ASSEMBLY BILL NO. 346–ASSEMBLYMAN COBB

MARCH 13, 2009

Referred to Committee on Commerce and Labor

SUMMARY—Makes various changes to provisions governing health insurance policies and plans. (BDR 57-385)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Yes.

~

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

AN ACT relating to insurance; revising requirements regarding the filing and approval of certain health insurance policies and plans; allowing basic coverage policies and plans to exclude certain mandatory coverage; revising provisions governing the availability and portability of certain health insurance; revising provisions governing continuing coverage under certain group health insurance; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Sections 2-18 of this bill amend the Nevada Insurance Code by adding a new chapter, designated as the Accident and Health Policy Rate and Form Filing Law, which is based on a model act of the National Association of Insurance Commissioners. (Title 57 of NRS) The purpose of **sections 2-18** is to provide a uniform standard for the processing of rate and form filings by accident and health insurance carriers. **Sections 19-21, 27, 30 and 32** of this bill make conforming changes relating to the new chapter.

Existing law requires individual and group health care policies and plans to provide mandatory coverage for certain health care services. (Chapters 689A, 689B, 695B, 695C and 695G of NRS) **Sections 22, 26, 31, 33 and 34** of this bill allow insurers and organizations offering such health care policies and plans to also offer a basic coverage policy or plan which covers basic medical, surgical and hospital care, prescription drugs and emergency transportation, but which may exclude any other mandatory coverage.

Under existing law, a person is entitled to certain statutory rights regarding the availability and portability of health insurance if the person has creditable coverage under various health care policies and plans for a prescribed period. (NRS 689A.470-689A.740) **Sections 23 and 25** of this bill ensure that creditable coverage is interpreted to include coverage under an individual health benefit plan. (NRS 689A.505, 689A.540) **Section 24** of this bill reduces the required period of

creditable coverage from 18 months to 12 months. In addition, **section 24** extends the statutory rights to a person who moves into this State from another state or federal jurisdiction while covered by an individual health benefit plan which was issued in the other jurisdiction by a carrier that does not offer an individual health benefit plan in this State. (NRS 689A.515)

Under existing law, when an employee and his dependents have been covered under certain group health insurance for at least 12 consecutive months, they may elect to continue that coverage for a prescribed period if the employer terminates the employee's employment for any reason other than gross misconduct. (NRS 689B.245-689B.249) **Section 28** of this bill reduces the period to qualify from 12 consecutive months to 30 consecutive days. **Section 28** also provides that an employee and his dependents may elect to continue coverage if the employee voluntarily terminates his employment. (NRS 689B.245) **Section 29** of this bill reduces the maximum premium that may be charged for continuation of coverage from 125 percent to 102 percent of the premium charged by the insurer on the date of eligibility for continuation of coverage, and **section 29** also provides that the premiums must be paid monthly, rather than quarterly. (NRS 689B.247)

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

Section 1. Title 57 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 2 to 18, inclusive, of this act.

Sec. 2. ***This chapter may be cited as the Accident and Health Policy Rate and Form Filing Law.***

Sec. 3. ***As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 4 to 10, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 4. ***1. "Accident and health carrier" or "carrier" means any person who is licensed pursuant to this Code or is otherwise subject to this Code or the jurisdiction of the Commissioner and who offers to provide or provides in this State:***

(a) Accident and health insurance;

(b) Insurance for supplemental disability income;

(c) Supplemental insurance which provides for the payment of expenses that are not covered by Medicare;

(d) Long-term care insurance; or

(e) Any other policy or contract to provide, deliver, arrange for, pay for or reimburse any costs of health care services.

2. The term includes, without limitation, a fraternal benefit society, a health maintenance organization, a nonprofit hospital and health service corporation, a health insurance company and any other person providing a plan of health insurance or health benefits subject to this Code.

