefits and mental health benefits: Aggregate lifetime and annual limits on benefits. [Expires by limitation on September 30, 2001.]

1. Except as otherwise provided in this section, if group health insurance for groups of 51 persons or more which is issued or delivered for issuance in this state and which offers both medical and surgical benefits and mental health benefits:

(a) Does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the group health insurance may not impose an aggregate lifetime limit on the mental health benefits.

(b) Includes an aggregate lifetime limit on substantially all medical and surgical benefits, the aggregate lifetime limit on the mental health benefits

offered by the group health insurance must not be less than the aggregate lifetime limit set for the medical and surgical benefits.

(c) Includes no aggregate lifetime limits, or different aggregate lifetime limits, on different categories of medical and surgical benefits, the applicable aggregate lifetime limit that must be applied in accordance with paragraph (b) to the mental health benefits of the group health insurance must be computed by taking into account the weighted average of the aggregate lifetime limits applicable to such categories of medical and surgical benefits offered by the group health insurance. The computation of the aggregate lifetime limit must be consistent with the rules adopted by the Secretary of the United States Department of Labor pursuant to 29 U.S.C. § 1185a.

2. Except as otherwise provided in this section, if group health insurance for groups of 51 persons or more which is issued or delivered for issuance in this state and which offers both medical and surgical benefits and mental health benefits:

(a) Does not include an annual limit on substantially all medical and surgical benefits, the group health insurance may not impose an annual limit on the mental health benefits.

(b) Includes an annual limit on substantially all medical and surgical benefits, the annual limit on the mental health benefits offered by the group health insurance must not be less than the annual limit set for the medical and surgical benefits.

(c) Includes no annual limit, or different annual limits, on different categories of medical and surgical benefits, the applicable annual limit that must be applied in accordance with paragraph (b) to the mental health benefits of the group health insurance must be computed by taking into account the weighted average of the annual limits applicable to such categories of medical and surgical benefits offered by the group health insurance. The computation of the annual limit must be consistent with the rules adopted by the Secretary of the United States Department of Labor pursuant to 29 U.S.C. § 1185a.

3. Nothing in this section:

(a) Requires group health insurance to provide mental health benefits.

(b) Except as specifically provided in subsection 1, affects the terms or conditions of group health insurance that provides mental health benefits, relating to the amount, duration or scope of those benefits, including, but not limited to, cost sharing, limits on numbers of visits or days of coverage and requirements relating to medical necessity.

4. Group health insurance is not required to comply with the provisions of this section if the application of this section would result in an increase in the cost under the group health insurance of 1 percent or more.

5. If the group health insurance offers a participant or beneficiary more than one benefit package option, the provisions of this section must be applied separately to each such option offered.

6. As used in this section:

(a) “Aggregate lifetime limit” means a limitation on the total amount of benefits that may be paid with respect to those benefits under group health insurance with respect to a policyholder or other coverage unit.

(b) “Annual limit” means a limitation on the total amount of benefits that may be paid with respect to those benefits in a 12-month period under group health insurance with respect to an individual or other coverage unit.

(c) “Medical and surgical benefits” means benefits, as defined under the group health insurance, provided by such insurance for medical or surgical services. The term does not include benefits for services relating to mental health.

(d) “Mental health benefits” means benefits, as defined under the group health insurance, provided by such insurance for services relating to mental health. The term does not include benefits provided for the treatment of substance abuse or chemical dependency.

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