ASSEMBLY BILL NO. 74–COMMITTEE
ON COMMERCE AND LABOR

(ON BEHALF OF THE DIVISION OF INSURANCE)

PREFILED DECEMBER 15, 2010

Referred to Committee on Commerce and Labor

SUMMARY—Revises various provisions relating to the regulation of the insurance industry. (BDR 57-472)

FISCAL NOTE: Effect on Local Government: Increases or Newly Provides for Term of Imprisonment in County or City Jail or Detention Facility.
Effect on the State: Yes.

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

AN ACT relating to insurance; requiring the Commissioner of Insurance to adopt regulations relating to electronic signatures, records and payments; revising provisions relating to the external review of adverse determinations by enacting the National Association of Insurance Commissioners' Uniform Health Carrier External Review Model Act; clarifying the circumstances under which an actuary is not liable for damages with respect to the actuary's opinion; authorizing the electronic transmission of fingerprints with an application for a license; revising provisions relating to the licensing of adjusters; revising provisions relating to surplus lines insurance; revising provisions relating to the use of credit information; requiring that certain policies of group insurance be filed with and approved by the Commissioner; revising provisions relating to annuities, pure endowment contracts and policies of life insurance; revising provisions relating to evidence of insurance for motor vehicles; revising provisions relating to disciplinary action by the Commissioner; revising and clarifying provisions relating to employee leasing companies; providing a penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law provides a set of procedures for the external review of an adverse determination by a managed care organization. (NRS 695G.241-695G.310) **Sections 2, 3, 8, 9, 71-118, 123-127 and 129-131** of this bill enact the National Association of Insurance Commissioner's Uniform Health Carrier External Review Model Act and revise various provisions of existing law to conform with the Model Act.

Existing law limits the liability of a qualified actuary for damages relating to the actuary's opinion regarding an insurer who offers life insurance. (NRS 681B.250) **Section 6** of this bill clarifies that this limitation of liability applies not only for life insurance but for any opinion an actuary issues pursuant to chapter 681B of NRS or any regulations adopted thereto.

Existing law requires the Commissioner of Insurance to adopt regulations governing the use of certain electronic methods relating to insurance. (NRS 679B.136, 685A.210) **Sections 1 and 29** of this bill expand the electronic methods that the Commissioner can allow the use of for insurance transactions. Additionally, **sections 10, 11, 20, 44-47 and 122** of this bill allow for the fingerprints required to be submitted with an application for a license pursuant to the Nevada Insurance Code to be submitted electronically.

Existing law requires an applicant for a license as an insurance adjuster to be a resident of this State with certain exceptions. (NRS 684A.070) On December 9, 2009, the United States District Court for the District of Nevada held that the residency requirement to obtain a license as an insurance adjuster violates the Privileges and Immunities Clause of the United States Constitution. (*Reitz v. Kipper*, 674 F.Supp.2d 1194 (D. Nev. 2009)) **Sections 15-26** of this bill revise provisions relating to the licensing of insurance adjusters to remove the residency requirement. **Sections 15-26** also require that an applicant either pass an examination in this State before receiving a license as an insurance adjuster or, if not a resident of this State, be currently licensed in a state that requires an examination before licensure.

Existing law governs trade practices and frauds relating to the insurance business and gives the Commissioner exclusive jurisdiction to regulate trade practices in the insurance business. (Chapter 686A of NRS) **Section 30** of this bill requires an insurer that uses credit information to provide reasonable exceptions to their rates in certain circumstances.

Under existing law, an insurer may not market certain insurance products without first filing the product with the Commissioner and receiving the Commissioner's approval. (NRS 687B.120) **Section 35** of this bill also requires any group insurance policies to be issued pursuant to NRS 688B.030 or 689B.026 to be filed with and approved by the Commissioner before being marketed.

Under existing law, an employee leasing company is deemed to be the employer of its leased employees for the purposes of sponsoring and maintaining any benefit plans. (NRS 616B.691) In 2007, this section was amended to clarify that such a company is also deemed to be the employer for the purposes of the Employee Retirement Income Security Act of 1974 (ERISA). (Chapter 536, Statutes of Nevada 2007, p. 3339) On August 6, 2010, the United States District Court for the District of Nevada held that NRS 616B.691 was preempted by federal law to the extent that it declares the status of any benefit plans for purposes of ERISA. (*Payroll Solutions Group, Ltd. v. Nevada*, No. 02-CV-06-00927-JCM-RJJ (D. Nev. Aug. 6, 2010)) **Section 128** of this bill reverses the changes made to NRS 616B.691 during the 2007 Legislative Session. In addition, **section 128** clarifies that the provisions of subsection 1 of that section apply only for the purposes of chapters 612 and 616A-617 of NRS. **Section 128** also clarifies that the provisions of subsection 2 of that section do not affect the existing employer-employee relationship between a leased employee and a client company.

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

Section 1. NRS 679B.136 is hereby amended to read as follows:

679B.136 1. The Commissioner shall adopt regulations governing:

(a) The use of electronic signatures, and the acceptance and transmission of electronic records ~~[, in]~~ ***and payments, including transactions involving claims and other*** transactions relating to insurance; and

(b) The electronic filing of forms and payment of fees, and the storage and reproduction of records, filed with the Division.

2. As used in this section:

(a) "Electronic" means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic or similar capabilities.

(b) "Electronic record" means a record created, generated, sent, communicated, received or stored by electronic means.

(c) "Electronic signature" means an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

(d) "Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

(e) "Transaction" means an action or set of actions occurring between two or more persons relating to the transaction of business, commercial or governmental affairs.

Sec. 2. NRS 679B.240 is hereby amended to read as follows:

679B.240 To ascertain compliance with law, or relationships and transactions between any person and any insurer or proposed insurer, the Commissioner may, as often as he or she deems advisable, examine the accounts, records, documents and transactions relating to such compliance or relationships of:

1. Any insurance agent, solicitor, broker, surplus lines broker, general agent, adjuster, insurer representative, bail agent, motor club agent or any other licensee or any other person the Commissioner has reason to believe may be acting as or holding himself or herself out as any of the foregoing.

2. Any person having a contract under which the person enjoys in fact the exclusive or dominant right to manage or control an insurer.

3. Any insurance holding company or other person holding the shares of voting stock or the proxies of policyholders of a domestic insurer, to control the management thereof, as voting trustee or otherwise.

4. Any subsidiary of the insurer.

5. Any person engaged in this state in, or proposing to be engaged in this state in, or holding himself or herself out in this state as so engaging or proposing, or in this state assisting in, the promotion, formation or financing of an insurer or insurance holding corporation, or corporation or other group to finance an insurer or the production of its business.

6. Any ~~[external]~~ ***independent*** review organization, as defined in NRS 695G.018.

Sec. 3. NRS 680C.110 is hereby amended to read as follows:

680C.110 1. In addition to any other fee or charge, the Commissioner shall collect in advance and receipt for, and persons so served must pay to the Commissioner, the fees required by this section.

2. A fee required by this section must be:

(a) If an initial fee, paid at the time of an initial application or issuance of a license, as applicable;

(b) If an annual fee, paid on or before March 1 of every year;

(c) If a triennial fee, paid on or before the time of continuation, renewal or other similar action in regard to a certificate, license, permit or other type of authorization, as applicable; and

(d) Deposited in the Fund for Insurance Administration and Enforcement created by NRS 680C.100.

3. The fees required pursuant to this section are not refundable.

4. The following fees must be paid by the following persons to the Commissioner:

(a) Associations of self-insured private employers, as defined in NRS 616A.050:

(1) Initial fee..... $1,300

(2) Annual fee $1,300

(b) Associations of self-insured public employers, as defined in NRS 616A.055:

(1) Initial fee..... $1,300

(2) Annual fee $1,300

(c) ~~[External]~~ ***Independent*** review organizations, as provided for in NRS 616A.469 or ~~[683A.371,]~~ ***section 8 of this act,*** or both:

(1) Initial fee..... $60

(2) Annual fee $60

(d) Insurers not otherwise provided for in this subsection:

(1) Initial fee..... $1,300

(2) Annual fee $1,300

(e) Producers of insurance, as defined in NRS 679A.117:
(1) Initial fee $60
(2) Triennial fee $60
(f) Accredited reinsurers, as provided for in NRS 681A.160:
(1) Initial fee $1,300
(2) Annual fee $1,300
(g) Intermediaries, as defined in NRS 681A.330:
(1) Initial fee $60
(2) Triennial fee $60
(h) Reinsurers, as defined in NRS 681A.370:
(1) Initial fee $1,300
(2) Annual fee $1,300
(i) Administrators, as defined in NRS 683A.025:
(1) Initial fee $60
(2) Triennial fee $60
(j) Managing general agents, as defined in NRS 683A.060:
(1) Initial fee $60
(2) Triennial fee $60
(k) Agents who perform utilization reviews, as defined in NRS 683A.376:
(1) Initial fee $60
(2) Annual fee $60
(l) Insurance consultants, as defined in NRS 683C.010:
(1) Initial fee $60
(2) Triennial fee $60
(m) Independent adjusters, as defined in NRS 684A.030:
(1) Initial fee $60
(2) Triennial fee $60
(n) Public adjusters, as defined in NRS 684A.030:
(1) Initial fee $60
(2) Triennial fee $60
(o) Associate adjusters, as defined in NRS 684A.030:
(1) Initial fee $60
(2) Triennial fee $60
(p) Motor vehicle physical damage appraisers, as defined in NRS 684B.010:
(1) Initial fee $60
(2) Triennial fee $60
(q) Brokers, as defined in NRS 685A.030:
(1) Initial fee $60
(2) Triennial fee $60
(r) Eligible surplus line insurers, as provided for in NRS 685A.070:
(1) Initial fee $1,300
(2) Annual fee $1,300

(s) Companies, as defined in NRS 686A.330:
(1) Initial fee $1,300
(2) Annual fee $1,300
(t) Rate service organizations, as defined in NRS 686B.020:
(1) Initial fee $1,300
(2) Annual fee $1,300
(u) Brokers of viatical settlements, as defined in NRS 688C.030:
(1) Initial fee $60
(2) Annual fee $60
(v) Providers of viatical settlements, as defined in NRS 688C.080:
(1) Initial fee $60
(2) Annual fee $60
(w) Agents for prepaid burial contracts subject to the provisions of chapter 689 of NRS:
(1) Initial fee $60
(2) Triennial fee $60
(x) Agents for prepaid funeral contracts subject to the provisions of chapter 689 of NRS:
(1) Initial fee $60
(2) Triennial fee $60
(y) Sellers of prepaid burial contracts subject to the provisions of chapter 689 of NRS:
(1) Initial fee $60
(2) Triennial fee $60
(z) Sellers of prepaid funeral contracts subject to the provisions of chapter 689 of NRS:
(1) Initial fee $60
(2) Triennial fee $60
(aa) Providers, as defined in NRS 690C.070:
(1) Initial fee $1,300
(2) Annual fee $1,300
(bb) Escrow officers, as defined in NRS 692A.028:
(1) Initial fee $60
(2) Triennial fee $60
(cc) Title agents, as defined in NRS 692A.060:
(1) Initial fee $60
(2) Triennial fee $60
(dd) Captive insurers, as defined in NRS 694C.060:
(1) Initial fee $250
(2) Annual fee $250
(ee) Fraternal benefit societies, as defined in NRS 695A.010:
(1) Initial fee $1,300
(2) Annual fee $1,300

(ff) Insurance agents for societies, as provided for in NRS 695A.330:
(1) Initial fee..... $60
(2) Triennial fee..... $60
(gg) Corporations subject to the provisions of chapter 695B of NRS:
(1) Initial fee..... $1,300
(2) Annual fee $1,300
(hh) Health maintenance organizations, as defined in NRS 695C.030:
(1) Initial fee..... $1,300
(2) Annual fee $1,300
(ii) Organizations for dental care, as defined in NRS 695D.060:
(1) Initial fee..... $1,300
(2) Annual fee $1,300
(jj) Purchasing groups, as defined in NRS 695E.100:
(1) Initial fee..... $250
(2) Annual fee $250
(kk) Risk retention groups, as defined in NRS 695E.110:
(1) Initial fee..... $250
(2) Annual fee $250
(ll) Prepaid limited health service organizations, as defined in NRS 695F.050:
(1) Initial fee..... $1,300
(2) Annual fee $1,300
(mm) Medical discount plans, as defined in NRS 695H.050:
(1) Initial fee..... $1,300
(2) Annual fee $1,300
(nn) Club agents, as defined in NRS 696A.040:
(1) Initial fee..... $60
(2) Triennial fee..... $60
(oo) Motor clubs, as defined in NRS 696A.050:
(1) Initial fee..... $1,300
(2) Annual fee $1,300
(pp) Bail agents, as defined in NRS 697.040:
(1) Initial fee..... $60
(2) Triennial fee..... $60
(qq) Bail enforcement agents, as defined in NRS 697.055:
(1) Initial fee..... $60
(2) Triennial fee..... $60
(rr) Bail solicitors, as defined in NRS 697.060:
(1) Initial fee..... $60
(2) Triennial fee..... $60
(ss) General agents, as defined in NRS 697.070:
(1) Initial fee..... $60

(2) Triennial fee..... $60

Sec. 4. NRS 681A.040 is hereby amended to read as follows:

681A.040 ***1.*** "Life insurance" is insurance on human lives. The transaction of life insurance includes the granting of endowment benefits, additional incidental benefits in the event of death or dismemberment by accident or accidental means, additional incidental benefits in the event of the insured's disability, optional modes of settlement of proceeds of life insurance, and provisions operating to safeguard contracts of life insurance against lapse.

2. The term includes a policy of life insurance which incorporates long-term care insurance if the policy of life insurance may incorporate the long-term care insurance pursuant to section 36 of this act.

Sec. 5. NRS 681B.200 is hereby amended to read as follows:

681B.200 As used in NRS 681B.200 to 681B.260, inclusive, "qualified actuary" means ~~[a member in good standing of the American Academy of Actuaries, or a successor organization approved by the Commissioner who meets the requirements set forth in the organization's regulations.]~~ ***a person who is qualified to sign the applicable statement of actuarial opinion in accordance with the qualification standards set by the American Academy of Actuaries for an actuary signing such a statement.***

Sec. 6. NRS 681B.250 is hereby amended to read as follows:

681B.250 1. Except in a case of fraud or willful misconduct, a qualified actuary ***who is appointed by an insurer to issue an opinion pursuant to this chapter or any regulation adopted pursuant thereto*** is not liable for damages to any person other than an affected insurer or the Commissioner for any act, error, omission, decision or conduct with respect to the actuary's opinion.

