ASSEMBLY BILL NO. 206–COMMITTEE ON COMMERCE AND LABOR

FEBRUARY 20, 2001

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions governing mandated benefits for health insurance. (BDR 57-293)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: Contains Appropriation not included in Executive Budget.

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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; establishing a temporary moratorium on the enactment of mandated benefits for health insurance; creating the legislative committee to review mandated benefits for health insurance; prospectively repealing all existing mandated benefits for health insurance; prospectively requiring the health insurance provided by the state and local governments to comply with all mandated benefits for health insurance applicable to health insurance policies regulated by the commissioner of insurance; making an appropriation; 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 679A of NRS is hereby amended by adding thereto a new section to read as follows:

The legislature hereby declares that it will not enact an additional mandated benefit for health insurance from the effective date of this section through January 1, 2007.

Sec. 2. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. [~~Except as otherwise provided in NRS 689A.0405, 689A.0413, 689B.031, 689B.0374, 695B.1912, 695B.1914, 695C.1713, 695C.1735 and 695G.170, any~~] ***Any*** contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:

(a) File its procedure for obtaining approval of care pursuant to this section for approval by the commissioner; and

(b) Respond to any request for approval by the insured or member pursuant to this section within 20 days after it receives the request.

2. The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

Sec. 3. NRS 689A.030 is hereby amended to read as follows:

689A.030 A policy of health insurance must not be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:

1. The entire money and other considerations for the policy must be expressed therein.

2. The time when the insurance takes effect and terminates must be expressed therein.

3. It must purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two or more eligible members of that family, including the husband, wife, dependent children, from the time of birth, adoption or placement for the purpose of adoption , ~~[as provided in NRS 689A.043,]~~ or any children under a specified age which must not exceed 19 years , ~~[except as provided in NRS 689A.045,]~~ and any other person dependent upon the policyholder.

4. The style, arrangement and overall appearance of the policy must not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers must be plainly printed in light-faced type of a style in general use, the size of which must be uniform and not less than 10 points with a lower case unspaced alphabet length not less than 120 points. "Text" includes all printed matter except the name and address of the insurer, the name or the title of the policy, the brief description, if any, and captions and subcaptions.

5. The exceptions and reductions of indemnity must be set forth in the policy and, other than those contained in NRS 689A.050 to 689A.290, inclusive, must be printed, at the insurer's option, with the benefit provision to which they apply or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of that exception or reduction must be included with the benefit provision to which it applies.

6. Each such form, including riders and endorsements, must be identified by a number in the lower left-hand corner of the first page thereof.

7. The policy must not contain any provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless that portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the commissioner.

~~[8. The policy must provide benefits for expense arising from care at home or health supportive services if that 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.~~

~~9. The policy must provide, at the option of the applicant, benefits for expenses incurred for the treatment of abuse of alcohol or drugs, unless the policy provides coverage only for a specified disease or provides for the payment of a specific amount of money if the insured is hospitalized or receiving health care in his home.~~

~~10. The policy must provide benefits for expense arising from hospice care.]~~

Sec. 4. NRS 689A.040 is hereby amended to read as follows:

689A.040 1. Except as ***otherwise*** provided in ~~[subsections 2 and 3,]~~ ***subsection 2,*** 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, 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. 5. NRS 689A.280 is hereby amended to read as follows:

689A.280 ~~[1.]~~ There may be a provision as follows:

Intoxicants and Narcotics: The insurer is not liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

~~[2. If the insurer includes the provision set forth in subsection 1, he shall also provide that such provision in no way affects benefits payable for the treatment of alcohol or drug abuse, as required by subsection 9 of NRS 689A.030.]~~

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 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.]~~

Sec. 7. NRS 689B.080 is hereby amended to read as follows:

689B.080 Any insurer authorized to write health insurance in this state, including a nonprofit corporation for hospital, medical or dental services that has a certificate of authority issued pursuant to chapter 695B of NRS, may issue blanket health insurance. No blanket policy, except as ***otherwise*** provided in subsection 4 of NRS 687B.120, may be issued or delivered in this state unless a copy of the form thereof has been filed in accordance with NRS 687B.120. ~~[Every]~~ ***Each*** blanket policy must contain provisions which **,** in the opinion of the commissioner **,** are not less favorable to the policyholder and the individual insured than the following:

1. A provision that the policy, including endorsements and a copy of the application, if any, of the policyholder and the persons insured constitutes the entire contract between the parties, and that any statement made by the policyholder or by a person insured is in the absence of fraud a representation and not a warranty, and that no such statements may be used in defense to a claim under the policy, unless contained in a written application. The insured, his beneficiary or assignee ~~[has the right to]~~ ***may*** make a written request to the insurer for a copy of an application, and the insurer shall, within 15 days after the receipt of a request at its home office or any branch office of the insurer, deliver or mail to the person making the request a copy of the application. If a copy is not so delivered or mailed, the insurer is precluded from introducing the application as evidence in any action based upon or involving any statements contained therein.