Sec. 5. *"Administrative order" means any administrative order, publication or bulletin of the Commissioner or the Division having the force and effect of law in this State.*

Sec. 6. *"Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.*

Sec. 7. *"Medicare" means the program of health insurance for aged persons and persons with disabilities established pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq.*

Sec. 8. *"Policy form" or "form" means any policy, contract, certificate, rider, endorsement or evidence of coverage, or any amendment thereto, which is issued by an accident and health carrier and which is required by law to be filed with the Commissioner for approval before its sale or issuance for sale in this State.*

Sec. 9. *"Supplemental documents" means documents required to be filed in support of policy forms that may or may not be subject to approval by the Commissioner.*

Sec. 10. *"Type of insurance" means those coverages listed by the National Association of Insurance Commissioners on the Uniform Life, Accident and Health, Annuity and Credit Product Coding Matrix, or any successor document, under the headings:*

1. Continuing Care Retirement Communities;

2. Health;

3. Long Term Care; and

4. Medicare Supplement.

Sec. 11. *1. The provisions of this chapter apply to any individual or group policy form which is issued by an accident and health carrier and which is required by law to be filed with the Commissioner for approval before its sale or issuance for sale in this State.*

2. The provisions of this chapter must be interpreted so as to effectuate their general purpose to provide a uniform standard for the processing of rate and form filings by accident and health carriers. To that end, if there is a conflict between the provisions of this chapter and any other provisions of this Code regarding the processing of rate and form filings by accident and health carriers, the provisions of this chapter control.

Sec. 12. *1. Subject to the provisions of this chapter, a policy form must not be delivered or issued for delivery in this State unless the policy form has been filed with and approved by the Commissioner.*

2. All persons involved in the process of filing and reviewing policy forms shall act in good faith and with due diligence in the performance of their duties pursuant to this chapter.

Sec. 13. *1. The Commissioner shall create a document containing the filing requirements for each type of insurance. The document must list all filing requirements contained in the applicable statutes, regulations and administrative orders of this State, with appropriate citations to each such authority.*

2. The Commissioner shall make the document available on the Internet website of the Division.

3. The Commissioner shall update the document:

(a) At least once each year; and

(b) If there are any changes in the applicable statutes, regulations or administrative orders of this State which require the document to be revised in order to be accurate, within 30 days after the changes become effective.

4. When an accident and health carrier files a policy form, the carrier shall submit a copy of the document which:

(a) Specifies each location within the policy form or supplemental documents that is intended to comply with each applicable requirement contained in the document; and

(b) Certifies that the policy form meets all requirements contained in the applicable statutes, regulations and administrative orders of this State.

Sec. 14. *1. Not later than 60 days after the date on which an accident and health carrier files a policy form, the Commissioner shall provide the carrier with a notice of:*

(a) Approval of the policy form;

(b) Deficiencies in the policy form; or

(c) Disapproval of the policy form.

2. If the Commissioner does not provide the notice to the carrier within the 60-day period, the policy form shall be deemed approved.

3. If the Commissioner provides the carrier with a notice of deficiencies or disapproval, the notice:

(a) Must be in writing;

(b) Must be based only on the specific provisions of applicable statutes, regulations and administrative orders of this State which are contained in the document created by the Commissioner pursuant to section 13 of this act;

(c) Must provide reasons for the deficiencies or disapproval and sufficient detail for the carrier to bring the policy form into compliance; and

(d) Must cite the specific provisions of applicable statutes, regulations and administrative orders of this State upon which the deficiencies or disapproval is based.

4. Not later than 30 days after the date on which the Commissioner provides the carrier with a notice of deficiencies or

disapproval, the carrier may resubmit a policy form that remedies the reasons for the deficiencies or disapproval. The resubmitted policy form must be accompanied by a revised certification that complies with section 13 of this act.

5. If the carrier does not resubmit the policy form within the 30-day period, the policy form shall be deemed:

(a) Withdrawn, if the Commissioner provided the carrier with a notice of deficiencies; or

(b) Disapproved, if the Commissioner provided the carrier with a notice of disapproval.