2. Disciplinary action by the Commissioner against an actuary must be prescribed by regulation by the Commissioner.

Sec. 7. Chapter 683A of NRS is hereby amended by adding thereto the provisions set forth as sections 8 and 9 of this act.

Sec. 8. ***1. An independent review organization must be approved by the Commissioner to be eligible to be assigned to conduct external reviews.***

2. In order to be eligible for approval or reapproval by the Commissioner to conduct external reviews, an independent review organization:

(a) Except as otherwise provided in this section, must be accredited by a nationally recognized private accrediting entity which the Commissioner has determined has standards for the accreditation of independent review organizations that are equivalent to or exceed the minimum qualifications for

independent review organizations established under section 9 of this act; and

(b) Must submit an application in accordance with subsection 4.

3. The Commissioner shall develop an application form for the initial approval and reapproval of an independent review organization to conduct external reviews.

4. An independent review organization wishing to be approved or reapproved to conduct external reviews must submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the independent review organization satisfies the minimum qualifications established under section 9 of this act.

5. The Commissioner may approve an independent review organization that is not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing accreditation of independent review organizations.

6. The Commissioner may charge any applicable fee which an independent review organization must submit to the Commissioner with its application for initial approval or reapproval.

7. An approval or reapproval is effective for 2 years unless the Commissioner determines before its expiration that the independent review organization does not satisfy the minimum qualifications established under section 9 of this act.

8. Whenever the Commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under section 9 of this act, the Commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews that is maintained by the Commissioner pursuant to subsection 9.

9. The Commissioner shall maintain and periodically update a list of approved independent review organizations.

10. The Commissioner may adopt regulations to carry out the provisions of this section.

11. As used in this section, "independent review organization" has the meaning ascribed to it in NRS 695G.018.

Sec. 9. *1. To be approved under section 8 of this act to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process*

and the expedited external review process which include, without limitation:

(a) A quality assurance mechanism which ensures:

(1) That an external review is conducted within the specified time frames and required notices are provided in a timely manner;

(2) The selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization, suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this requirement;

(3) The confidentiality of medical and treatment records and clinical review criteria; and

(4) That a person employed by or under contract with the independent review organization adheres to the requirements of the external review process;

(b) A toll-free telephone service that is capable of accepting, recording or providing appropriate instruction relating to external reviews to incoming telephone callers 24 hours a day, 7 days a week; and

(c) An agreement to maintain and provide to the Commissioner the information required pursuant to section 110 of this act.

2. A clinical reviewer assigned by an independent review organization to conduct an external review must be a physician or other appropriate health care provider who must:

(a) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(b) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition as the covered person;

(c) Hold a nonrestricted license in a state or territory of the United States and, if a physician, hold a current certification by a specialty board of the American Board of Medical Specialties in the area or areas appropriate to the subject of the external review; and

(d) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.

3. In addition to the requirements set forth in subsection 1, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care providers.

4. In addition to the requirements set forth in subsections 1, 2 and 3, to be approved pursuant to section 8 of this act to conduct an external review of a specific case, neither the independent review organization selected to conduct the external review nor a clinical reviewer assigned by the independent review organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

(a) The health carrier that is the subject of the external review;

(b) The covered person whose treatment is the subject of the external review or the covered person's authorized representative;

(c) Any officer, director or management employee of the health carrier that is the subject of the external review;

(d) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(e) The facility at which the recommended health care service or treatment would be provided; or

(f) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.

5. In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of subsection 4, the Commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specific case or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specific case may have an apparent professional, familial or financial relationship or connection with a person described in subsection 4, but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

6. The Commissioner shall initially review and periodically review the standards of a nationally recognized private accrediting entity for accreditation of independent review organizations to determine whether the entity's standards are equivalent to or exceed the minimum qualifications established in this section. The Commissioner may accept a review conducted by the National Association of Insurance Commissioners for the purpose of the determination under this subsection and subsection 7.

7. Upon request, a nationally recognized private accrediting entity shall make its current standards for the accreditation of independent review organizations available to the Commissioner or to the National Association of Insurance Commissioners in order for the Commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established in this section. The Commissioner may exclude any private accrediting entity that is not reviewed by the National Association of Insurance Commissioners.

8. An independent review organization must be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

9. As used in this section, the words and terms defined in sections 76, 80, 87, 88, 90, 91 and 92 of this act and NRS 695G.014 and 695G.018 have the meanings ascribed to them in those sections.

Sec. 10. NRS 683A.160 is hereby amended to read as follows:

683A.160 ***1.*** Each applicant for a license as a managing general agent must submit with his or her application:

~~[1. A complete set of his or her fingerprints which the Commissioner may forward to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report;~~

~~2.]~~ ***(a)*** The appointment of the applicant as a managing general agent by each insurer or underwriter department to be so represented; and

~~[3.]~~ ***(b)*** The application and license fee specified in NRS 680B.010 and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110.

2. Each applicant must, as part of his or her application and at the applicant's own expense:

(a) Arrange to have a complete set of his or her fingerprints taken by a law enforcement agency or other authorized entity acceptable to the Commissioner; and

(b) Submit to the Commissioner:

(1) A completed fingerprint card and written permission authorizing the Commissioner to submit the applicant's fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary; or

(2) Written verification, on a form prescribed by the Commissioner, stating that the fingerprints of the applicant were taken and directly forwarded electronically or by another means to the Central Repository and that the applicant has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary.

3. The Commissioner may:

(a) Unless the applicant's fingerprints are directly forwarded pursuant to subparagraph (2) of paragraph (b) of subsection 2, submit those fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Commissioner deems necessary;

(b) Request from each such agency any information regarding the applicant's background as the Commissioner deems necessary; and

(c) Adopt regulations concerning the procedures for obtaining this information.

Sec. 11. NRS 683A.251 is hereby amended to read as follows:

683A.251 1. The Commissioner shall prescribe the form of application by a natural person for a license as a resident producer of insurance. The applicant must declare, under penalty of refusal to issue, or suspension or revocation of, the license, that the statements made in the application are true, correct and complete to the best of his or her knowledge and belief. Before approving the application, the Commissioner must find that the applicant has:

(a) Attained the age of 18 years;

(b) Not committed any act that is a ground for refusal to issue, or suspension or revocation of, a license;

(c) Completed a course of study for the lines of authority for which the application is made, unless the applicant is exempt from this requirement;

(d) Paid all applicable fees prescribed for the license and a fee established by the Commissioner of not more than $15 for deposit

in the Insurance Recovery Account, neither of which may be refunded; and

(e) Successfully passed the examinations for the lines of authority for which application is made, unless the applicant is exempt from this requirement.

2. A business organization must be licensed as a producer of insurance in order to act as such. Application must be made on a form prescribed by the Commissioner. Before approving the application, the Commissioner must find that the applicant has:

(a) Paid all applicable fees prescribed for the license and a fee established by the Commissioner of not more than $15 for deposit in the Insurance Recovery Account, neither of which may be refunded;

(b) Designated a natural person who is licensed as a producer of insurance and who is authorized to transact business on behalf of the business organization to be responsible for the organization's compliance with the laws and regulations of this State relating to insurance; and

(c) If the business organization has authorized a producer of insurance not designated pursuant to paragraph (b) to transact business on behalf of the business organization, submitted to the Commissioner on a form prescribed by the Commissioner the name of each producer of insurance authorized to transact business on behalf of the business organization.

3. A natural person who is a resident of this State applying for a license must ~~[furnish a complete set of his or her fingerprints which the Commissioner may forward to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report. The Commissioner shall adopt]~~ ***, as part of his or her application and at the applicant's own expense:***

(a) Arrange to have a complete set of his or her fingerprints taken by a law enforcement agency or other authorized entity acceptable to the Commissioner; and

(b) Submit to the Commissioner:

(1) A completed fingerprint card and written permission authorizing the Commissioner to submit the applicant's fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary; or

(2) Written verification, on a form prescribed by the Commissioner, stating that the fingerprints of the applicant were taken and directly forwarded electronically or by another means

to the Central Repository and that the applicant has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary.

4. The Commissioner may:

(a) Unless the applicant's fingerprints are directly forwarded pursuant to subparagraph (2) of paragraph (b) of subsection 3, submit those fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Commissioner deems necessary;

(b) Request from each such agency any information regarding the applicant's background as the Commissioner deems necessary; and

(c) Adopt regulations concerning the procedures for obtaining this information.

~~[4.]~~ ***5.*** The Commissioner may require any document reasonably necessary to verify information contained in an application.

Sec. 12. NRS 683A.261 is hereby amended to read as follows:

683A.261 1. Unless the Commissioner refuses to issue the license under NRS 683A.451, the Commissioner shall issue a license as a producer of insurance to a person who has satisfied the requirements of NRS 683A.241 and 683A.251. A producer of insurance may qualify for a license in one or more of the lines of authority permitted by statute or regulation, including:

(a) Life insurance on human lives, which includes benefits from endowments and annuities and may include additional benefits from death by accident and benefits for dismemberment by accident and for disability ~~[.]~~ ***income.***

(b) ~~[Health]~~ ***Accident and health*** insurance for sickness, bodily injury or accidental death, which may include benefits for disability ~~[.]~~ ***income.***

(c) Property insurance for direct or consequential loss or damage to property of every kind.

(d) Casualty insurance against legal liability, including liability for death, injury or disability and damage to real or personal property.

(e) ~~[Surety indemnifying financial institutions or providing bonds for fidelity, performance of contracts or financial guaranty.~~

~~(f)]~~ Variable annuities and variable life insurance, including coverage ~~[reflecting the results of a separate investment account.~~

~~(g)~~ ***provided under variable annuities and variable life insurance.***

(f) Credit insurance, including ***credit*** life, ***credit*** disability, ***credit*** property, ***credit*** unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed ***automobile*** protection ***,*** ~~of assets,~~ and any other form of insurance offered in connection with an extension of credit that is limited to wholly or partially extinguishing the obligation which the Commissioner determines should be considered as limited-line credit insurance.

~~(h)~~ ***(g)*** Personal lines, consisting of automobile and motorcycle insurance and residential property insurance, including coverage for flood, of personal watercraft and of excess liability, written over one or more underlying policies of automobile or residential property insurance.

~~(i)~~ ***(h)*** Fixed annuities as a limited line.

~~(j)~~ ***(i)*** Travel and baggage as a limited line.

~~(k)~~ ***(j)*** Rental car agency as a limited line.

~~(l) Continuous care coverage, which includes health insurance, as set forth in paragraph (b), and may include insurance for workers' compensation.~~

(k) Crop as a limited line.

2. A license as a producer of insurance remains in effect unless revoked, suspended or otherwise terminated if a request for a renewal is submitted on or before the date for the renewal specified on the license, all applicable fees for renewal and a fee established by the Commissioner of not more than $15 for deposit in the Insurance Recovery Account are paid for each license and each authorization to transact business on behalf of a business organization licensed pursuant to subsection 2 of NRS 683A.251, and any requirement for education or any other requirement to renew the license is satisfied by the date specified on the license for the renewal. A producer of insurance may submit a request for a renewal of his or her license within 30 days after the date specified on the license for the renewal if the producer of insurance otherwise complies with the provisions of this subsection and pays, in addition to any fee paid pursuant to this subsection, a penalty of 50 percent of all applicable renewal fees, except for any fee required pursuant to NRS 680C.110. A license as a producer of insurance expires if the Commissioner receives a request for a renewal of the license more than 30 days after the date specified on the license for the renewal. A fee paid pursuant to this subsection is nonrefundable.

3. A natural person who allows his or her license as a producer of insurance to expire may reapply for the same license within 12 months after the date specified on the license for a renewal without

passing a written examination or completing a course of study required by paragraph (c) of subsection 1 of NRS 683A.251, but a penalty of twice all applicable renewal fees, except for any fee required pursuant to NRS 680C.110, is required for any request for a renewal of the license that is received after the date specified on the license for the renewal.

4. A licensed producer of insurance who is unable to renew his or her license because of military service, extended medical disability or other extenuating circumstance may request a waiver of the time limit and of any fine or sanction otherwise required or imposed because of the failure to renew.

5. A license must state the licensee's name, address, personal identification number, the date of issuance, the lines of authority and the date of expiration and must contain any other information the Commissioner considers necessary. A resident producer of insurance shall maintain a place of business in this State which is accessible to the public and where the resident producer of insurance principally conducts transactions under his or her license. The place of business may be in his or her residence. The license must be conspicuously displayed in an area of the place of business which is open to the public.

6. A licensee shall inform the Commissioner of each change of location from which the licensee conducts business as a producer of insurance and each change of business or residence address, in writing or by other means acceptable to the Commissioner, within 30 days after the change. If a licensee changes the location from which the licensee conducts business as a producer of insurance or his or her business or residence address without giving written notice and the Commissioner is unable to locate the licensee after diligent effort, the Commissioner may revoke the license without a hearing. The mailing of a letter by certified mail, return receipt requested, addressed to the licensee at his or her last mailing address appearing on the records of the Division, and the return of the letter undelivered, constitutes a diligent effort by the Commissioner.

Sec. 13. Chapter 684A of NRS is hereby amended by adding thereto the provisions set forth as sections 14, 15 and 16 of this act.

Sec. 14. ***As used in this Code, unless the context otherwise requires, the words and terms defined in NRS 684A.020 and 684A.030 and section 15 of this act have the meanings ascribed to them in those sections.***

Sec. 15. ***"Home state" means:***

1. The District of Columbia or any state or territory of the United States in which an adjuster maintains his or her principal

place of residence or principal place of business and is licensed to act as an adjuster; or

2. If neither the state in which the adjuster maintains his or her principal place of residence nor the state in which the adjuster maintains his or her principal place of business has a licensing or examination requirement, a state:

(a) Which has an examination requirement;

(b) In which the adjuster is licensed; and

(c) Which the adjuster declares to be the home state.

Sec. 16. ***1. The provisions of NRS 683A.341 and 686A.310 apply to adjusters and associate adjusters.***

2. For the purposes of subsection 1, unless the context requires that a section apply only to producers of insurance or insurers, any reference in those sections to "producer of insurance" or "insurer" must be replaced by a reference to "adjuster or associate adjuster."

Sec. 17. NRS 684A.020 is hereby amended to read as follows:

684A.020 1. ~~[As used in this Code, "adjuster"]~~ ***"Adjuster"*** means any person who, for compensation as an independent contractor or for a fee or commission, investigates and settles, and reports to his or her principal relative to, claims:

(a) Arising under insurance contracts for property, casualty or surety coverage, on behalf solely of the insurer or the insured; or

(b) Against a self-insurer who is providing similar coverage, unless the coverage provided relates to a claim for industrial insurance.