2. A provision that ***a*** written notice of sickness or of injury must be given to the insurer within 20 days after the date when the sickness or injury occurred. Failure to give notice within that time does not invalidate or reduce any claim if it is shown that it was not reasonably possible to give notice and that notice was given as soon as was reasonably possible.

3. A provision that the insurer will furnish to the claimant or to the policyholder for delivery to the claimant such forms as are usually

furnished by it for filing proof of loss. If the forms are not furnished before the expiration of 15 days after giving ***a*** written notice of sickness or injury, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

4. A provision that in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within 90 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within 90 days after the date of the loss. Failure to furnish such proof within that time does not invalidate or reduce any claim if it is shown that it was not reasonably possible to furnish proof and that the proof was furnished as soon as was reasonably possible.

5. A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of written proof of loss, and that, subject to proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of that period will be paid immediately upon receipt of proof.

6. A provision that the insurer at its own expense has the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of ***a*** claim under the policy and also the right and opportunity to make an autopsy where it is not prohibited by law.

7. A provision ~~[, if applicable, setting forth the provisions of NRS 689B.035.~~

~~8. A provision for benefits for expense arising from care at home or health supportive services if that 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.~~

~~9. A provision]~~ that no action at law or in equity may be brought to recover under the policy before the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Sec. 8. NRS 689B.120 is hereby amended to read as follows:

689B.120 1. ~~[Except as otherwise provided in subsection 3, all policies]~~ ***Each policy*** of group health insurance delivered or issued for delivery in this state providing for hospital, surgical or major medical expense insurance, or any combination of ~~[these]~~ ***those*** coverages, on an expense-incurred basis must contain a provision that the employee or member is entitled to have issued to him by the insurer a policy of health

insurance when the employee or member is no longer covered by the group policy.

2. The requirement in subsection 1 does not apply to policies providing benefits only for specific diseases or accidental injuries, and it applies to other policies only if:

(a) The termination of coverage under the group policy is not due to termination of the group policy ~~[itself]~~ unless the termination of the group policy has resulted from failure of the policyholder to remit the required premiums;

(b) The termination is not due to failure of the employee or member to remit any required contributions;

(c) The employee or member has been continuously insured under any group policy of the employer for at least 3 consecutive months immediately before the termination; and

(d) The employee or member applies in writing for the converted policy and pays his first premium to the insurer no later than 31 days after the termination.

~~[3. If an employee or member was a recipient of benefits under the coverage provided pursuant to NRS 689B.0345, he is not entitled to have issued to him by a replacement insurer a policy of health insurance 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 689B.0345.]~~

Sec. 9. 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 abuse of alcohol or drugs, as provided in NRS 695B.194.~~

~~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. 10. 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, 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. 11. NRS 695C.170 is hereby amended to read as follows:

695C.170 1. ~~[Every]~~ ***Each*** 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; ***and***

(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 abuse of alcohol or drugs, as provided in NRS 695C.174.]~~

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]~~ ***set forth in*** 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]~~ ***those*** provisions do not apply to the requirements ***set forth*** in subsection 3, ~~[such]~~ ***those*** provisions are amended to incorporate the requirements of ***that*** subsection ~~[3]~~ in approving or disapproving an evidence of coverage required by subsection 2.

Sec. 12. 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, 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. 13. Chapter 218 of NRS is hereby amended by adding thereto the provisions set forth as sections 14 to 21, inclusive, of this act.

Sec. 14. ***As used in sections 14 to 21, inclusive, of this act, unless the context otherwise requires, "committee" means the legislative committee to review mandated benefits for health insurance created by section 15 of this act.***

Sec. 15. ***1. The legislative committee to review mandated benefits for health insurance is hereby created. The committee consists of:***

(a) Three members of the senate who are appointed by the majority leader of the senate; and

(b) Three members of the assembly who are appointed by the speaker of the assembly.