6. Except as otherwise provided in this subsection, not later than 30 days after the date on which a carrier resubmits a policy form, the Commissioner shall provide the carrier with a notice of approval or disapproval. A notice of disapproval must comply with the provisions of subsection 3. The Commissioner may extend the 30-day period by not more than 30 additional days if the carrier has introduced any new provision in the resubmitted policy form or has materially modified any substantive provision of the resubmitted policy form. If the Commissioner does not provide the notice to the carrier within the 30-day period or any period of extension, whichever is later, the resubmitted policy form shall be deemed approved.

7. The Commissioner may not disapprove a resubmitted policy form for reasons other than those set forth in the original notice of deficiencies or disapproval unless:

(a) The carrier has introduced any new provision in the resubmitted policy form or has materially modified any substantive provision of the resubmitted policy form;

(b) There has been a change in the applicable statutes, regulations or administrative orders of this State which supports the disapproval; or

(c) The original notice of deficiencies or disapproval contained a legal error because it failed to cite one or more specific provisions of applicable statutes, regulations or administrative orders of this State that must be satisfied in order for the policy to comply with the requirements of state law.

8. Notwithstanding any other provision of this section, the Commissioner may return a grossly inadequate policy form to the carrier without triggering any of the deadlines set forth in this section.

9. As used in this section, "grossly inadequate policy form" means a policy form which:

(a) Fails to provide key information, including, without limitation, information specific to this State regarding a product, policy or rate; or

(b) Demonstrates that the carrier has an insufficient understanding of what is required to comply with the applicable statutes, regulations or administrative orders of this State.

Sec. 15. *1. Notwithstanding any other provision of this chapter, a carrier may elect to self-certify a policy form pursuant to this section and opt out of the review procedures set forth in sections 13 and 14 of this act.*

2. If a carrier elects to self-certify a policy form pursuant to this section, the carrier shall file with the Commissioner:

(a) A valid self-certification made by an appropriate officer of the carrier on a form prescribed by the Commissioner which certifies that:

(1) The carrier intends to opt out of the review procedures set forth in sections 13 and 14 of this act; and

(2) The policy form meets all requirements contained in the applicable statutes, regulations and administrative orders of this State; and

(b) A copy of the document created by the Commissioner pursuant to section 13 of this act which specifies each location within the policy form or supplemental documents that is intended to comply with each applicable requirement contained in the document.

3. If the Commissioner determines that there are material errors or omissions in a policy form that has been self-certified, the Commissioner may:

(a) Disapprove the policy form by providing the carrier with a notice of disapproval;

(b) Order the carrier to take appropriate action with respect to its existing policyholders; and

(c) Order that the self-certification option is no longer available to that carrier for a period as determined by the Commissioner.

4. A notice of disapproval:

(a) Must be in writing;

(b) Must be based only on the specific provisions of applicable statutes, regulations and administrative orders of this State which are contained in the document created by the Commissioner pursuant to section 13 of this act;

(c) Must provide reasons for the disapproval and sufficient detail for the carrier to bring the policy form into compliance; and

(d) Must cite the specific provisions of applicable statutes, regulations and administrative orders of this State upon which the disapproval is based.

5. Not later than 60 days after the date on which the Commissioner provides the carrier with a notice of disapproval,

the carrier may resubmit a policy form that remedies the reasons for the disapproval. The resubmitted policy form must be accompanied by a revised certification that complies with subsection 2.

6. If the carrier does not resubmit the policy form within the 60-day period, the policy form shall be deemed withdrawn.

7. Except as otherwise provided in this subsection, not later than 30 days after the date on which a carrier resubmits a policy form, the Commissioner shall provide the carrier with a notice of approval or disapproval. A notice of disapproval must comply with the provisions of subsection 4. The Commissioner may extend the 30-day period by not more than 30 additional days if the carrier has introduced any new provision in the resubmitted policy form or has materially modified any substantive provision of the resubmitted policy form. If the Commissioner does not provide the notice to the carrier within the 30-day period or any period of extension, whichever is later, the resubmitted policy form shall be deemed approved.