2. For the purposes of this chapter:

(a) An associate adjuster, as defined in NRS 684A.030;

(b) An attorney at law who adjusts insurance losses from time to time incidental to the practice of his or her profession;

(c) An adjuster of ocean marine losses;

(d) A salaried employee of an insurer; or

(e) A salaried employee of a managing general agent maintaining an underwriting office in this state,

➥ is not considered an adjuster.

Sec. 18. NRS 684A.030 is hereby amended to read as follows:

684A.030 ~~[As used in this Code:]~~

1. "Independent adjuster" means an adjuster representing the interests of an insurer or a self-insurer.

2. "Public adjuster" means an adjuster employed by and representing solely the financial interests of the insured named in the policy.

3. "Associate adjuster" means an employee of an adjuster who, under the direct supervision of the adjuster, assists in the

investigation and settlement of insurance losses on behalf of his or her employer.

Sec. 19. NRS 684A.040 is hereby amended to read as follows:

684A.040 1. No person may act as, or hold himself or herself out to be, an adjuster or associate adjuster in this State unless then licensed as such under the applicable independent adjuster's license, public adjuster's license or associate adjuster's license, as the case may be, issued under the provisions of this chapter.

2. ~~[For purposes of this chapter, the Commissioner may issue a limited license to an adjuster handling claims under a contract of one or more of the kinds of insurance defined in NRS 681A.010 to 681A.080, inclusive.~~

~~3.]~~ Any person violating the provisions of this section is guilty of a gross misdemeanor.

~~[4.]~~ ***3.*** A person who acts as an adjuster in this State without a license is subject to an administrative fine of not more than $1,000 for each violation.

Sec. 20. NRS 684A.070 is hereby amended to read as follows:

684A.070 1. For the protection of the people of this State, the Commissioner may not issue or continue any license as an adjuster except in compliance with the provisions of this chapter. Any person for whom a license is issued or continued must:

(a) Be at least 18 years of age;

(b) ~~[Except as otherwise provided in subsection 2, be a resident of this State, and have resided therein for at least 90 days before his or her application for the license;~~

~~(c)]~~ Be competent, trustworthy, financially responsible and of good reputation;

~~[(d)]~~ ***(c)*** Never have been convicted of, or entered a plea of guilty, guilty but mentally ill or nolo contendere to, forgery, embezzlement, obtaining money under false pretenses, larceny, extortion, conspiracy to defraud or any crime involving moral turpitude;

~~[(e) Have had at least 2 years' recent experience with respect to the handling of loss claims of sufficient character reasonably to enable the person to fulfill the responsibilities of an adjuster;~~

~~(f) Pass]~~

(d) Unless exempted pursuant to NRS 684A.100 or 684A.105, pass all examinations required under this chapter; and

~~[(g)]~~ ***(e)*** Not be concurrently licensed as a producer of insurance for property, casualty or surety or a surplus lines broker, except as a bail agent.

2. ~~[The Commissioner may waive the residency requirement set forth in paragraph (b) of subsection 1 if the applicant is:~~

~~(a) An adjuster licensed under the laws of another state who has been brought to this State by a firm or corporation with whom the adjuster is employed that is licensed as an adjuster in this State to fill a vacancy in the firm or corporation in this State;~~

~~(b) An adjuster licensed in an adjoining state whose principal place of business is located within 50 miles from the boundary of this State; or~~

~~(c) An adjuster who is applying for a limited license pursuant to NRS 684A.155.~~

~~3.~~] ***A natural person who is a resident of this State applying for a license must, as part of his or her application and at the applicant's own expense:***

(a) Arrange to have a complete set of his or her fingerprints taken by a law enforcement agency or other authorized entity acceptable to the Commissioner; and

(b) Submit to the Commissioner:

(1) A completed fingerprint card and written permission authorizing the Commissioner to submit the applicant's fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary; or

(2) Written verification, on a form prescribed by the Commissioner, stating that the fingerprints of the applicant were taken and directly forwarded electronically or by another means to the Central Repository and that the applicant has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary.

3. The Commissioner may:

(a) Unless the applicant's fingerprints are directly forwarded pursuant to subparagraph (2) of paragraph (b) of subsection 2, submit those fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Commissioner deems necessary;

(b) Request from each such agency any information regarding the applicant's background as the Commissioner deems necessary; and

(c) Adopt regulations concerning the procedures for obtaining this information.

4. A conviction of, or plea of guilty, guilty but mentally ill or nolo contendere by, an applicant or licensee for any crime listed in paragraph ~~[(d)]~~ ***(c)*** of subsection 1 is a sufficient ground for the Commissioner to deny a license to the applicant, or to suspend, revoke or limit the license of an adjuster pursuant to NRS 684A.210.

Sec. 21. NRS 684A.100 is hereby amended to read as follows:

684A.100 Each person who intends to apply for a license as an adjuster must, before applying for the license, personally take and pass to the Commissioner's satisfaction a written examination testing the applicant's qualifications and competence to act as an adjuster and his or her knowledge of pertinent provisions of this Code ~~[.]~~ ***unless:***

1. The person:

(a) Is not a resident of this State;

(b) Has passed an examination to become licensed as an adjuster in the person's home state; and

(c) Is currently licensed and in good standing in the person's home state as an adjuster; or

2. The person was licensed in this State as the same type of adjuster within the 24-month period immediately preceding the date of the application, unless the previous license was revoked or suspended or its continuation was refused by the Commissioner.

Sec. 22. NRS 684A.105 is hereby amended to read as follows:

684A.105 An adjuster whose license expires is exempt from retaking the examination required by NRS 684A.100 if ~~[the adjuster applies and is relicensed within 6 months after the date of expiration.]~~ ***:***

1. The adjuster:

(a) Is not a resident of this State;

(b) Has passed an examination to become licensed as an adjuster in the person's home state; and

(c) Is currently licensed and in good standing in the person's home state as an adjuster; or

2. The adjuster was licensed in this State as the same type of adjuster within the 24-month period immediately preceding the date of the application, unless the previous license was revoked or suspended or its continuation was refused by the Commissioner.

Sec. 23. NRS 684A.130 is hereby amended to read as follows:

684A.130 1. Each license issued under this chapter continues in force for 3 years unless it is suspended, revoked or otherwise terminated. A license may be renewed upon payment of all applicable fees for renewal to the Commissioner and submission of the statement required pursuant to NRS 684A.143 if the licensee is a natural person. The statement, if required, must be submitted and

all applicable fees must be paid on or before the last day of the month in which the license is renewable.

2. Any license not so renewed expires at midnight on the last day specified for its renewal. The Commissioner may accept a request for renewal received by the Commissioner within 30 days after the expiration of the license if the request is accompanied by:

(a) A fee for renewal of 150 percent of all applicable fees otherwise required, except for any fee required pursuant to NRS 680C.110; ~~[and]~~

(b) If the person requesting renewal is a natural person, the statement required pursuant to NRS 684A.143 ~~[.]~~ ***;***

(c) Proof of successful completion of any requirement for an examination unless exempt pursuant to NRS 684A.105; and

(d) If applicable, a request for a waiver of the time limit for renewal and of any fine or sanction otherwise required or imposed because of the failure of the licensee to renew his or her license because of military service, extended medical disability or other extenuating circumstance.

3. This section does not apply to temporary licenses issued under NRS 684A.150.

Sec. 24. NRS 684A.143 is hereby amended to read as follows:

684A.143 1. A natural person who applies for the issuance or renewal of a license shall submit to the Commissioner the statement prescribed by the Division of Welfare and Supportive Services of the Department of Health and Human Services pursuant to NRS 425.520. The statement must be completed and signed by the applicant.

2. The Commissioner shall include the statement required pursuant to subsection 1 in:

(a) The application or any other forms that must be submitted for the issuance or renewal of the license; or

(b) A separate form prescribed by the Commissioner.

3. A license may not be issued or renewed by the Commissioner if the applicant is a natural person who:

(a) Fails to submit the statement required pursuant to subsection 1; or

(b) Indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

4. If an applicant indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing

the order for the repayment of the amount owed pursuant to the order, the Commissioner shall advise the applicant to contact the district attorney or other public agency enforcing the order to determine the actions that the applicant may take to satisfy the arrearage.

5. As used in this section, "license" means:

(a) A license as an adjuster; ***and***

(b) A license as an associate adjuster **.** ~~[; and~~

~~(c) A limited license issued pursuant to NRS 684A.155.]~~

Sec. 25. NRS 684A.147 is hereby amended to read as follows:

684A.147 1. If the Commissioner receives a copy of a court order issued pursuant to NRS 425.540 that provides for the suspension of all professional, occupational and recreational licenses, certificates and permits issued to a person who is the holder of a license, the Commissioner shall deem the license issued to that person to be suspended at the end of the 30th day after the date on which the court order was issued unless the Commissioner receives a letter issued to the holder of the license by the district attorney or other public agency pursuant to NRS 425.550 stating that the holder of the license has complied with the subpoena or warrant or has satisfied the arrearage pursuant to NRS 425.560.

2. The Commissioner shall reinstate a license that has been suspended by a district court pursuant to NRS 425.540 if the Commissioner receives a letter issued by the district attorney or other public agency pursuant to NRS 425.550 to the person whose license was suspended stating that the person whose license was suspended has complied with the subpoena or warrant or has satisfied the arrearage pursuant to NRS 425.560.

3. As used in this section, "license" means:

(a) A license as an adjuster; ***and***

(b) A license as an associate adjuster **.** ~~[; and~~

~~(c) A limited license issued pursuant to NRS 684A.155.]~~

Sec. 26. NRS 684A.200 is hereby amended to read as follows:

684A.200 Nonresidents of this state who are granted licenses as adjusters pursuant to ~~[subsection 2 of]~~ NRS 684A.070 are also subject to NRS 683A.281.

Sec. 27. NRS 685A.050 is hereby amended to read as follows:

685A.050 1. At the time of effecting any surplus lines insurance the broker shall execute an affidavit, in the form prescribed or accepted by the Commissioner, setting forth facts from which it can be determined whether such insurance is eligible for export under NRS 685A.040.

2. The broker shall file this affidavit with the report of coverage and any other information the Commissioner requires

within 90 days after the insurance is so effected, as required under regulations adopted pursuant to NRS 685A.210.

3. A broker that effectuates any surplus lines insurance for an out-of-state risk or exposure that includes any risk or exposure in this State shall report such transactions within 45 days after the end of each calendar quarter to the Commissioner on a form approved by the Commissioner.

Sec. 28. NRS 685A.170 is hereby amended to read as follows:

685A.170 1. Each broker shall on or before March 1 of each year file with the Commissioner ***, or with a nonprofit organization of brokers in accordance with regulations adopted by the Commissioner pursuant to NRS 685A.210,*** a statement verified by the broker of all surplus lines insurance transacted by the broker during the preceding calendar year. A statement must be filed whether or not the broker has transacted any business during the preceding year.

2. The statement must be on forms as prescribed and furnished by the Commissioner, and must contain such information as the Commissioner may reasonably require.

3. If a broker has filed any reports pursuant to NRS 685A.175, the annual statement must include any necessary reconciliation of the quarterly reports.

Sec. 29. NRS 685A.210 is hereby amended to read as follows:

685A.210 1. The Commissioner may adopt reasonable regulations, consistent with the provisions of this chapter, for any of the following purposes:

(a) Effectuation of the law;

(b) Establishment of procedures through which determination is to be made as to the eligibility of particular proposed coverages for export; ~~[and]~~

(c) Establishment of procedures for the operation of a nonprofit organization of brokers designed to assist brokers in complying with the provisions of this chapter ~~[.]~~ ***; and***

(d) The use of electronic signatures and the acceptance and transmission of electronic records and payments, including transactions involving claims and other transactions relating to surplus lines insurance.

2. Such regulations carry the penalty provided by NRS 679B.130.

Sec. 30. Chapter 686A of NRS is hereby amended by adding thereto a new section to read as follows:

1. Notwithstanding any other law or regulation, an insurer that uses credit information shall, upon receipt of a written request from an applicant or policyholder, provide reasonable exceptions to the insurer's rates, rating classifications, company

or tier placement, or underwriting rules or guidelines for an applicant or policyholder who has experienced and whose credit information has been directly influenced by any of the following:

(a) A catastrophic event, as declared by the Federal or State Government;

(b) A serious illness or injury, or a serious illness or injury to an immediate family member;

(c) The death of a spouse, child or parent;

(d) Divorce or involuntary interruption of legally-owed alimony or support payments;

(e) Identify theft;

(f) Temporary loss of employment for a period of 3 months or more, if it results from involuntary termination;

(g) Military deployment overseas; or

(h) Other events, as determined by the insurer.

2. If an applicant or policyholder submits a request for an exception as set forth in subsection 1, an insurer may, in its sole discretion:

(a) Require the applicant or policyholder to provide reasonable written and independently verifiable documentation of the event;

(b) Require the applicant or policyholder to demonstrate that the event had direct and meaningful impact on the credit information of the applicant or policyholder;

(c) Require that such a request be made not more than 60 days after the date of the application for insurance or the policy renewal;

(d) Grant an exception despite the applicant or policyholder not providing the initial request for an exception in writing; or

(e) Grant an exception where the applicant or policyholder asks for consideration of repeated events or the insurer has considered this event previously.

3. An insurer is not out of compliance with any law or rule relating to underwriting, rating or rate filing as a result of granting an exception under this section. Nothing in this section shall be construed to provide an applicant or policyholder with a cause of action that does not exist in the absence of this section.

4. The insurer shall provide notice to each applicant and policyholder that reasonable exceptions are available and include information about how the applicant or policyholder may inquire further about such exceptions.

5. Within 30 days after the insurer's receipt of sufficient documentation of an event described in subsection 1, the insurer shall inform the applicant or policyholder of the outcome of the request for a reasonable exception. Such communication must be

in writing or provided to the applicant or policyholder in the same medium as the request.

6. The Commissioner may adopt regulations to carry out the provisions of this section.

Sec. 31. NRS 686A.600 is hereby amended to read as follows:

686A.600 As used in NRS 686A.600 to 686A.730, inclusive, ***and section 30 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 686A.610 to 686A.660, inclusive, have the meanings ascribed to them in those sections.

Sec. 32. NRS 686A.670 is hereby amended to read as follows:

686A.670 The provisions of NRS 686A.600 to 686A.730, inclusive, ***and section 30 of this act*** do not apply to a contract of surety insurance issued pursuant to chapter 691B of NRS or any commercial or business policy.