2. The members of the committee shall elect a chairman and vice chairman from among their members. The chairman must be elected from one house of the legislature and the vice chairman from the other house. After the initial election of a chairman and vice chairman, each of those officers holds office for a term of 2 years commencing on July 1 of each odd-numbered year. If a vacancy occurs in the chairmanship or vice chairmanship, the members of the committee shall elect a replacement for the remainder of the unexpired term.

3. Any member of the committee who is not a candidate for reelection or who is defeated for reelection continues to serve until the convening of the next session of the legislature.

4. A vacancy on the committee must be filled in the same manner as the original appointment.

Sec. 16. ***1. The members of the committee shall meet at the times and places specified by a call of the chairman or by a majority of the members of the committee. The research director of the legislative counsel bureau or a person designated by him shall act as the nonvoting recording secretary.***

2. A majority of the members of the committee constitute a quorum, and a quorum may exercise all of the powers and duties of the committee.

3. Except during a regular or special session of the legislature, the members of the committee are entitled to receive the compensation

provided for a majority of the members of the legislature during the first 60 days of the preceding session, the per diem allowance provided for state officers and employees generally and the travel expenses provided pursuant to NRS 218.2207 for each day or portion of a day of attendance at a meeting of the committee and while engaged in the business of the committee. The salaries and expenses of the members of the committee and any other expenses incurred by the committee in carrying out its duties must be paid as other claims against the state are paid.

Sec. 17. *1. The committee shall contract with an independent actuary on or before January 1 of each even-numbered year to review all mandated benefits for health insurance that have been in effect for 4 or more years as of that January 1.*

2. The independent actuary shall review each mandated benefit to determine the social and economic effect of that benefit on the residents of this state. In making that determination, the independent actuary shall determine the extent to which:

(a) The mandated benefit is used by a substantial number of residents of this state;

(b) The mandated benefit is available to the residents of this state;

(c) The mandated benefit, if it were not included in a policy, would impose an unreasonable financial hardship on the residents of this state or would prevent those residents from receiving services for health care;

(d) There is a demand for the mandated benefit;

(e) The mandated benefit is included as a benefit negotiated as part of a collective bargaining agreement;

(f) The mandated benefit increases or decreases the cost of providing treatment or service;

(g) Claims for the mandated benefit have increased because of the availability of the benefit;

(h) The mandated benefit is a substitute for a benefit for which the premiums are more expensive;

(i) The availability of the mandated benefit increases or decreases:

(1) The administrative expenses of a health insurer or an insured under the policy; and

(2) The cost of the premiums for the mandated benefit;

(j) The mandated benefit increases or decreases the total cost of services for health care and the total cost for premiums for health insurance in this state;

(k) The inclusion of the mandated benefit in a policy:

(1) Increases or decreases the costs for health care provided for state employees; and

(2) Affects the affordability of and access to coverage;

(l) Any studies that have been conducted demonstrate the health consequences of the mandated benefit compared to no benefit or an alternative benefit;

(m) If the mandated benefit is for a category of provider of health care, any studies that have been conducted demonstrate the health consequences realized by the benefit for that category of provider of health care; and

(n) The mandated benefit improves the health of the residents of this state.

3. Within 10 days after making the determination for each mandated benefit, the independent actuary shall submit the results of the determination to the committee. As soon as practicable after receiving the results of the determination, the committee shall review the mandated benefit to determine whether the mandated benefit should remain in effect or be amended or repealed by the legislature.

Sec. 18. *The committee may:*

1. Review and consider any issue relating to benefits for health care provided under a policy; and

2. Apply for and accept any gift, grant, donation or appropriation, and use the gift, grant, donation or appropriation to carry out the provisions of sections 14 to 21, inclusive, of this act.

Sec. 19. *On or before February 1 of each odd-numbered year, the committee shall prepare and submit to the director of the legislative counsel bureau for transmittal to the legislature and to each elected state officer in this state a written report concerning the activities of the committee for the immediately preceding biennium. The written report must include, without limitation:*

1. A discussion and analysis of each determination made by the independent actuary made pursuant to section 17 of this act or the committee pursuant to the provisions of this section; and

2. If the committee determines that a mandated benefit for health insurance set forth in Title 57 of NRS should remain in effect, a statement setting forth the reasons for that determination.