8. The Commissioner may not disapprove a resubmitted policy form for reasons other than those set forth in the original notice of disapproval unless:

(a) The carrier has introduced any new provision in the resubmitted policy form or has materially modified any substantive provision of the resubmitted policy form;

(b) There has been a change in the applicable statutes, regulations or administrative orders of this State which supports the disapproval; or

(c) The original notice of disapproval contained a legal error because it failed to cite one or more specific provisions of applicable statutes, regulations or administrative orders of this State that must be satisfied in order for the policy to comply with the requirements of state law.

Sec. 16. *1. Except as otherwise provided in subsection 2, if a policy form has been approved or deemed approved pursuant to this chapter, the Commissioner shall not:*

(a) Retroactively disapprove that policy form; or

(b) During a routine or targeted examination of the carrier, examine that policy form for compliance with any requirements governing the filing of policy forms that became effective after the date on which the policy form was approved or deemed approved.

2. The provisions of this section do not apply to a policy form that has been approved or deemed approved pursuant to this chapter if the Commissioner determines that the policy form contains a material error or omission.

Sec. 17. ***Unless otherwise required by statute, if a regulation or administrative order governing the filing of policy forms becomes effective after the date on which a policy form has been approved or deemed approved pursuant to this chapter, the regulation or administrative order may not be applied to that policy form except upon the renewal or anniversary date of the policy.***

Sec. 18. ***If a carrier is required by state law to obtain approval from the Commissioner of a rate or marketing material for a specific policy form, the procedures and time frames for filing and obtaining approval of the rate or marketing material must be, to the extent practicable, the same as those provided for in this chapter for the filing and approval of policy forms.***

Sec. 19. NRS 686B.030 is hereby amended to read as follows:

686B.030 1. Except as otherwise provided in subsection 2, ***and sections 2 to 18, inclusive, of this act, the provisions of*** NRS 686B.010 to 686B.1799, inclusive, apply to all kinds and lines of direct insurance written on risks or operations in this State by any insurer authorized to do business in this State, except:

(a) Ocean marine insurance;

(b) Contracts issued by fraternal benefit societies;

(c) Life insurance and credit life insurance;

(d) Variable and fixed annuities;

(e) Group and blanket health insurance and credit health insurance;

(f) Property insurance for business and commercial risks;

(g) Casualty insurance for business and commercial risks other than insurance covering the liability of a practitioner licensed pursuant to chapters 630 to 640, inclusive, of NRS; and

(h) Surety insurance.

2. The exclusions set forth in paragraphs (f) and (g) of subsection 1 extend only to issues related to the determination or approval of premium rates.

Sec. 20. NRS 687B.113 is hereby amended to read as follows:

687B.113 An insurer shall include provisions in a policy of health insurance encouraging the insured's use, if medically appropriate, of services and facilities that are the most efficient or that tend to control or reduce the cost of health care. Any policy or other form filed with the Commissioner pursuant to NRS 687B.120 ***or sections 2 to 18, inclusive, of this act, as applicable,*** must specifically indicate which provisions satisfy the requirements of this section.

Sec. 21. NRS 687B.120 is hereby amended to read as follows:

687B.120 1. ~~[No]~~ ***Except as otherwise provided in sections 2 to 18, inclusive, of this act, no*** life or health insurance policy or

contract, annuity contract form, policy form, health care plan or plan for dental care, whether individual, group or blanket, including those to be issued by a health maintenance organization, organization for dental care or prepaid limited health service organization, or application form where a written application is required and is to be made a part of the policy or contract, or printed rider or endorsement form or form of renewal certificate, or form of individual certificate or statement of coverage to be issued under group or blanket contracts, or by a health maintenance organization, organization for dental care or prepaid limited health service organization, may be delivered or issued for delivery in this state, unless the form has been filed with and approved by the Commissioner. This subsection does not apply to any special rider or endorsement which relates to the manner of distribution of benefits or to the reservation of rights and benefits under life or health insurance policies, which special riders or endorsements are used at the request of the individual policyholder, contract holder or certificate holder. As to group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the group certificates to be delivered or issued for delivery in this state must be filed, for informational purposes only, with the Commissioner at his request.