Sec. 33. NRS 686B.030 is hereby amended to read as follows:

686B.030 1. Except as otherwise provided in subsection 2, 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~~]~~ ***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. 34. NRS 687A.037 is hereby amended to read as follows:

687A.037 "Member insurer" means any person, except a fraternal or nonprofit service corporation which:

1. Writes any kind of insurance to which this chapter applies, including the exchange of reciprocal or interinsurance agreements of indemnity.

2. Is ~~[~~licensed~~]~~ ***authorized*** to transact insurance in this state.

Sec. 35. NRS 687B.120 is hereby amended to read as follows:

687B.120 1. ***Except as otherwise provided in subsection 2:***

(a) 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.]~~

(b) 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 the request of the Commissioner.

2. ***As to group insurance policies to be issued to a group approved pursuant to NRS 688B.030 or 689B.026, no policies of group insurance may be marketed to a resident or employer of this State unless the policy and any form or certificate to be issued pursuant to the policy has been filed with and approved by the Commissioner.***

3. Every ~~[such]~~ filing ***made pursuant to the provisions of subsection 1 or 2*** must be made not less than 45 days in advance of any ~~[such]~~ delivery ~~[.]~~ ***pursuant to subsection 1 or marketing pursuant to subsection 2.*** 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 the Commissioner 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.]~~ ***4.*** 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.]~~ ***5.*** The Commissioner may, by order, exempt from the requirements of this section for so long as the Commissioner deems proper any insurance document or form or type thereof specified in the order, to which, in the opinion of the Commissioner, this section may not practicably be applied, or the filing and approval of which are, in the opinion of the Commissioner, not desirable or necessary for the protection of the public.

~~[5.]~~ ***6.*** 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. 36. Chapter 688A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An annuity or policy of life insurance may incorporate long-term care insurance if:

(a) The long-term care insurance incorporated into the annuity or policy of life insurance complies with regulations adopted by the Commissioner.

(b) The Commissioner approves the incorporation of long-term care insurance into the annuity or policy of life insurance.

2. The Commissioner shall adopt regulations that define "long-term care insurance" for the purposes of this section.

Sec. 37. NRS 688A.020 is hereby amended to read as follows:

688A.020 ***1.*** For the purposes of this Code, an "annuity" is a contract under which obligations are assumed to make periodic payments for a specific term or terms or where the making or continuance of all or some such payments, or the amount of any such payment, is dependent upon continuance of human life, except payments made pursuant to optional modes of settlement under the authority of NRS 681A.040 . ~~[("life insurance" defined). Such a contract which includes extra benefits of the kinds set forth in NRS 681A.030 ("health insurance" defined) and NRS 681A.040 ("life insurance" defined) shall nevertheless be deemed to be an annuity if such extra benefits constitute a subsidiary or incidental part of the entire contract.]~~

2. The term includes an annuity contract which incorporates long-term care insurance if the annuity contract may incorporate the long-term care insurance pursuant to section 36 of this act.

Sec. 38. NRS 688A.165 is hereby amended to read as follows:

688A.165 ***1.*** No ***annuity contract, pure endowment contract or*** policy of life insurance, other than ~~[an industrial life insurance]~~ ***a***

replacement contract or policy, may be delivered or issued for delivery in this state unless it contains a provision, or a notice attached to the ***contract or*** policy, which, in substance, states that during a period of 10 days from the date the ***contract or*** policy is delivered to the ***contract or*** policy owner, it may be surrendered to the insurer together with a written request for cancellation of the ***contract or*** policy and in such event, the insurer will refund any premium paid therefor, including any ***contract or*** policy fees or other charges.

2. No annuity contract, pure endowment contract or policy of life insurance that is a replacement contract or policy may be delivered or issued for delivery in this State unless it contains a provision, or a notice attached to the contract or policy, which, in substance, states that during a period of 30 days after the date on which the contract or policy is delivered to the contract or policy owner, it may be surrendered to the insurer together with a written request for cancellation of the contract or policy and in such event, the insurer will refund any premium paid therefor, including any contract or policy fees or other charges.

3. This section does not apply to industrial life insurance policies.

Sec. 39. NRS 688A.180 is hereby amended to read as follows:

688A.180 1. No annuity or pure endowment contract, other than reversionary annuities (also called survivorship annuities) or group annuities and except as stated in this section, shall be delivered or issued for delivery in this state unless it contains in substance each of the provisions specified in NRS ***688A.165 and*** 688A.190 to 688A.240, inclusive. Any of such provisions not applicable to single-premium annuities or single-premium pure endowment contracts shall not, to that extent, be incorporated therein.

2. This section does not apply to contracts for deferred annuities included in, or upon the lives of beneficiaries under, life insurance policies.

Sec. 40. NRS 688A.363 is hereby amended to read as follows:

688A.363 1. The minimum values, specified in NRS 688A.3631 to 688A.3637, inclusive, and 688A.366, of any paid-up annuity, cash surrender or death benefits available under an annuity contract must be based upon minimum nonforfeiture amounts as defined in this section.

2. ~~[With respect to contracts providing for flexible considerations, the]~~ ***The*** minimum nonforfeiture amount for any time at or before the commencement of any annuity payments is equal to an accumulation ***of 87.5 percent of the gross***

considerations up to such time at a rate of interest calculated pursuant to subsection 3, which must be decreased by the sum of:

(a) Any prior withdrawals from or partial surrenders of the contract, accumulated at a rate of interest calculated pursuant to subsection 3;

(b) An annual charge in the amount of $50, accumulated at rates of interest calculated pursuant to subsection 3;

(c) Any premium tax paid by the company for the contract, accumulated at rates of interest calculated pursuant to subsection 3; and

(d) The amount of any indebtedness to the company on the contract, including interest due and accrued.

~~[➞ The net considerations for a given contract year used to define the minimum nonforfeiture amount must be an amount that is equal to 87.5 percent of the gross considerations credited to the contract during that contract year.]~~

3. For the purpose of this section, the rate of interest used to determine the minimum nonforfeiture amounts must be an annual rate of interest determined as the lesser of 3 percent per annum or a rate specified in the contract if the rate is calculated in accordance with regulations adopted by the Commissioner, except that at no time may the resulting rate be less than 1 percent per annum.

4. The Commissioner may provide by regulation for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit or for other contracts that the Commissioner determines require adjustment. An adjustment to the calculation of the interest rate used to determine the minimum nonforfeiture amounts authorized under this subsection may not result in an interest rate of less than 1 percent per annum.

Sec. 41. NRS 688A.3633 is hereby amended to read as follows:

688A.3633 ***1.*** For contracts which provide cash surrender benefits, such benefits available before maturity shall not be less than the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity arising from considerations paid before the time of cash surrender, reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract, such present value being calculated on the basis of an interest rate of not more than 1 percent higher than the interest rate specified in the contract for accumulating the net considerations to determine such maturity value, decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued, and increased by any existing

additional amounts credited by the company to the contract. Any cash surrender benefit shall not be less than the minimum nonforfeiture amount at that time. The death benefit under such contracts shall be at least equal to the cash surrender benefit.

2. For annuity contracts issued on or after January 1, 2012, that provide cash surrender benefits:

(a) The cash surrender value on or past the maturity date must be equal to the amount used to determine the annuity benefits;

(b) A surrender charge may not be imposed on or past the maturity date of the annuity contract; and

(c) For annuity contracts with one or more renewable guaranteed periods, a new surrender charge schedule may be imposed for each new guaranteed period if:

(1) The surrender charge is zero at the end of each guaranteed period and remains zero for at least 30 days;

(2) The contract provides for continuation of the contract without surrender charges unless the contract holder specifically elects a new guaranteed period with a new surrender charge schedule; and

(3) The renewal period does not exceed 10 years and the maturity date complies with NRS 688A.3637.

3. An annuity contract that provides for flexible considerations may have separate surrender charge schedules associated with each consideration.

Sec. 42. NRS 688A.3637 is hereby amended to read as follows:

688A.3637 ***1.*** For the purpose of determining the benefits calculated under NRS 688A.3633 and 688A.3635 ~~[, in]~~ ***:***

(a) In the case of annuity contracts ***issued before January 1, 2012,*** under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be deemed to be the latest date for which election is permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's 70th birthday or the 10th anniversary of the contract, whichever is later.

(b) In the case of annuity contracts issued on or after January 1, 2012, the maturity date shall be deemed to be the latest date permitted by the contract, but shall not be deemed to be later than the anniversary of the contract next following the annuitant's 70th birthday or the 10th anniversary of the contract, whichever is later.

2. For the purpose of determining the maturity date under this section for an annuity contract that provides for flexible considerations, the 10th anniversary of the contract is determined separately for each consideration.

Sec. 43. NRS 688C.200 is hereby amended to read as follows:

688C.200 1. Upon the filing of an application and payment of all applicable fees, the Commissioner shall investigate the applicant, and issue a license if the Commissioner finds that the applicant:

(a) If a provider of viatical settlements, has set forth a detailed plan of operation;

(b) Is competent and trustworthy and intends to act in good faith in the capacity for which the license is sought;

(c) Has a good reputation in business and, if a natural person, has had experience, training or education which qualifies the applicant in that capacity;

(d) If an organization, provides a certificate of good standing from the state of its domicile; and

(e) If a provider or broker of viatical settlements:

(1) Has included a plan to prevent fraud which satisfies the requirements of NRS 688C.490; and

(2) Has demonstrated evidence of financial responsibility through either:

(I) A surety bond executed and issued by an authorized surety in favor of the State of Nevada, continuous in form and in an amount as determined by the Commissioner, of not less than $250,000; or

(II) A deposit of cash, certificates of deposit, securities or any combination thereof in the amount of $250,000.

2. The Commissioner shall not issue a license to a nonresident unless a written designation of an agent for service of process, or an irrevocable written consent to the commencement of an action against the applicant by service of process upon the Commissioner, accompanies the application.

3. A provider or broker of viatical settlements shall furnish to the Commissioner new or revised information concerning partners, members, officers, holders of more than 10 percent of its stock, and designated employees within 30 days after a change occurs.

4. Notwithstanding any provision of this section to the contrary, the Commissioner shall accept as evidence of financial responsibility proof that financial instruments complying with the requirements of this section have been filed with a state where the applicant is licensed as a ***provider or*** broker of viatical settlements.

5. A surety bond issued for the purposes of this section must specifically authorize recovery by the Commissioner on behalf of any person in this State who sustained damages as a result of:

(a) Erroneous acts;

(b) Failure to act; or

(c) Conviction of:

(1) Fraud; or

(2) Unfair practices,

➥ by the provider or broker of viatical settlements.

6. The Commissioner may request evidence of financial responsibility as described in subparagraph (2) of paragraph (e) of subsection 1 at any time the Commissioner deems necessary.

Sec. 44. NRS 689.175 is hereby amended to read as follows:

689.175 1. The proposed seller, or the appropriate corporate officer of the proposed seller, shall apply in writing to the Commissioner for a seller's certificate of authority, showing:

(a) The proposed seller's name and address, and his or her occupations during the preceding 5 years;

(b) The name and address of the proposed trustee;

(c) The names and addresses of the proposed performers, specifying what particular services, supplies and equipment each performer is to furnish under the proposed prepaid contract; and

(d) Such other pertinent information as the Commissioner may reasonably require.

2. The application must be accompanied by:

(a) A copy of the proposed trust agreement and a written statement signed by an authorized officer of the proposed trustee to the effect that the proposed trustee understands the nature of the proposed trust fund and accepts it;

(b) A copy of each contract or understanding, existing or proposed, between the seller and performers relating to the proposed prepaid contract or items to be supplied under it;

(c) A certified copy of the articles of incorporation and the bylaws of any corporate applicant;

(d) A copy of any other document relating to the proposed seller, trustee, trust, performer or prepaid contract, as required by the Commissioner;

(e) ~~[A complete set of the fingerprints of the proposed seller, or the appropriate corporate officer of the proposed seller, and written permission authorizing the Commissioner to forward those fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report;~~

~~(f) A fee representing the amount charged by the Federal Bureau of Investigation for processing the fingerprints of the applicant; and~~

~~(g)]~~ The applicable fee established in NRS 680B.010, which is not refundable, and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110.

3. A natural person who is a resident of this State must, as part of his or her application and at the applicant's own expense:

(a) Arrange to have a complete set of his or her fingerprints taken by a law enforcement agency or other authorized entity acceptable to the Commissioner; and

(b) Submit to the Commissioner:

(1) A completed fingerprint card and written permission authorizing the Commissioner to submit the applicant's fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary; or

(2) Written verification, on a form prescribed by the Commissioner, stating that the fingerprints of the applicant were taken and directly forwarded electronically or by another means to the Central Repository and that the applicant has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary.

4. The Commissioner may:

(a) Unless the applicant's fingerprints are directly forwarded pursuant to subparagraph (2) of paragraph (b) of subsection 3, submit those fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Commissioner deems necessary; and

(b) Request from each such agency any information regarding the applicant's background as the Commissioner deems necessary.

Sec. 45. NRS 689.235 is hereby amended to read as follows:

689.235 1. To qualify for an agent's license, the applicant:

(a) Must file a written application with the Commissioner on forms prescribed by the Commissioner;

(b) Must have a good business and personal reputation; and

(c) Must not have been convicted of, or entered a plea of guilty, guilty but mentally ill or nolo contendere to, forgery, embezzlement, obtaining money under false pretenses, larceny, extortion, conspiracy to defraud or any crime involving moral turpitude.

2. The application must:

(a) Contain information concerning the applicant's identity, address, social security number and personal background and business, professional or work history.

(b) Contain such other pertinent information as the Commissioner may require.

(c) ~~[Be accompanied by a complete set of the fingerprints of the applicant and written permission authorizing the Commissioner to forward those fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report.~~

~~(d) Be accompanied by a fee representing the amount charged by the Federal Bureau of Investigation for processing the fingerprints of the applicant.~~

~~(e)]~~ Be accompanied by the statement required pursuant to NRS 689.258.

~~[(f)]~~ ***(d)*** Be accompanied by the applicable fee established in NRS 680B.010, which is not refundable, and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110.

3. A conviction of, or plea of guilty, guilty but mentally ill or nolo contendere by, an applicant or licensee for any crime listed in paragraph (c) of subsection 1 is a sufficient ground for the Commissioner to deny a license to the applicant, or to suspend or revoke the agent's license pursuant to NRS 689.265.