Sec. 20. *1. In conducting the investigations and hearings of the committee:*

(a) The secretary of the committee, or in his absence any member of the committee, may administer oaths;

(b) The secretary or chairman of the committee may cause the deposition of witnesses, residing within or without the state, to be taken in the manner prescribed by rule of court for taking depositions in civil actions in the district courts; and

(c) The secretary or chairman of the committee may issue subpoenas to compel the attendance of witnesses and the production of books and papers.

2. If any witness refuses to attend or testify or produce any books and papers as required by the subpoena, the secretary or chairman of the committee may report to the district court by petition, setting forth that:

(a) A notice has been given of the time and place for the attendance of the witness or the production of the books and papers;

(b) The witness has been subpoenaed by the committee pursuant to the provisions of this section; and

(c) The witness has failed or refused to attend or produce the books and papers required by the subpoena before the committee which is named in the subpoena, or has refused to answer questions propounded to him,

and requesting an order of the court compelling the witness to attend and testify or produce the books and papers before the committee.

3. Upon such a petition, the court shall enter an order directing the witness to appear before the court at a time and place to be fixed by the court in its order, the time to be not more than 10 days after the date of the order, and then and there show cause why he has not attended or testified or produced the books or papers before the committee. A certified copy of the order must be served upon the witness.

4. If it appears to the court that the subpoena was regularly issued by the committee, the court shall enter an order that the witness appear before the committee at the time and place fixed in the order and testify or produce the required books or papers, and upon failure to comply with the order the witness must be dealt with as for contempt of court.

Sec. 21. ***Each witness who appears before the committee by its order, except a state officer or employee, is entitled to receive for his attendance the fees and mileage provided for witnesses in civil cases in the courts of record of this state. The fees and mileage must be audited and paid upon the presentation of proper claims sworn to by the witness and approved by the secretary and chairman of the committee.***

Sec. 22. 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 or credit union 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,] ***and 689B.050 and any mandated benefits for health insurance required by Title 57 of NRS*** apply to coverage provided pursuant to this paragraph . [, except that the provisions of NRS 689B.0359 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. 23. 1. The legislative committee to review mandated benefits for health insurance shall, in accordance with the provisions of section 17 of this act:

(a) Before October 1, 2004, conduct a review of each mandated benefit specified in that section that has been in effect for 4 or more years as of July 1, 2001; and

(b) For each mandated benefit specified in section 17 of this act that is enacted on or after January 1, 2007, conduct a review of that mandated benefit not later than the fourth year after it is enacted.

2. Before October 1, 2002, the committee shall, in accordance with the provisions of section 17 of this act, conduct a review of not less than one-half of the mandated benefits specified in paragraph (a) of subsection 1.

Sec. 24. 1. There is hereby appropriated from the state general fund to the legislative fund the sum of $150,000 for the costs incurred by the legislative committee to review mandated benefits for health insurance, including the costs to retain an independent actuary pursuant to the provisions of section 17 of this act.

2. Any unencumbered balance of the appropriation specified in subsection 1 does not revert to the state general fund but constitutes a balance carried forward to the succeeding fiscal year.

Sec. 25. NRS 608.156, 608.157, 608.1575, 689A.0404, 689A.0405, 689A.041, 689A.0413, 689A.0415, 689A.0417, 689A.042, 689A.0423, 689A.0425, 689A.0427, 689A.043, 689A.045, 689A.0455, 689A.046, 689A.0465, 689A.0475, 689A.048, 689A.0483, 689A.0485, 689A.049, 689A.0495, 689A.0497, 689B.031, 689B.033, 689B.034, 689B.0345, 689B.035, 689B.0353, 689B.0357, 689B.0359, 689B.036, 689B.0365, 689B.0374, 689B.0375, 689B.0376, 689B.0377, 689B.0379, 689B.038, 689B.0383, 689B.0385, 689B.039, 689B.045, 689B.047, 689B.049, 689B.260, 689C.115, 695B.1908, 695B.191, 695B.1912, 695B.1914, 695B.1916, 695B.1918, 695B.192, 695B.1923, 695B.1927, 695B.193, 695B.1931, 695B.1938, 695B.194, 695B.1944, 695B.196, 695B.197, 695B.1973, 695B.1975, 695B.198, 695B.199, 695B.1995, 695C.1709, 695C.171, 695C.1713, 695C.1715, 695C.1717, 695C.172, 695C.1723,

695C.1727, 695C.173, 695C.1733, 695C.1735, 695C.1738, 695C.174, 695C.1755, 695C.176, 695C.1765, 695C.177, 695C.1773, 695C.1775, 695C.178, 695C.179, 695C.1795, 695D.210, 695F.215 and 695G.170 are hereby repealed.