2. Every such filing must be made not less than 45 days in advance of any such delivery. At the expiration of 45 days the form so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the Commissioner. Approval of any such form by the Commissioner constitutes a waiver of any unexpired portion of such waiting period. The Commissioner may extend by not more than an additional 30 days the period within which he may so affirmatively approve or disapprove any such form, by giving notice to the insurer of the extension before expiration of the initial 45-day period. At the expiration of any such period as so extended, and in the absence of prior affirmative approval or disapproval, any such form shall be deemed approved. The Commissioner may at any time, after notice and for cause shown, withdraw any such approval.

3. Any order of the Commissioner disapproving any such form or withdrawing a previous approval must state the grounds therefor and the particulars thereof in such detail as reasonably to inform the insurer thereof. Any such withdrawal of a previously approved form is effective at the expiration of such a period, not less than 30 days after the giving of notice of withdrawal, as the Commissioner in such notice prescribes.

4. The Commissioner may, by order, exempt from the requirements of this section for so long as he deems proper any

insurance document or form or type thereof specified in the order, to which, in his opinion, this section may not practicably be applied, or the filing and approval of which are, in his opinion, not desirable or necessary for the protection of the public.

5. Appeals from orders of the Commissioner disapproving any such form or withdrawing a previous approval may be taken as provided in NRS 679B.310 to 679B.370, inclusive.

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

1. Notwithstanding any other provision of this chapter, if an insurer offers a policy of health insurance that includes all coverage required by this chapter, the insurer may also offer a policy of health insurance, designated as a basic coverage policy, which:

(a) Must include coverage of basic medical, surgical and hospital care, prescription drugs and emergency transportation; and

(b) May exclude any other coverage that would otherwise be required by this chapter.

2. An insurer that offers a basic coverage policy shall provide persons who are seeking to be insured with information regarding:

(a) The availability of the basic coverage policy; and

(b) The differences in coverage provided by the basic coverage policy and a policy that includes all coverage required by this chapter.

3. The Office for Consumer Health Assistance shall develop a disclosure that must appear on each basic coverage policy in a clear and conspicuous manner. The disclosure must be written in language that is easily understood and must include:

(a) A statement that the policy is a basic coverage policy and that the coverage provided by the basic coverage policy is limited;

(b) A statement that the basic coverage policy should be read to determine the governing contractual provisions; and

(c) Any other information that the Office for Consumer Health Assistance finds necessary to provide for full and fair disclosure of the limitations of the basic coverage policy.

Sec. 23. NRS 689A.505 is hereby amended to read as follows:

689A.505 "Creditable coverage" means, with respect to a person, health benefits or coverage provided pursuant to:

1. A group health plan;

2. A health benefit plan ~~[;]~~ ***, including an individual health benefit plan;***

3. Part A or Part B of Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395c et seq., also known as Medicare;

4. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., also known as Medicaid, other than coverage consisting solely of benefits under section 1928 of that Title, 42 U.S.C. § 1396s;

5. The Civilian Health and Medical Program of Uniformed Services, CHAMPUS, 10 U.S.C. §§ 1071 et seq.;

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefit risk pool;

8. A health plan offered pursuant to the Federal Employees Health Benefits Program, FEHBP, 5 U.S.C. §§ 8901 et seq.;

9. A public health plan as defined in 45 C.F.R. § 146.113, authorized by the Public Health Service Act, 42 U.S.C. § 300gg(c)(1)(I);

10. A health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. § 2504(e);

11. The Children's Health Insurance Program established pursuant to 42 U.S.C. §§ 1397aa to 1397jj, inclusive;

12. A short-term health insurance policy; or

13. A blanket student accident and health insurance policy.

Sec. 24. NRS 689A.515 is hereby amended to read as follows:

689A.515 "Eligible person" means:

1. A person:

(a) Who, as of the date on which he seeks coverage pursuant to this chapter, has an aggregate period of creditable coverage that is ~~[18]~~ ***12*** months or more;

(b) Whose most recent prior creditable coverage, other than coverage under a short-term health insurance policy, was under ~~[a]~~ ***:***