4. A natural person who is a resident of this State must, as part of his or her application and at the applicant's own expense:

(a) Arrange to have a complete set of his or her fingerprints taken by a law enforcement agency or other authorized entity acceptable to the Commissioner; and

(b) Submit to the Commissioner:

(1) A completed fingerprint card and written permission authorizing the Commissioner to submit the applicant's fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary; or

(2) Written verification, on a form prescribed by the Commissioner, stating that the fingerprints of the applicant were taken and directly forwarded electronically or by another means to the Central Repository and that the applicant has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary.

5. The Commissioner may:

(a) Unless the applicant's fingerprints are directly forwarded pursuant to subparagraph (2) of paragraph (b) of subsection 4, submit those fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Commissioner deems necessary; and

(b) Request from each such agency any information regarding the applicant's background as the Commissioner deems necessary.

Sec. 46. NRS 689.490 is hereby amended to read as follows:

689.490 1. The proposed seller, or the appropriate corporate officer of the seller, shall apply in writing to the Commissioner for a seller's permit, showing:

(a) The proposed seller's name and address and his or her occupations during the preceding 5 years;

(b) The name and address of the proposed trustee;

(c) The names and addresses of the proposed performers, specifying what particular services, supplies and equipment each performer is to furnish under the proposed prepaid contract; and

(d) Such other pertinent information as the Commissioner may reasonably require.

2. The application must be accompanied by:

(a) A copy of the proposed trust agreement and a written statement signed by an authorized officer of the proposed trustee to the effect that the proposed trustee understands the nature of the proposed trust fund and accepts it;

(b) A copy of each contract or understanding, existing or proposed, between the seller and performers relating to the proposed prepaid contract or items to be supplied under it;

(c) A certified copy of the articles of incorporation and the bylaws of any corporate applicant;

(d) A copy of any other document relating to the proposed seller, trustee, trust, performer or prepaid contract, as required by the Commissioner; ***and***

(e) ~~[A complete set of the fingerprints of the proposed seller, or the appropriate corporate officer of the seller, and written permission authorizing the Commissioner to forward those fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report;~~

~~(f) A fee representing the amount charged by the Federal Bureau of Investigation for processing the fingerprints of the applicant; and~~

~~(g)]~~ The applicable fee established in NRS 680B.010, which is not refundable, and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110.

3. A natural person who is a resident of this State must, as part of his or her application and at the applicant's own expense:

(a) Arrange to have a complete set of his or her fingerprints taken by a law enforcement agency or other authorized entity acceptable to the Commissioner; and

(b) Submit to the Commissioner:

(1) A completed fingerprint card and written permission authorizing the Commissioner to submit the applicant's fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary; or

(2) Written verification, on a form prescribed by the Commissioner, stating that the fingerprints of the applicant were taken and directly forwarded electronically or by another means to the Central Repository and that the applicant has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary.

4. The Commissioner may:

(a) Unless the applicant's fingerprints are directly forwarded pursuant to subparagraph (2) of paragraph (b) of subsection 3, submit those fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Commissioner deems necessary; and

(b) Request from each such agency any information regarding the applicant's background as the Commissioner deems necessary.

Sec. 47. NRS 689.520 is hereby amended to read as follows:

689.520 1. To qualify for an agent's license, the applicant:

(a) Must file a written application with the Commissioner on forms prescribed by the Commissioner; and

(b) Must not have been convicted of, or entered a plea of guilty, guilty but mentally ill or nolo contendere to, forgery, embezzlement, obtaining money under false pretenses, larceny, extortion, conspiracy to defraud or any crime involving moral turpitude.

2. The application must:

(a) Contain information concerning the applicant's identity, address, social security number, personal background and business, professional or work history.

(b) Contain such other pertinent information as the Commissioner may require.

(c) ~~[Be accompanied by a complete set of fingerprints and written permission authorizing the Commissioner to forward those fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report.~~

~~(d) Be accompanied by a fee representing the amount charged by the Federal Bureau of Investigation for processing the fingerprints of the applicant.~~

~~(e)]~~ Be accompanied by the statement required pursuant to NRS 689.258.

~~[(f)]~~ ***(d)*** Be accompanied by the applicable fee established in NRS 680B.010, which is not refundable, and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110.

3. A conviction of, or plea of guilty, guilty but mentally ill or nolo contendere by, an applicant or licensee for any crime listed in paragraph (b) of subsection 1 is a sufficient ground for the Commissioner to deny a license to the applicant, or to suspend or revoke the agent's license pursuant to NRS 689.535.

4. A natural person who is a resident of this State must, as part of his or her application and at the applicant's own expense:

(a) Arrange to have a complete set of his or her fingerprints taken by a law enforcement agency or other authorized entity acceptable to the Commissioner; and

(b) Submit to the Commissioner:

(1) A completed fingerprint card and written permission authorizing the Commissioner to submit the applicant's fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary; or

(2) Written verification, on a form prescribed by the Commissioner, stating that the fingerprints of the applicant were taken and directly forwarded electronically or by another means to the Central Repository and that the applicant has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary.

5. The Commissioner may:

(a) Unless the applicant's fingerprints are directly forwarded pursuant to subparagraph (2) of paragraph (b) of subsection 4, submit those fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Commissioner deems necessary; and

(b) Request from each such agency any information regarding the applicant's background as the Commissioner deems necessary.

Sec. 48. NRS 689A.745 is hereby amended to read as follows:

689A.745 1. Except as otherwise provided in subsection 4, each insurer that issues a policy of health insurance in this State shall establish a system for resolving any complaints of an insured concerning health care services covered under the policy. The system must be approved by the Commissioner in consultation with the State Board of Health.

2. A system for resolving complaints established pursuant to subsection 1 must include an initial investigation, a review of the complaint by a review board and a procedure for appealing a determination regarding the complaint. The majority of the members on a review board must be insureds who receive health care services pursuant to a policy of health insurance issued by the insurer.

3. The Commissioner or the State Board of Health may examine the system for resolving complaints established pursuant to subsection 1 at such times as either deems necessary or appropriate.

4. Each insurer that issues a policy of health insurance in this State that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care shall provide a system for resolving any complaints of an insured concerning those health care services that complies with the provisions of NRS 695G.200 to ~~[695G.310,]~~ ***695G.230,*** inclusive ~~[.]~~ ***, and sections 102 to 112, inclusive, of this act.***

Sec. 49. NRS 689B.026 is hereby amended to read as follows:

689B.026 1. Except as otherwise provided in this section, no policy of group health insurance may be delivered or issued for delivery in this state to a group which was formed for the purpose of purchasing one or more policies of group health insurance.

2. A policy of group health insurance may be delivered to a group described in subsection 1 if the Commissioner approves the issuance. The Commissioner shall not grant approval unless the Commissioner finds that:

(a) The benefits of the policy are reasonable in relation to the premiums charged; ~~[and]~~

(b) The group to which the policy is issued is organized and operated in a fiscally sound manner ~~[.]~~ ***; and***

(c) All policy rates and forms are filed with and approved by the Division before marketing to a resident or employer in this State.

3. ~~[Upon approval by the Commissioner, an insurer may exclude or limit the coverage in a policy issued pursuant to this section of any person as to whom evidence of insurability is not satisfactory to the insurer.]~~ ***The Commissioner shall use the provisions of this chapter and chapter 689C of NRS to review insurance products marketed to employers in this State. The Commissioner shall use the provisions of chapter 689A of NRS to review insurance products marketed to natural persons in this State.***

4. The provisions of this section apply to the offering in this state of a policy issued in another state.

Sec. 50. NRS 689B.0285 is hereby amended to read as follows:

689B.0285 1. Except as otherwise provided in subsection 4, each insurer that issues a policy of group health insurance in this State shall establish a system for resolving any complaints of an insured concerning health care services covered under the policy. The system must be approved by the Commissioner in consultation with the State Board of Health.

2. A system for resolving complaints established pursuant to subsection 1 must include an initial investigation, a review of the complaint by a review board and a procedure for appealing a determination regarding the complaint. The majority of the members on a review board must be insureds who receive health care services pursuant to a policy of group health insurance issued by the insurer.

3. The Commissioner or the State Board of Health may examine the system for resolving complaints established pursuant to subsection 1 at such times as either deems necessary or appropriate.

4. Each insurer that issues a policy of group health insurance in this State that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care shall provide a system for resolving any complaints of an insured concerning the health care services that complies with the provisions of NRS 695G.200 to ~~[695G.310,]~~ ***695G.230,*** inclusive ~~[.]~~ ***, and sections 102 to 112, inclusive, of this act.***

Sec. 51. 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]~~ ***5***

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 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 or the beneficiary or assignee of the insured 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. 52. NRS 689C.156 is hereby amended to read as follows:

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

2. A carrier shall issue to a small employer any health benefit plan marketed in accordance with this section if the eligible small employer applies for the plan and agrees to make the required premium payments and satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with NRS 689C.015 to 689C.355, inclusive, and 689C.610 to 689C.980, inclusive,

except that a carrier is not required to issue a health benefit plan to a self-employed person who is covered by, or is eligible for coverage under, a health benefit plan offered by another employer.

3. If a health benefit plan marketed pursuant to this section provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care, the carrier shall provide a system for resolving any complaints of an employee concerning those health care services that complies with the provisions of NRS 695G.200 to ~~[695G.310,]~~ ***695G.230,*** inclusive ~~[.]~~ ***, and sections 102 to 112, inclusive, of this act.***

Sec. 53. NRS 690B.023 is hereby amended to read as follows:

690B.023 If insurance for the operation of a motor vehicle required pursuant to NRS 485.185 is provided by a contract of insurance, the insurer shall:

1. Provide evidence of insurance to the insured on a form approved by the Commissioner. The evidence of insurance must include:

(a) The name and address of the policyholder;

(b) The name and address of the insurer;

(c) ***Vehicle information, consisting of:***

(1) The year, make and complete identification number of the insured vehicle or vehicles; ***or***

(2) The word "Fleet" if the vehicle is covered under a fleet policy written on an any auto basis or blanket policy basis;

(d) The term of the insurance, including the day, month and year on which the policy:

(1) Becomes effective; and

(2) Expires;

(e) The number of the policy;

(f) A statement that the coverage meets the requirements set forth in NRS 485.185; and

(g) The statement "This card must be carried in the insured motor vehicle for production upon demand." The statement must be prominently displayed.

2. Provide new evidence of insurance if:

(a) The information regarding the insured vehicle or vehicles required pursuant to paragraph (c) of subsection 1 no longer is accurate;

(b) An additional motor vehicle is added to the policy;

(c) A new number is assigned to the policy; or

(d) The insured notifies the insurer that the original evidence of insurance has been lost.

Sec. 54. Chapter 690C of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Commissioner may refuse to renew or may suspend, limit or revoke a provider's certificate of registration if the Commissioner finds after a hearing thereon, or upon waiver of hearing by the provider, that the provider has:

(a) Violated or failed to comply with any lawful order of the Commissioner;

(b) Conducted business in an unsuitable manner;

(c) Willfully violated or willfully failed to comply with any lawful regulation of the Commissioner; or

(d) Violated any provision of this chapter.

➥ In lieu of such a suspension or revocation, the Commissioner may levy upon the provider, and the provider shall pay forthwith, an administrative fine of not more than $1,000 for each act or violation.

2. The Commissioner shall suspend or revoke a provider's certificate of registration on any of the following grounds if the Commissioner finds after a hearing thereon that the provider:

(a) Is in unsound condition, is being fraudulently conducted, or is in such a condition or is using such methods and practices in the conduct of its business as to render its further transaction of service contracts in this State currently or prospectively injurious to service contract holders or to the public.

(b) Refuses to be examined, or its directors, officers, employees or representatives refuse to submit to examination relative to its affairs, or to produce its books, papers, records, contracts, correspondence or other documents for examination by the Commissioner when required, or refuse to perform any legal obligation relative to the examination.

(c) Has failed to pay any final judgment rendered against it in this State upon any policy, bond, recognizance or undertaking as issued or guaranteed by it, within 30 days after the judgment became final or within 30 days after dismissal of an appeal before final determination, whichever date is the later.

3. The Commissioner may, without advance notice or a hearing thereon, immediately suspend the certificate of registration of any provider that has filed for bankruptcy or otherwise been deemed insolvent.

Sec. 55. NRS 690C.170 is hereby amended to read as follows:

690C.170 To be issued a certificate of registration, a provider must comply with one of the following:

1. Purchase a contractual liability insurance policy which insures the obligations of each service contract the provider issues, sells or offers for sale. The contractual liability insurance policy

must be issued by an insurer ***which is not an affiliate of the provider and which is*** authorized to transact insurance in this state or pursuant to the provisions of chapter 685A of NRS ~~[.]~~ ***; or***

2. ~~[Maintain a reserve account and deposit with the Commissioner security as provided in this subsection. The reserve account must contain at all times an amount of money equal to at least 40 percent of the gross consideration received by the provider for any unexpired service contracts, less any claims paid on those unexpired service contracts. The Commissioner may examine the reserve account at any time. The provider shall also deposit with the Commissioner security in an amount that is equal to $25,000 or 5 percent of the gross consideration received by the provider for any unexpired service contracts, less any claims paid on the unexpired service contracts, whichever is greater. The security must be:~~

~~(a) A surety bond issued by a surety company authorized to do business in this state;~~

~~(b) Securities of the type eligible for deposit pursuant to NRS 682B.030;~~

~~(c) Cash;~~

~~(d) An irrevocable letter of credit issued by a financial institution approved by the Commissioner; or~~

~~(e) In any other form prescribed by the Commissioner.~~

~~3.]~~ Maintain, or be a subsidiary of a parent company that maintains, a net worth or stockholders' equity of at least $100,000,000. Upon request, a provider shall provide to the Commissioner a copy of the most recent Form 10-K report or Form 20-F report filed by the provider or parent company of the provider with the Securities and Exchange Commission within the previous year. If the provider or parent company is not required to file those reports with the Securities and Exchange Commission, the provider shall provide to the Commissioner a copy of the most recently audited financial statements of the provider or parent company. If the net worth or stockholders' equity of the parent company of the provider is used to comply with the requirements of this subsection, the parent company must guarantee to carry out the duties of the provider under any service contract issued or sold by the provider.

Sec. 56. Chapter 691A of NRS is hereby amended by adding thereto a new section to read as follows:

The Commissioner may adopt regulations to carry out the provisions of this chapter.