Sec. 26. NRS 689A.0455, 689B.0359, 695B.1938 and 695C.1738 are hereby repealed.

Sec. 27. 1. This section and sections 1 and 13 to 21, inclusive, and 23 and 24 of this act become effective upon passage and approval.

2. Sections 2 to 12, inclusive, 22 and 25 of this act becomes effective on October 1, 2005.

3. Section 26 of this act becomes effective on October 1, 2005, only if the commissioner of insurance does not, on January 1, 2003, issue a determination that the cumulative average increase in premiums specified in section 9 of chapter 577, Statutes of Nevada 1999, at page 3107, that is directly attributable to coverage for the treatment of a condition relating to severe mental illness is greater than 6 percent.

4. Section 1 of this act expires by limitation on January 1, 2007.

LEADLINES OF REPEALED SECTIONS

608.156 Benefits for health care: Expenses for treatment of abuse of alcohol and drugs.

608.157 Benefits for health care: Coverage for mastectomy and reconstructive surgery.

608.1575 Benefits for health care: Services provided by certain nurses.

689A.0404 Coverage for use of certain drugs for treatment of cancer.

689A.0405 Coverage for cytologic screening test and mammograms for certain women.

689A.041 Coverage for mastectomy and reconstructive surgery.

689A.0413 Coverage for certain gynecological or obstetrical services without authorization or referral from primary care physician.

689A.0415 Coverage for drug or device for contraception and for hormone replacement therapy in certain circumstances; prohibited actions by insurer; exceptions.

689A.0417 Coverage for health care services related to contraceptives and hormone replacement therapy in certain circumstances; prohibited actions by insurer; exceptions.

689A.042 Coverage relating to complications of pregnancy.

689A.0423 Coverage for treatment of certain inherited metabolic diseases.

689A.0425 Individual health benefit plan that includes coverage for maternity care and pediatric care: Requirement to allow minimum stay in hospital in connection with childbirth; prohibited acts.

689A.0427 Coverage for management and treatment of diabetes.
689A.043 Coverage of newly born and adopted children and children placed for adoption.
689A.045 Termination of coverage on dependent child.
689A.0455 Coverage for treatment of conditions relating to severe mental illness.
689A.046 Benefits for treatment of abuse of alcohol or drugs.
689A.0465 Coverage of treatment of temporomandibular joint.
689A.0475 Acupuncture.
689A.048 Treatment by licensed psychologist.
689A.0483 Treatment by licensed marriage and family therapist.
689A.0485 Treatment by licensed associate in social work, social worker, independent social worker or clinical social worker.
689A.049 Treatment by licensed chiropractor; restriction on policy limitations.
689A.0495 Services provided by certain registered nurses; restriction on policy limitations; exception.
689A.0497 Provider of medical transportation.
689B.031 Required provision concerning coverage of certain gynecological or obstetrical services without authorization or referral from primary care physician.
689B.033 Required provision concerning coverage for newly born and adopted children and children placed for adoption.
689B.034 Required provision concerning effect of benefits under other valid group coverage; subrogation.
689B.0345 Required provision concerning coverage for employee or member on leave without pay as result of total disability.
689B.035 Required provision concerning termination of coverage on dependent child.
689B.0353 Required provision concerning coverage for treatment of certain inherited metabolic diseases.
689B.0357 Required provision concerning coverage for management and treatment of diabetes.
689B.0359 Required provision concerning coverage for treatment of conditions relating to severe mental illness.
689B.036 Required provision concerning benefits for treatment of abuse of alcohol or drugs.
689B.0365 Required provision concerning coverage for use of certain drugs for treatment of cancer.
689B.0374 Required provision concerning coverage for cytologic screening tests and mammograms for certain women.
689B.0375 Policy covering mastectomy to provide coverage for prosthetic devices and reconstructive surgery.
689B.0376 Policy covering prescription drugs or devices to provide coverage for drug or device for contraception and of hormone replacement therapy in certain circumstances; prohibited actions by insurer; exceptions.

689B.0377 Policy covering outpatient care to provide coverage for health care services related to contraceptives and hormone replacement therapy; prohibited actions by insurer; exceptions.

689B.0379 Coverage concerning treatment of temporomandibular joint.