(1) A group health plan, governmental plan, church plan or health insurance coverage offered in connection with any such plan; ***or***

(2) An individual health benefit plan which provided coverage to the person while he was a resident of another state, the District of Columbia or a territory, possession, commonwealth or dependency of the United States and which was issued in accordance with the laws of the other jurisdiction;

(c) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395c et seq., also known as Medicare, a state plan pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., also known as Medicaid, or any successor program, and who does not have any other health insurance coverage;

(d) Whose most recent health insurance coverage within the period of aggregate creditable coverage was not terminated because of a failure to pay premiums or fraud;

(e) Who has exhausted his continuation of coverage under the Consolidation Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, or under a similar state program, if any; and

(f) Who has not had a break of more than 63 consecutive days in his creditable coverage.

2. A person whose most recent prior creditable coverage was under a basic or standard health benefit plan and was not renewed by a carrier who discontinued offering and renewing individual health benefit plans in this state pursuant to NRS 689A.630.

3. ***A person who moves into this State from another state, the District of Columbia or a territory, possession, commonwealth or dependency of the United States while covered by an individual health benefit plan which was issued in accordance with the laws of the other jurisdiction by a carrier that does not offer an individual health benefit plan in this State.***

4. Notwithstanding the provisions of paragraph (a) of subsection 1, a newborn child or a child placed for adoption, if the child was enrolled timely and would have otherwise met the requirements of an eligible person as set forth in subsection 1.

Sec. 25. NRS 689A.540 is hereby amended to read as follows:

689A.540 1. "Health benefit plan" means a policy, contract, certificate or agreement offered by a carrier to provide for, deliver payment for, arrange for the payment of, pay for or reimburse any of the costs of health care services. Except as otherwise provided in this section, the term includes ***an individual health benefit plan,*** catastrophic health insurance policies and a policy that pays on a cost-incurred basis.

2. The term does not include:

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

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

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

(d) Workers' compensation or similar insurance;

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

(f) Credit insurance;

(g) Coverage for on-site medical clinics;

(h) Other similar insurance coverage specified in federal regulations issued pursuant to Public Law 104-191 under which benefits for medical care are secondary or incidental to other insurance benefits;

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

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

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

(a) Limited-scope dental or vision benefits;

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

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

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

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

(b) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

Sec. 26. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. Notwithstanding any other provision of this chapter, if an insurer offers a policy of group health insurance that includes all coverage required by this chapter, the insurer may also offer a policy of group health insurance, designated as a basic coverage policy, which:

(a) Must include coverage of basic medical, surgical and hospital care, prescription drugs and emergency transportation; and

(b) May exclude any other coverage that would otherwise be required by this chapter.

2. An insurer that offers a basic coverage policy shall provide persons who are seeking to be insured with information regarding:

(a) The availability of the basic coverage policy; and

(b) The differences in coverage provided by the basic coverage policy and a policy that includes all coverage required by this chapter.

3. The Office for Consumer Health Assistance shall develop a disclosure that must appear on each basic coverage policy in a clear and conspicuous manner. The disclosure must be written in language that is easily understood and must include:

(a) A statement that the policy is a basic coverage policy and that the coverage provided by the basic coverage policy is limited;

(b) A statement that the basic coverage policy should be read to determine the governing contractual provisions; and

(c) Any other information that the Office for Consumer Health Assistance finds necessary to provide for full and fair disclosure of the limitations of the basic coverage policy.

Sec. 27. 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 accident and health insurance. No blanket policy ~~[, except as 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 ***and approved*** in accordance with NRS 687B.120 ~~[.]~~ ***or sections 2 to 18, inclusive, of this act, as applicable.*** Every 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 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 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 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 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. 28. NRS 689B.245 is hereby amended to read as follows:

689B.245 1. If an employer who employs less than 20 employees maintains a policy of group health insurance which covers those employees, the policy must contain a provision which permits:

(a) An employee to elect to continue identical coverage under the policy, excluding coverage provided for eye or dental care, if:

(1) His employment is terminated for any reason other than gross misconduct; ~~[or]~~

(2) The number of his working hours is reduced so that he ceases to be eligible for coverage ~~[.]~~ ***; or***

(3) He voluntarily terminates his employment.