Sec. 57. NRS 691A.020 is hereby amended to read as follows:

691A.020 1. Each insurer which provides property insurance covering ***manufactured homes or*** mobile homes in Nevada shall offer ~~[,]~~ ***to an insured, on a form approved by the Commissioner and*** in addition to any other insurance, ***the option of purchasing***

insurance to pay the ~~[market]~~ ***replacement*** value of the ***manufactured home or*** mobile home in the event of a total loss of the ***manufactured home or*** mobile home ~~[.]~~ ***, including, without limitation, the cost for:***

(a) Transporting and installing the replacement manufactured home or mobile home; and

(b) Debris removal.

2. Nothing in this section requires any insurer to offer any insurance on ***manufactured homes or*** mobile homes at a premium which is not fair and adequate.

3. As used in this section, "manufactured home" has the meaning ascribed to it in NRS 489.113.

Sec. 58. NRS 692A.1041 is hereby amended to read as follows:

692A.1041 1. In addition to all other requirements set forth in this title and except as otherwise provided in subsection 4 and NRS 692A.1042, as a condition to doing business in this State, each title agent and title insurer shall deposit with the Commissioner and keep in full force and effect a corporate surety bond payable to the State of Nevada, in the amount set forth in subsection 3, which is executed by a corporate surety satisfactory to the Commissioner and which names as principals the title agency or title insurer and all escrow officers employed by or associated with the title agent or title insurer.

2. The bond must be in substantially the following form:

Know All Persons by These Presents, that ....., as principal, and ....., as surety, are held and firmly bound unto the State of Nevada for the use and benefit of any person who suffers damages because of a violation of any of the provisions of chapter 692A of NRS, in the sum of ....., lawful money of the United States, to be paid to the State of Nevada for such use and benefit, for which payment well and truly to be made, and that we bind ourselves, our heirs, executors, administrators, successors and assigns, jointly and severally, firmly by these presents.

The condition of that obligation is such that: Whereas, the Commissioner of Insurance of the Department of Business and Industry of the State of Nevada has issued the principal a license or certificate of authority as a title agent or title insurer, and the principal is required to furnish a bond, which is conditioned as set forth in this bond:

Now, therefore, if the principal, the principal's agents and employees, strictly, honestly and faithfully comply with the provisions of chapter 692A of NRS, and pay all damages suffered by any person because of a violation of any of the provisions of chapter 692A of NRS, or by reason of any fraud, dishonesty,

misrepresentation or concealment of material facts growing out of any transaction governed by the provisions of chapter 692A of NRS, then this obligation is void; otherwise it remains in full force.

This bond becomes effective on the .....(day) of .....(month) of .....(year), and remains in force until the surety is released from liability by the Commissioner of Insurance or until this bond is cancelled by the surety. The surety may cancel this bond and be relieved of further liability hereunder by giving 60 days' written notice to the principal and to the Commissioner of Insurance of the Department of Business and Industry of the State of Nevada.

In Witness Whereof, the seal and signature of the principal hereto is affixed, and the corporate seal and the name of the surety hereto is affixed and attested by its authorized officers at ....., Nevada, this .....(day) of .....(month) of .....(year).

.....(Seal)
Principal
.....(Seal)
Surety
By .....
Attorney-in-fact
.....
~~[Licensed resident]~~ ***Nevada licensed insurance*** agent

3. Each title agent and title insurer shall deposit a corporate surety bond that complies with the provisions of this section or a substitute form of security that complies with the provisions of NRS 692A.1042 in an amount that:

(a) Is not less than $20,000 or 2 percent of the average collected balance of the trust account or escrow account maintained by the title agent or title insurer pursuant to NRS 692A.250, whichever is greater; and

(b) Is not more than $250,000.

➥ The Commissioner shall determine the appropriate amount of the surety bond or substitute form of security that must be deposited initially by the title agent or title insurer based upon the expected average collected balance of the trust account or escrow account maintained by the title agent or title insurer pursuant to NRS 692A.250. After the initial deposit, the Commissioner shall, on an annual basis, determine the appropriate amount of the surety bond or substitute form of security that must be deposited by the title agent or title insurer based upon the average collected balance of the

trust account or escrow account maintained by the title agent or title insurer pursuant to NRS 692A.250.

4. A title agent or title insurer may offset or reduce the amount of the surety bond or substitute form of security that the title agent or title insurer is required to deposit pursuant to subsection 3 by the amount of any of the following:

(a) Cash or securities deposited with the Commissioner in this State pursuant to NRS 680A.140 or 682B.015.

(b) Reserves against unpaid losses and loss expenses maintained pursuant to NRS 692A.150 or 692A.170.

(c) Unearned premium reserves maintained pursuant to NRS 692A.160 or 692A.170.

(d) Fidelity bonds maintained by the title agent or title insurer.

(e) Other bonds or policies of insurance maintained by the title agent or title insurer covering liability for economic losses to customers caused by the title agent or title insurer.

Sec. 59. NRS 692B.070 is hereby amended to read as follows:

692B.070 1. A written application for any permit required under NRS 692B.040 must be filed with the Commissioner. The application must include or be accompanied by:

(a) The name, type and purposes of the insurer, corporation, syndicate, association, firm or organization formed or proposed to be formed or financed;

(b) On forms furnished by the Commissioner, for each person associated or to be associated as incorporator, director, promoter, manager or in other similar capacity in the enterprise, or in the formation of the proposed insurer, corporation, syndicate, association, firm or organization, or in the proposed financing:

(1) The person's name, residential address and qualifications; ***and***

(2) The person's business background and experience for the preceding 10 years; ~~[and~~

~~(3) A complete set of the person's fingerprints which the Commissioner may forward to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report;]~~

(c) A full disclosure of the terms of all pertinent understandings and agreements existing or proposed among any persons or entities so associated or to be associated, and a copy of each such agreement;

(d) Executed quadruplicate originals of the articles of incorporation of a proposed domestic stock or mutual insurer;

(e) The original and one copy of the proposed bylaws of a proposed domestic stock or mutual insurer;

(f) The plan according to which solicitations are to be made and a reasonably detailed estimate of all organization and sales expenses to be incurred in the proposed organization and offering;

(g) A copy of any security, receipt or certificate proposed to be offered, and a copy of any proposed subscription agreement or application therefor;

(h) A copy of any prospectus, offering circular, advertising or sales literature or material proposed to be used;

(i) A copy of the proposed form of any escrow agreement required;

(j) A copy of:

(1) The articles of incorporation of any corporation, other than a proposed domestic insurer, proposing to offer its securities, certified by the public officer having custody of the original thereof;

(2) Any syndicate, association, firm, organization or other similar agreement, by whatever name called, if funds for any of the purposes referred to in subsection 1 of NRS 692B.040 are to be secured through the sale of any security, interest or right in or relative to such syndicate, association, firm or organization; and

(3) If the insurer is, or is to be, a reciprocal insurer, the power of attorney and of other agreements existing or proposed affecting subscribers, investors, the attorney-in-fact or the insurer;

(k) If the applicant is a natural person, the statement required pursuant to NRS 692B.193; and

(l) Such additional pertinent information as the Commissioner may reasonably require.

2. The application must be accompanied by a deposit of the fees required under NRS 680B.010 for the filing of the application and for issuance of the permit, if granted.

3. If the applicant is a natural person, the application must include the social security number of the applicant.

4. In lieu of a special filing thereof of information required by subsection 1, the Commissioner may accept a copy of any pertinent filing made with the Securities and Exchange Commission relative to the same offering.

5. Each person identified in paragraph (b) of subsection 1 who is a resident of this State must, as part of his or her application and at the person's own expense:

(a) Arrange to have a complete set of his or her fingerprints taken by a law enforcement agency or other authorized entity acceptable to the Commissioner; and

(b) Submit to the Commissioner:

(1) A completed fingerprint card and written permission authorizing the Commissioner to submit the person's fingerprints to the Central Repository for Nevada Records of Criminal History

for submission to the Federal Bureau of Investigation for a report on the person's background and to such other law enforcement agencies as the Commissioner deems necessary; or

(2) Written verification, on a form prescribed by the Commissioner, stating that the fingerprints of the person were taken and directly forwarded electronically or by another means to the Central Repository and that the person has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation for a report on the person's background and to such other law enforcement agencies as the Commissioner deems necessary.

6. The Commissioner may:

(a) Unless the person's fingerprints are directly forwarded pursuant to subparagraph (2) of paragraph (b) of subsection 5, submit those fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Commissioner deems necessary; and

(b) Request from each such agency any information regarding the person's background as the Commissioner deems necessary.

Sec. 60. NRS 692B.190 is hereby amended to read as follows:

692B.190 1. No person may in this State solicit subscription to or purchase of any security covered by a solicitation permit issued under this chapter, unless then licensed therefor by the Commissioner.

2. Such a license may be issued only to natural persons, and the Commissioner shall not license any person found by the Commissioner to be:

(a) Dishonest or untrustworthy;

(b) Financially irresponsible;

(c) Of unfavorable personal or business history or reputation; or

(d) For any other cause, reasonably unsuited for fulfillment of the responsibilities of such a licensee.

3. The applicant for such a license must file a written application therefor with the Commissioner, on forms and containing inquiries as designated and required by the Commissioner. The application must include or be accompanied by:

(a) The social security number of the applicant;

(b) An endorsement by the holder of the permit under which the securities are proposed to be sold; ***and***

(c) ~~[A complete set of the fingerprints of the applicant on forms furnished by the Commissioner; and~~

~~(d)]~~ The application fee specified in NRS 680B.010.

4. The Commissioner ~~[~~:

~~(a) May forward the complete set of fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report; and~~

~~(b) Shall~~ ***shall*** promptly cause an investigation to be made of the identity and qualifications of the applicant.

5. The license, if issued, must be for the period of the permit, and must automatically be extended if the permit is extended.

6. The Commissioner shall revoke the license if at any time after issuance the Commissioner has found that the license was obtained through misrepresentation or concealment of facts, or that the licensee is no longer qualified therefor, or that the licensee has misrepresented the securities offered, or has otherwise conducted himself or herself in or with respect to transactions under the license in a manner injurious to the permit holder or to subscribers or prospects or the public.

7. This section does not apply to securities broker-dealers registered as such under the Securities Exchange Act of 1934, or with respect to securities the sale of which is underwritten, other than on a best efforts basis, by such a broker-dealer.

8. With respect to solicitation of subscriptions to or purchase of securities covered by a solicitation permit issued by the Commissioner, the license required by this section is in lieu of a license or permit otherwise required of the solicitor under any other law of this State.

9. An applicant who is a resident of this State must, as part of his or her application and at the applicant's own expense:

(a) Arrange to have a complete set of his or her fingerprints taken by a law enforcement agency or other authorized entity acceptable to the Commissioner; and

(b) Submit to the Commissioner:

(1) A completed fingerprint card and written permission authorizing the Commissioner to submit the applicant's fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary; or

(2) Written verification, on a form prescribed by the Commissioner, stating that the fingerprints of the applicant were taken and directly forwarded electronically or by another means to the Central Repository and that the applicant has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation for a report on the applicant's background and to

such other law enforcement agencies as the Commissioner deems necessary.

10. The Commissioner may:

(a) Unless the applicant's fingerprints are directly forwarded pursuant to subparagraph (2) of paragraph (b) of subsection 9, submit those fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Commissioner deems necessary; and

(b) Request from each such agency any information regarding the applicant's background as the Commissioner deems necessary.

Sec. 61. NRS 692C.370 is hereby amended to read as follows:

692C.370 For the purposes of this chapter, in determining whether or not an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors among others must be considered:

1. The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, ***operating results,*** insurance in force and other appropriate criteria.

2. The extent to which the insurer's business is diversified among the several lines of insurance.

3. The number and size of risks insured in each line of business.

4. The extent of the geographical dispersion of the insurer's insured risks.

5. The nature and extent of the insurer's reinsurance program.

6. The quality, diversification and liquidity of the insurer's investment portfolio.

7. The recent past and projected future trend in the size of the insurer's surplus as regards policyholders.

8. The surplus as regards policyholders maintained by other comparable insurers.

9. The adequacy of the insurer's reserves.

10. The quality and liquidity of investments in ***affiliates or*** subsidiaries made pursuant to NRS 692C.180 to 692C.250, inclusive. The Commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the judgment of the Commissioner such investment so warrants.

11. The quality of the insurer's earnings and the extent to which the reported earnings of the insurer include extraordinary items. As used in this subsection, the term "extraordinary item" means a nonrecurring occurrence or event.

Sec. 62. NRS 692C.380 is hereby amended to read as follows:

692C.380 For purposes of NRS 692C.360 to 692C.400, inclusive, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding 12 months exceeds the ~~[greater]~~ ***lesser*** of:

1. Ten percent of the insurer's surplus as regards policyholders as of December 31 next preceding the dividend or distribution; or

2. The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, not including realized capital gains if the insurer is not a life insurer, for the 12-month period ending December 31 next preceding the dividend or distribution,

➥ but does not include pro rata distributions of any class of the insurer's own securities.

Sec. 63. NRS 694C.330 is hereby amended to read as follows:

694C.330 Except as otherwise provided in this section, a captive insurer shall pay dividends out of, or make any other distributions from, its capital or surplus, or both, in accordance with the provisions set forth in NRS ***692C.370,*** 693A.140, 693A.150 and 693A.160. A captive insurer shall not pay dividends out of, or make any other distribution with respect to, its capital or surplus, or both, in violation of this section unless the captive insurer has obtained the prior approval of the Commissioner to make such a payment or distribution.

Sec. 64. NRS 694C.400 is hereby amended to read as follows:

694C.400 1. On or before March 1 of each year, a captive insurer shall submit to the Commissioner a report of its financial condition, as prepared by a certified public accountant. A captive insurer shall use generally accepted accounting principles and include any useful or necessary modifications or adaptations thereof that have been approved or accepted by the Commissioner for the type of insurance and kinds of insurers to be reported upon, and as supplemented by additional information required by the Commissioner. Except as otherwise provided in this section, each association captive insurer, agency captive insurer, rental captive insurer or sponsored captive insurer shall file its report in the form required by NRS ~~[680A.265.]~~ ***680A.270.*** The Commissioner shall adopt regulations designating the form in which pure captive insurers must report.

2. A pure captive insurer may apply, in writing, for authorization to file its annual report based on a fiscal year that is consistent with the fiscal year of the parent company of the pure captive insurer. If an alternative date is granted:

(a) The annual report is due not later than 60 days after the end of each such fiscal year; and

(b) The pure captive insurer shall file on or before March 1 of each year such forms as required by the Commissioner by regulation to provide sufficient detail to support its premium tax return filed pursuant to NRS 694C.450.