689B.038 Reimbursement for treatments by licensed psychologist.

689B.0383 Reimbursement for treatments by licensed marriage and family therapist.

689B.0385 Reimbursement for treatments by licensed associate in social work, social worker, independent social worker or clinical social worker.

689B.039 Reimbursement for treatments by chiropractor.

689B.045 Reimbursement for services provided by certain nurses; prohibited limitations; exception.

689B.047 Reimbursement to provider of medical transportation.

689B.049 Reimbursement for acupuncture.

689B.260 Required provision concerning coverage relating to complications of pregnancy.

689C.115 Mandatory and optional coverage.

695B.1908 Coverage for use of certain drugs for treatment of cancer.

695B.191 Policy covering mastectomy to provide coverage for prosthetic devices and reconstructive surgery.

695B.1912 Required provision concerning coverage for cytologic screening tests and mammograms for certain women.

695B.1914 Coverage of certain gynecological and obstetrical services without authorization or referral from primary care physician.

695B.1916 Coverage of drug or device for contraception and of hormone replacement therapy in certain circumstances; prohibited actions by insurer; exceptions.

695B.1918 Coverage of health care services related to contraceptives and hormone replacement therapy in certain circumstances; prohibited actions by insurer; exceptions.

695B.192 Coverage relating to complications of pregnancy.

695B.1923 Coverage for treatment of certain inherited metabolic diseases.

695B.1927 Coverage for management and treatment of diabetes.

695B.193 Coverage for newly born and adopted children and children placed for adoption.

695B.1931 Coverage relating to treatment of temporomandibular joint.

695B.1938 Required provision concerning coverage for treatment of conditions relating to severe mental illness.

695B.194 Required provision concerning benefits for treatment of abuse of alcohol or drugs.

695B.1944 Required provision concerning coverage for employee or member on leave without pay as result of total disability.

695B.196 Reimbursement for acupuncture.

695B.197 Reimbursement for treatment by licensed psychologist.
695B.1973 Reimbursement for treatment by licensed marriage and family therapist.
695B.1975 Reimbursement for treatment by licensed associate in social work, social worker, independent social worker or clinical social worker.
695B.198 Reimbursement for treatment by chiropractor.
695B.199 Reimbursement for services provided by certain nurses; prohibited limitations; exception.
695B.1995 Reimbursement to provider of medical transportation.
695C.1709 Required provision concerning coverage for enrollee on leave without pay as result of total disability.
695C.171 Plans covering mastectomy to provide coverage for prosthetic devices and reconstructive surgery.
695C.1713 Coverage of certain gynecological and obstetrical services without authorization or referral from primary care physician.
695C.1715 Coverage of drug or device for contraception and of hormone replacement therapy in certain circumstances; prohibited actions by health maintenance organization; exceptions.
695C.1717 Coverage of health care services related to contraceptives and hormone replacement therapy in certain circumstances; prohibited actions by health maintenance organization; exceptions.
695C.172 Coverage relating to complications of pregnancy.
695C.1723 Coverage for treatment of certain inherited metabolic diseases.
695C.1727 Coverage for management and treatment of diabetes.
695C.173 Coverage for newly born and adopted children and children placed for adoption.
695C.1733 Coverage for certain drugs for treatment of cancer.
695C.1735 Required provision concerning coverage for cytologic screening tests and mammograms for certain women.
695C.1738 Required provision concerning coverage for treatment of conditions relating to severe mental illness.
695C.174 Required provision concerning benefits for treatment of abuse of alcohol or drugs.
695C.1755 Coverage relating to treatment of temporomandibular joint.
695C.176 Coverage for hospice care.
695C.1765 Reimbursement for acupuncture.
695C.177 Reimbursement for treatments by licensed psychologist.
695C.1773 Reimbursement for treatment by licensed marriage and family therapist.
695C.1775 Reimbursement for treatment by licensed associate in social work, social worker, independent social worker or clinical social worker.
695C.178 Reimbursement for treatment by chiropractor.

695C.179 Reimbursement for services provided by certain nurses; prohibited limitations; exceptions.

695C.1795 Reimbursement to provider of medical transportation.

695D.210 Coverage for newly born and adopted children and children placed for adoption.

695F.215 Required contract with insurance company for provision of insurance, indemnity or reimbursement against cost of health care services.

695G.170 Medically necessary emergency services: Coverage required; requiring prior authorization prohibited.

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