(b) The spouse or dependent child of an employee to elect to continue coverage, excluding coverage provided for eye or dental care, if:

(1) The employee's employment is terminated for any reason other than gross misconduct ***,*** ~~[or]~~ the number of his working hours is reduced so that he ceases to be eligible for coverage ~~[;]~~ ***or he voluntarily terminates his employment;***

(2) The employee dies;

(3) The employee and his spouse are divorced or legally separated;

(4) The dependent child ceases to be eligible for coverage under the terms of the policy; or

(5) The spouse ceases to be eligible for coverage after becoming eligible for Medicare.

2. The period of continued coverage is limited to:

(a) Eighteen months for an employee.

(b) Thirty-six months for an employee's spouse or dependent child.

3. ~~[An employee who voluntarily leaves his employment, or the spouse or dependent child of that employee, is not eligible to continue coverage pursuant to this section.~~

~~4.]~~ An employee, spouse or dependent child who has not been covered under any group policy of the employer for at least ~~[12 consecutive months]~~ ***30 consecutive days*** before the termination of his coverage is not eligible to continue coverage pursuant to this section.

~~[5.]~~ ***4.*** A provision for continued coverage must include coverage for any child born to, legally adopted by or placed for adoption with the employee during the period of continued coverage. Such a child is eligible for continued coverage only to the end of the period of continued coverage as established pursuant to subsection 2.

Sec. 29. NRS 689B.247 is hereby amended to read as follows:

689B.247 1. Any person who elects to continue coverage pursuant to NRS 689B.245 shall pay the premium for that coverage in an amount not to exceed ~~[125]~~ ***102*** percent of the premium charged to the employer by the insurer on the date on which that person became eligible for continued coverage.

2. If there is a change in the rate charged or benefits provided under the policy during the time of continued coverage, the premium may not exceed ~~[125]~~ ***102*** percent of the new rate charged to the employer.

3. The premiums must be paid to the insurer on a ~~[quarterly]~~ ***monthly*** basis.

4. If the payment of a premium is not received by the insurer within 30 days after the date on which it is due, continued coverage must be terminated.

Sec. 30. NRS 695A.240 is hereby amended to read as follows:

695A.240 1. No certificate may be delivered or issued for delivery in this state unless a copy of the form of the certificate has been filed with and approved by the Commissioner in conformity with the requirements of NRS 687B.120 ~~[.]~~ ***or sections 2 to 18, inclusive, of this act, as applicable.***

2. The certificate must contain:

(a) A provision stating the amount of premiums which are payable under the certificate;

(b) A provision setting forth the society's laws or rules which, if violated, will result in the termination or reduction of benefits payable under the certificate;

(c) If the laws of the society provide for the expulsion or suspension of a member, a provision that any member who is expelled or suspended, except for nonpayment of a premium or, during the period of contestability, for material misrepresentation in the application for membership or insurance, may maintain the certificate in force by continuing payment of the required premium; and

(d) All standard contractual provisions which are required by the provisions of chapters 687B, 688A, 688B, 689, 689A and 689B of NRS to be included in similar policies issued by life or health insurers in this state, and which are not inconsistent with the provisions of this chapter.

3. The certificate may contain:

(a) A provision that the member is entitled to a grace period of 1 month in which the payment of any premium after the first may be made.

(b) For a benefit contract issued on the life of a person under the society's minimum age for membership as an adult, a provision governing the transfer of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to make the transfer, and may provide for the regulation, government and control of such a certificate and all rights, obligations and liabilities incident to the certificate, including rights of ownership before the transfer.

(c) The terms and conditions governing the assignability of the benefit contract.

Sec. 31. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. Notwithstanding any other provision of this chapter, if a hospital or medical service corporation offers a policy of health insurance that includes all coverage required by this chapter, the hospital or medical service corporation may also offer a policy of health insurance, designated as a basic coverage policy, which:

(a) Must include coverage of basic medical, surgical and hospital care, prescription drugs and emergency transportation; and

(b) May exclude any other coverage that would otherwise be required by this chapter.