3. Any captive insurer failing, without just cause beyond the reasonable control of the captive insurer, to file its annual statement as required by subsection 1 shall pay a penalty of $100 for each day the captive insurer fails to file the report, but not to exceed an aggregate amount of $3,000, to be recovered in the name of the State of Nevada by the Attorney General.

4. Any director, officer, agent or employee of a captive insurer who subscribes to, makes or concurs in making or publishing, any annual or other statement required by law, knowing the same to contain any material statement which is false, is guilty of a gross misdemeanor.

Sec. 65. NRS 695B.380 is hereby amended to read as follows:

695B.380 1. Except as otherwise provided in subsection 4, each insurer that issues a contract for hospital or medical services in this State shall establish a system for resolving any complaints of an insured concerning health care services covered under the policy. The system must be approved by the Commissioner in consultation with the State Board of Health.

2. A system for resolving complaints established pursuant to subsection 1 must include an initial investigation, a review of the complaint by a review board and a procedure for appealing a determination regarding the complaint. The majority of the members on a review board must be insureds who receive health care services pursuant to a contract for hospital or medical services issued by the insurer.

3. The Commissioner or the State Board of Health may examine the system for resolving complaints established pursuant to subsection 1 at such times as either deems necessary or appropriate.

4. Each insurer that issues a contract specified in subsection 1 shall, if the contract provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care, provide a system for resolving any complaints of an insured concerning those health care services that complies with the provisions of NRS 695G.200 to ~~[695G.310,]~~ ***695G.230,*** inclusive ~~[.]~~ ***, and sections 102 to 112, inclusive, of this act.***

Sec. 66. NRS 695C.260 is hereby amended to read as follows:

695C.260 Each health maintenance organization shall establish:

1. A system for resolving complaints which complies with the provisions of NRS 695G.200 to 695G.230, inclusive; and

2. A system for conducting external reviews of ~~[final]~~ adverse determinations that complies with the provisions of ~~[NRS 695G.241 to 695G.310,]~~ ***sections 102 to 112,*** inclusive ~~[.]~~ ***, of this act.***

Sec. 67. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if the Commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The State Board of Health certifies to the Commissioner that the health maintenance organization:

(1) Does not meet the requirements of subsection 2 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of ~~[final]~~ adverse determinations that comply with the provisions of ~~[NRS 695G.241 to 695G.310,]~~ ***sections 102 to 112,*** inclusive ~~[;]~~ ***, of this act;***

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 68. NRS 695E.110 is hereby amended to read as follows:

695E.110 "Risk retention group" means any corporation or association with limited liability that is formed under the laws of any state, Bermuda or the Cayman Islands:

1. Whose primary activity consists of assuming and spreading all or any portion of the exposure of its ***corporation or association*** members to liability;

2. Which is organized primarily to conduct the activity described in subsection 1;

3. Which:

(a) Is chartered and licensed as a liability insurer and authorized to transact insurance under the laws of any state; or

(b) Before January 1, 1985, was chartered or licensed and authorized to transact insurance under the laws of Bermuda or the Cayman Islands and, before that date, had certified to the Commissioner of Insurance of at least one state that it satisfied the state's requirements for capitalization, except that such a group is considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability;

4. Which does not exclude any person from membership in the group solely to provide for members of the group a competitive advantage over an excluded person;

5. Which has as its:

(a) ~~[~~Members~~]~~ ***Owners*** only persons who ~~[~~have an ownership interest in the group and who are provided insurance by~~]~~ ***comprise the membership of*** the risk retention group ~~[.]~~ ***and who are provided insurance by the risk retention group;*** or

(b) Sole owner an organization which has as its:

(1) Members only persons who comprise the membership of the risk retention group; and

(2) Owners only persons who comprise the membership of the risk retention group and who are provided insurance by the group;

6. Whose members are engaged in businesses or activities similar or related with respect to the liability to which they are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;

7. Whose activities do not include the provision of insurance other than:

(a) Liability insurance for assuming and spreading all or any portion of the liability of the members of the group; and

(b) Reinsurance with respect to the liability of any other risk retention group, or any member of such a group, that is engaged in a business or activity such that the other group or member meets the requirements of subsection 6 for membership in the risk retention group that provides reinsurance; and

8. The name of which includes the phrase "risk retention group."

Sec. 69. NRS 695F.230 is hereby amended to read as follows:

695F.230 1. Each prepaid limited health service organization shall establish a system for the resolution of written complaints submitted by enrollees and providers.

2. The provisions of subsection 1 do not prohibit an enrollee or provider from filing a complaint with the Commissioner or limit the Commissioner's authority to investigate such a complaint.

3. Each prepaid limited health service organization that issues any evidence of coverage that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care shall provide a system for resolving any complaints of an enrollee or subscriber concerning those health care services that complies with the provisions of NRS 695G.200 to ~~[~~695G.310,~~]~~ ***695G.230,*** inclusive ~~[.]~~ ***, and sections 102 to 112, inclusive, of this act.***

Sec. 70. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 71 to 112, inclusive, of this act.

Sec. 71. ***"Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.***

Sec. 72. ***"Best evidence" means evidence based on:***

1. Randomized clinical trials;

2. If randomized clinical trials are not available, cohort studies or case-control studies;

3. If the methods described in subsections 1 and 2 are not available, case-series; or

4. If the methods described in subsections 1, 2 and 3 are not available, expert opinion.

Sec. 73. ***"Case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.***

Sec. 74. ***"Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.***

Sec. 75. ***"Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.***

Sec. 76. ***"Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the medical necessity and appropriateness of health care services.***

Sec. 77. ***"Cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention.***

Sec. 78. ***"Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.***

Sec. 79. ***"Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.***

Sec. 80. ***"Covered person" means a policyholder, subscriber, enrollee or other person participating in a health benefit plan.***

Sec. 81. ***"Discharge planning" means the formal process for determining, before discharge from a facility, the coordination and management of the care that a patient receives following discharge from the facility.***

Sec. 82. ***"Disclose" means to release, transfer or otherwise divulge protected health information to any person other than the person who is the subject of the protected health information.***

Sec. 83. *"Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy.*

Sec. 84. *"Emergency medical services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.*

Sec. 85. *"Evidence-based standard" means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of research in making decisions about the care of an individual patient.*

Sec. 86. *"Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy.*

Sec. 87. *"Facility" means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.*

Sec. 88. *"Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.*

Sec. 89. *"Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.*

Sec. 90. *"Health care provider" or "provider of health care" or "provider" means a health care professional or a facility.*

Sec. 91. *"Health care services" means services for the diagnosis, prevention, treatment, care or relief of a health condition, illness, injury or disease.*

Sec. 92. *"Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including, without limitation, a sickness and accident health insurance company, a health maintenance organization, a nonprofit hospital and health service corporation or any other entity providing a plan of health insurance, health benefits or health care services.*

Sec. 93. *"Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relate to:*

1. The past, present or future physical, mental or behavioral health or condition of a person or a member of the person's family;

2. The provision of health care services to a person; or

3. Payment for the provision of health care services to a person.

Sec. 94. *"Medical or scientific evidence" means evidence found in the following sources:*

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

2. Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Library of Medicine of the National Institutes of Health for indexing in Index Medicus (MEDLINE) and Elsevier for indexing in Excerpta Medica (EMBASE);

3. Medical journals recognized by the Secretary of Health and Human Services pursuant to section 1861(t)(2) of the Social Security Act, 42 U.S.C. § 1395x;

4. The following standard reference compendia:

(a) AHFS Drug Information published by the American Society of Health-System Pharmacists;

(b) Drug Facts and Comparisons published by Wolter Kluwers Health;

(c) Accepted Dental Therapeutics published by the American Dental Association; and

(d) The United States Pharmacopoeia's Drug Quality and Information Program;

5. Findings, studies or research conducted by or under the auspices of the Federal Government and nationally recognized federal research institutes, including, without limitation:

(a) The Agency for Healthcare Research and Quality;

(b) The National Institutes of Health;

(c) The National Cancer Institute;

(d) The National Academy of Sciences of the National Academies;

(e) The Centers for Medicare and Medicaid Services;

(f) The Food and Drug Administration; and

(g) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

6. Any other source of medical or scientific evidence that is comparable to the sources listed in subsections 1 to 5, inclusive.

Sec. 95. *"Prospective review" means utilization review conducted before an admission or a course of treatment.*

Sec. 96. *"Protected health information" means health information:*

1. That identifies a person who is the subject of the information; or

2. With respect to which there is a reasonable basis to believe that the information could be used to identify a person.

Sec. 97. *"Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.*

Sec. 98. *"Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.*

Sec. 99. *"Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider that originally made a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the proposed health care service.*

Sec. 100. *1. "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.*

2. As used in this section, "certification" means a determination by a health carrier or utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

Sec. 101. *"Utilization review organization" means an entity designated by a health carrier to conduct utilization reviews.*

Sec. 102. *1. Except as provided in subsection 2, the provisions of sections 102 to 112, inclusive, of this act and NRS 695G.200 to 695G.230, inclusive, apply to all health carriers.*

2. The provisions of subsection 1 do not apply to:

(a) A policy or certificate that provides only coverage for:

(1) A specified disease or accident;

(2) Accidents;

(3) Credit dental;

(4) Disability income;

(5) Hospital indemnity;

(6) Long-term care insurance;

(7) Vision care; or

(8) Any other limited supplemental benefit;

(b) A Medicare supplement policy of insurance, as defined in regulations adopted by the Commissioner;

(c) Coverage under a plan through Medicare, Medicaid or the Federal Employees Health Benefits Program, FEHBP, 5 U.S.C. §§ 8901 et seq.;

(d) Any coverage issued under the Civilian Health and Medical Program of the Uniformed Services, CHAMPUS, 10 U.S.C. §§ 1071 et seq., and any coverage issued as supplemental to that coverage;

(e) Any coverage issued as supplemental to liability insurance;

(f) Workers' compensation or similar insurance;

(g) Automobile medical payment insurance; or

(h) Any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis.

Sec. 103. *1. A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to section 105, 106 or 107 of this act and include the appropriate statements and information set forth in subsection 2 at the same time the health carrier sends written notice of an adverse determination upon completion of the health carrier's utilization review process set forth in NRS 683A.375 to 683A.379, inclusive, and the regulations adopted pursuant thereto.*

2. As part of the written notice required pursuant to subsection 1, a health carrier shall include the following, or substantially equivalent, language:

> *We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if*

our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Office of the Commissioner of Insurance.

3. The Commissioner may prescribe by regulation the form and content of the notice required pursuant to this section.

4. The health carrier shall include in the notice required pursuant to subsection 1 a statement informing the covered person that:

(a) If the covered person has a medical condition where the timeframe for completion of an expedited review of a grievance involving an adverse determination set forth in NRS 695G.200 to 695G.230, inclusive, would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may, at the same time the covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination as set forth in NRS 695G.210, file a request for an expedited external review to be conducted pursuant to section 106 or 107 of this act if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, and the independent review organization assigned to conduct the expedited external review will determine whether the covered person will be required to complete the expedited review of the grievance before conducting the expedited external review; and

(b) The covered person or the covered person's authorized representative may file a grievance under the health carrier's internal grievance process as set forth in NRS 695G.200 to 695G.230, inclusive, but if the health carrier has not issued a written decision to the covered person or the covered person's authorized representative within 30 days after the date on which the covered person or the covered person's authorized representative filed the grievance with the health carrier and the covered person or the covered person's authorized representative has not requested or agreed to a delay, the covered person or the covered person's authorized representative may file a request for

external review pursuant to section 105 of this act and shall be considered to have exhausted the health carrier's internal grievance process.

5. In addition to the information required to be provided pursuant to subsection 1, the health carrier shall include a copy of the description of both the standard and expedited external review procedures the health carrier is required to provide pursuant to section 112 of this act, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

6. As part of any forms provided pursuant to subsection 3, the health carrier shall include an authorization form, or other document approved by the Commissioner that complies with the requirements of 45 C.F.R. § 164.508, by which the covered person, for purposes of conducting an external review, authorizes the health carrier and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.

Sec. 104. *1. Except for a request for an expedited external review as set forth in section 106 or 107 of this act, all requests for external review must be made in writing to the Commissioner.*

2. The Commissioner may prescribe by regulation the form and content of requests for external review required to be submitted pursuant to this section.

3. A covered person or the covered person's authorized representative may submit a request for an external review of an adverse determination.

Sec. 105. *1. Within 4 months after receipt of a notice of an adverse determination pursuant to section 103 of this act, a covered person or the covered person's authorized representative may file a request for external review with the Commissioner pursuant to this section.*

2. Within 1 business day after receipt of a request for external review pursuant to subsection 1, the Commissioner shall send a copy of the request to the health carrier.

3. Within 5 business days after receipt of the copy of the request for external review from the Commissioner pursuant to subsection 2, the health carrier shall conduct and complete a preliminary review of the request to determine whether:

(a) The person is or was a covered person in the health benefit plan at the time the health care service was requested or, in the

case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;

(b) The health care service that is the subject of the adverse determination would have been a covered service under the covered person's health benefit plan but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(c) The covered person has exhausted the health carrier's internal grievance process as set forth in NRS 695G.200 to 695G.230, inclusive, unless the covered person is not required to exhaust the health carrier's internal grievance process; and

(d) The covered person has provided all the information and forms required by the Commissioner to process an external review, including the release form provided pursuant to subsection 6 of section 103 of this act.

4. Within 1 business day after completion of the preliminary review, the health carrier shall notify the Commissioner and the covered person, and, if applicable, the covered person's authorized representative, in writing, whether the request is:

(a) Complete;

(b) Eligible for external review;

(c) Not complete, in which case the health carrier shall include in the notice the information or materials that are needed to make the request complete; or

(d) Not eligible for external review, in which case the health carrier shall include in the notice the reasons for its ineligibility.

5. The Commissioner may specify the form for the notice of initial determination pursuant to subsection 4 and any supporting information to be included in the notice.

6. The notice of initial determination must include a statement that a health carrier's initial determination that a request which is ineligible for external review may be appealed to the Commissioner.

7. The Commissioner may determine that a request is eligible for external review pursuant to the provisions of subsection 3 and require that it be referred for external review notwithstanding a health carrier's initial determination pursuant to subsection 3 that the request is ineligible.

8. In making a determination pursuant to subsection 7, the Commissioner's decision must be made in accordance with the terms of the covered person's health benefit plan and is subject to all applicable provisions of sections 102 to 112, inclusive, of this act.

9. When the Commissioner receives a notice that a request is eligible for external review pursuant to subsection 4, within 1 business day after receipt of the notice, the Commissioner shall:

(a) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to section 8 of this act to conduct the external review;

(b) Notify the health carrier of the name of the assigned independent review organization; and

(c) Notify in writing the covered person and, if applicable, the covered person's authorized representative that the request is eligible for external review.