2. A hospital or medical service corporation that offers a basic coverage policy shall provide persons who are seeking to be insured with information regarding:

(a) The availability of the basic coverage policy; and

(b) The differences in coverage provided by the basic coverage policy and a policy that includes all coverage required by this chapter.

3. The Office for Consumer Health Assistance shall develop a disclosure that must appear on each basic coverage policy in a clear and conspicuous manner. The disclosure must be written in language that is easily understood and must include:

(a) A statement that the policy is a basic coverage policy and that the coverage provided by the basic coverage policy is limited;

(b) A statement that the basic coverage policy should be read to determine the governing contractual provisions; and

(c) Any other information that the Office for Consumer Health Assistance finds necessary to provide for full and fair disclosure of the limitations of the basic coverage policy.

Sec. 32. NRS 695B.320 is hereby amended to read as follows:

695B.320 Nonprofit hospital and medical or dental service corporations are subject to the provisions of this chapter, and to the provisions of chapters 679A and 679B of NRS, NRS 686A.010 to 686A.315, inclusive, 687B.010 to 687B.040, inclusive, 687B.070 to 687B.140, inclusive, 687B.150, 687B.160, 687B.180, 687B.200 to 687B.255, inclusive, 687B.270, 687B.310 to 687B.380, inclusive, 687B.410, 687B.420, 687B.430, and chapters 692C and 696B of NRS, ***and sections 2 to 18, inclusive, of this act,*** to the extent applicable and not in conflict with the express provisions of this chapter.

Sec. 33. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. Notwithstanding any other provision of this chapter, if a health maintenance organization offers a health care plan that includes all coverage required by this chapter, the health maintenance organization may also offer a health care plan, designated as a basic coverage plan, which:

(a) Must include coverage of basic medical, surgical and hospital care, prescription drugs and emergency transportation; and

(b) May exclude any other coverage that would otherwise be required by this chapter.

2. A health maintenance organization that offers a basic coverage plan shall provide persons who are seeking to be participants in a health care plan with information regarding:

(a) The availability of the basic coverage plan; and

(b) The differences in coverage provided by the basic coverage plan and a health care plan that includes all coverage required by this chapter.

3. The Office for Consumer Health Assistance shall develop a disclosure that must appear on each basic coverage plan in a clear and conspicuous manner. The disclosure must be written in language that is easily understood and must include:

(a) A statement that the health care plan is a basic coverage plan and that the coverage provided by the basic coverage plan is limited;

(b) A statement that the basic coverage plan documents should be read to determine the governing contractual provisions; and

(c) Any other information that the Office for Consumer Health Assistance finds necessary to provide for full and fair disclosure of the limitations of the basic coverage plan.

Sec. 34. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. Notwithstanding any other provision of this chapter, if a managed care organization offers a health care plan that includes all coverage required by this chapter, the managed care organization may also offer a health care plan, designated as a basic coverage plan, which:

(a) Must include coverage of basic medical, surgical and hospital care, prescription drugs and emergency transportation; and

(b) May exclude any other coverage that would otherwise be required by this chapter.

2. A managed care organization that offers a basic coverage plan shall provide persons who are seeking to be participants in a health care plan with information regarding:

(a) The availability of the basic coverage plan; and

(b) The differences in coverage provided by the basic coverage plan and a health care plan that includes all coverage required by this chapter.

3. The Office for Consumer Health Assistance shall develop a disclosure that must appear on each basic coverage plan in a clear and conspicuous manner. The disclosure must be written in language that is easily understood and must include:

(a) A statement that the health care plan is a basic coverage plan and that the coverage provided by the basic coverage plan is limited;

(b) A statement that the basic coverage plan documents should be read to determine the governing contractual provisions; and

(c) Any other information that the Office for Consumer Health Assistance finds necessary to provide for full and fair disclosure of the limitations of the basic coverage plan.