10. In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in NRS 683A.375 to 683A.379, inclusive, or the health carrier's internal grievance process as set forth in NRS 695G.200 to 695G.230, inclusive.

11. The Commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative pursuant to subsection 9 a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within 5 business days after receipt of the notice pursuant to subsection 9 additional information that the independent review organization shall consider when conducting the external review. The independent review organization may accept and consider additional information submitted after the 5 business days have elapsed.

12. Within 5 business days after receipt of the notice pursuant to subsection 9, the health carrier or utilization review organization shall provide to the assigned independent review organization any documents and information considered in making the adverse determination.

13. Except as otherwise provided in subsection 14, failure by the health carrier or utilization review organization to provide the documents and information within the time specified in subsection 12 must not delay the conduct of the external review.

14. If the health carrier or utilization review organization fails to provide the documents and information within the time specified in subsection 12, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination.

15. If the independent review organization elects to terminate the external review and reverse the adverse determination

pursuant to subsection 14, the independent review organization shall, within 1 business day, notify the covered person, the covered person's authorized representative, if applicable, the health carrier and the Commissioner of that decision.

16. The assigned independent review organization shall review all the information and documents received pursuant to subsections 11 and 12.

17. The assigned independent review organization shall forward any information submitted by the covered person or the covered person's authorized representative pursuant to subsection 11 to the health carrier within 1 business day after receipt of the information.

18. Upon receipt of any information required to be forwarded pursuant to subsection 17, the health carrier may reconsider the adverse determination that is the subject of the external review.

19. Reconsideration by the health carrier of its adverse determination pursuant to subsection 18 must not delay or terminate the external review.

20. Except as otherwise provided in subsection 14, the external review may only be terminated before completion if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination.

21. If the health carrier reverses its adverse determination pursuant to subsection 20, the health carrier shall, within 1 business day, notify the covered person, the covered person's authorized representative, if applicable, the assigned independent review organization and the Commissioner in writing of its decision.

22. The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier pursuant to subsection 21.

23. In addition to the documents and information provided pursuant to subsections 11 and 12, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(a) The covered person's medical records;

(b) The attending health care professional's recommendation;

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized

representative, if applicable, and the covered person's treating provider;

(d) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the health benefit plan;

(e) The most appropriate practice guidelines, which must include applicable evidence-based standards, and may include any other practice guidelines developed by the Federal Government or any national or professional medical societies, boards and associations;

(f) Any applicable clinical review criteria developed and used by the health carrier or utilization review organization in making adverse determinations; and

(g) The opinion of the independent review organization's clinical reviewers after considering paragraphs (a) to (f), inclusive, to the extent that the materials described in those paragraphs are available and to the extent that the clinical reviewers consider those materials appropriate.

24. Within 45 days after receipt of the request for external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination to the covered person, the covered person's authorized representative, if applicable, the health carrier and the Commissioner.

25. The independent review organization shall include in the notice sent pursuant to subsection 24:

(a) A general description of the reason for the request for external review;

(b) The date the independent review organization was assigned by the Commissioner to conduct the external review;

(c) The date on which the external review was conducted;

(d) The date of the decision;

(e) The principal reason or reasons for the decision, including any applicable evidence-based standards used as a basis for the decision;

(f) The rationale for the decision; and

(g) References to the evidence or documentation, including evidence-based standards, considered in reaching the decision.

26. Upon receipt of a notice of a decision pursuant to subsection 24 reversing the adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination.

27. The assignment by the Commissioner of an approved independent review organization to conduct an external review in

accordance with this section must be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination and other circumstances, including concerns regarding conflicts of interest pursuant to subsection 4 of section 9 of this act.

Sec. 106. *1. Except as otherwise provided in subsection 15, a covered person or the covered person's authorized representative may submit a request for an expedited external review pursuant to this section with the Commissioner at the time the covered person receives an adverse determination if:*

(a) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in NRS 695G.210 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(b) The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination as set forth in NRS 695G.210.

2. Upon receipt of a request for an expedited external review, the Commissioner shall immediately send a copy of the request to the health carrier.

3. Immediately upon receipt of the copy of the request pursuant to subsection 2, the health carrier shall determine whether the request meets the requirements for review set forth in subsection 3 of section 105 of this act. The health carrier shall immediately notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative of its determination regarding eligibility.

4. The Commissioner may specify the form for the notice of initial determination pursuant to subsection 3 and any supporting information to be included in the notice.

5. The notice of initial determination must include a statement that a health carrier's initial determination that a request which is ineligible for external review may be appealed to the Commissioner.

6. The Commissioner may determine that a request is eligible for external review pursuant to subsection 3 of section 105 of this act and require that it be referred for external review notwithstanding a health carrier's initial determination that the request is ineligible.

7. In making a determination pursuant to subsection 6, the Commissioner's decision must be made in accordance with the terms of the covered person's health benefit plan and is subject to all applicable provisions of the external review process.

8. Upon receipt of the notice that the request meets the requirements for review, the Commissioner shall immediately assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to section 8 of this act. The Commissioner shall immediately notify the health carrier of the name of the assigned independent review organization.

9. In reaching a decision pursuant to subsection 12, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in NRS 683A.375 to 683A.379, inclusive, or the health carrier's internal grievance process as set forth in NRS 695G.200 to 695G.230, inclusive.

10. Upon receipt of the notice pursuant to subsection 8, the health carrier or utilization review organization shall provide or transmit any documents and information considered in making the adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

11. In addition to the documents and information provided or transmitted pursuant to subsection 10, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(a) The covered person's medical records;

(b) The attending health care professional's recommendation;

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative or the covered person's treating provider;

(d) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the health benefit plan;

(e) The most appropriate practice guidelines, which must include applicable evidence-based standards, and may include any other practice guidelines developed by the Federal Government or any national or professional medical societies, boards and associations;

(f) Any applicable clinical review criteria developed and used by the health carrier or utilization review organization in making adverse determinations; and

(g) The opinion of the independent review organization's clinical reviewers after considering paragraphs (a) to (f), inclusive, to the extent that the materials described in those paragraphs are available and to the extent that the clinical reviewers consider those materials appropriate.

12. As expeditiously as the covered person's medical condition or circumstances require, but in no event more than 72 hours after receipt of the request for an expedited external review that meets the requirements for review set forth in subsection 3 of section 105 of this act, the assigned independent review organization shall:

(a) Make a decision to uphold or reverse the adverse determination; and

(b) Notify the covered person, the covered person's authorized representative, if applicable, the health carrier and the Commissioner of the decision.

13. If the notice provided pursuant to subsection 12 was not in writing, within 48 hours after providing that notice, the assigned independent review organization shall:

(a) Provide written confirmation of the decision to the covered person, the covered person's authorized representative, if applicable, the health carrier and the Commissioner; and

(b) Include the information set forth in subsection 25 of section 105 of this act.

14. Upon receipt of a notice of a decision pursuant to subsection 12 reversing the adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination.

15. An expedited external review may not be provided for retrospective adverse determinations.

16. The assignment by the Commissioner of an approved independent review organization to conduct an external review in accordance with this section must be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination and other circumstances, including concerns regarding conflicts of interest pursuant to subsection 4 of section 9 of this act.

Sec. 107. *1. Within 4 months after receipt of a notice of an adverse determination pursuant to section 103 of this act that involves a denial of coverage based on a determination that the*

health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the Commissioner pursuant to this section.

2. A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination pursuant to section 103 of this act that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

3. Upon receipt of a request for an expedited external review pursuant to subsection 2, the Commissioner shall immediately notify the health carrier.

4. Immediately upon notice of a request for an expedited external review pursuant to subsection 2, the health carrier shall determine whether the request meets the requirements for review set forth in subsection 12. The health carrier shall immediately notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative, of its determination regarding eligibility.

5. The Commissioner may specify the form for the notice of initial determination pursuant to subsection 4 and any supporting information to be included in the notice.

6. The notice of initial determination required by subsection 4 must include a statement that a health carrier's initial determination that a request which is ineligible for external review may be appealed to the Commissioner.

7. The Commissioner may determine that a request for an expedited external review is eligible for external review pursuant to subsection 12 and require that it be referred for expedited external review notwithstanding a health carrier's initial determination that the request is ineligible.

8. In making a determination pursuant to subsection 7, the Commissioner's decision must be made in accordance with the terms of the covered person's health benefit plan and is subject to all applicable provisions of the external review process.

9. Upon receipt of the notice that the request for expedited external review meets the requirements for review, the Commissioner shall immediately assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and

maintained by the Commissioner pursuant to section 8 of this act and notify the health carrier of the name of the assigned independent review organization.

10. Upon receipt of the notice pursuant to subsection 9, the health carrier or utilization review organization shall provide or transmit any documents and information considered in making the adverse determination to the assigned independent review organization electronically or by telephone or facsimile, or any other available expeditious method.

11. Except as otherwise provided in subsection 3, within 1 business day after receipt of a request for external review pursuant to subsection 1, the Commissioner shall notify the health carrier.

12. Within 5 business days after receipt of the notice sent pursuant to subsection 11, the health carrier shall conduct and complete a preliminary review of the request to determine whether:

(a) The person is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service or treatment was provided;

(b) The recommended or requested health care service or treatment that is the subject of the adverse determination:

(1) Would be a covered benefit under the covered person's health benefit plan but for the health carrier's determination that the health care service or treatment is experimental or investigational for a particular medical condition; and

(2) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan;

(c) The covered person's treating physician has certified that one of the following situations is applicable:

(1) Standard health care services or treatments have not been effective in improving the condition of the covered person;

(2) Standard health care services or treatments are not medically appropriate for the covered person; or

(3) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in paragraph (d);

(d) The covered person's treating physician:

(1) Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or

(2) Who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;

(e) The covered person has exhausted the health carrier's internal grievance process as set forth in NRS 695G.200 to 695G.230, inclusive, unless the covered person is not required to exhaust the health carrier's internal grievance process; and

(f) The covered person has provided all the information and forms required by the Commissioner to process an external review, including the release form provided pursuant to subsection 6 of section 103 of this act.

13. Within 1 business day after completion of the preliminary review, the health carrier shall notify the Commissioner and the covered person, and, if applicable, the covered person's authorized representative, in writing, whether the request is:

(a) Complete;

(b) Eligible for external review;

(c) Not complete, in which case the health carrier shall include in the notice the information or materials that are needed to make the request complete; or

(d) Not eligible for external review, in which case the health carrier shall include in the notice the reasons for its ineligibility.

14. The Commissioner may specify the form for the notice of initial determination pursuant to subsection 13 and any supporting information to be included in the notice.

15. The notice of initial determination must include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that a request which is ineligible for external review may be appealed to the Commissioner.

16. The Commissioner may determine that a request is eligible for external review pursuant to subsection 12 and require that it be referred for external review notwithstanding a health carrier's initial determination that the request is ineligible.

17. In making a determination pursuant to subsection 16, the Commissioner's decision must be made in accordance with the terms of the covered person's health benefit plan and is subject to all applicable provisions of the external review process.

18. When a health carrier determines that a request is eligible for external review pursuant to subsection 12, the health

carrier shall notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative.

19. Within 1 business day after receipt of the notice from the health carrier that the external review request is eligible for external review pursuant to subsection 18, the Commissioner shall:

(a) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to section 8 of this act to conduct the external review;

(b) Notify the health carrier of the name of the assigned independent review organization; and

(c) Notify in writing the covered person and, if applicable, the covered person's authorized representative that the request is eligible for external review and provide the name of the assigned independent review organization.

20. The Commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative pursuant to subsection 19 a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within 5 business days after receipt of the notice provided pursuant to subsection 19 additional information that the independent review organization shall consider when conducting the external review. The independent review organization may accept and consider additional information submitted after the 5 business days have elapsed.

21. Within 1 business day after receipt of the notice of assignment to conduct the external review pursuant to subsection 19, the assigned independent review organization shall:

(a) Select one or more clinical reviewers to conduct the external review, as it determines is appropriate; and

(b) Based on the opinion of the clinical reviewer, or opinions if more than one clinical reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination.

22. In selecting clinical reviewers pursuant to paragraph (a) of subsection 21, the assigned independent review organization shall select health care professionals who meet the minimum qualifications described in section 9 of this act and through clinical experience in the past 3 years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested health care service or treatment.

23. The covered person, the covered person's authorized representative, if applicable, and the health carrier may not

choose or control the choice of the health care professionals to be selected to conduct the external review.

24. In accordance with subsections 37 to 41, inclusive, each clinical reviewer shall provide a written opinion to the assigned independent review organization regarding whether the recommended or requested health care service or treatment should be covered.

25. In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process as set forth in NRS 683A.375 to 683A.379, inclusive, or the health carrier's internal grievance process as set forth in NRS 695G.200 to 695G.230, inclusive.

26. Within 5 business days after receipt of the notice pursuant to subsection 19, the health carrier or utilization review organization shall provide to the assigned independent review organization any documents and information considered in making the adverse determination.

27. Except as otherwise provided in subsection 28, failure by the health carrier or utilization review organization to provide the documents and information within the time specified in subsection 26 must not delay the conduct of the external review.

28. If the health carrier or utilization review organization fails to provide the documents and information within the time specified in subsection 26, the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination.

29. If the independent review organization elects to terminate the external review and reverse the adverse determination pursuant to subsection 28, the independent review organization shall immediately notify the covered person, the covered person's authorized representative, if applicable, the health carrier and the Commissioner.

30. Each clinical reviewer selected pursuant to subsection 21 shall review all the information and documents received pursuant to subsections 20 and 26.

31. The assigned independent review organization shall forward any information submitted by the covered person or the covered person's authorized representative pursuant to subsection 20 to the health carrier within 1 business day after receipt of the information.

32. Upon receipt of the information required to be forwarded pursuant to subsection 31, the health carrier may reconsider the adverse determination that is the subject of the external review.

33. Reconsideration by the health carrier of its adverse determination pursuant to subsection 32 must not delay or terminate the external review.

34. Except as otherwise provided in subsection 28, the external review may only be terminated before completion if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination.

35. If the health carrier reverses its adverse determination pursuant to subsection 28, the health carrier shall immediately notify the covered person, the covered person's authorized representative, if applicable, the assigned independent review organization and the Commissioner in writing of its decision.

36. The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier pursuant to subsection 35.

37. Except as otherwise provided in subsection 39, within 20 days after being selected in accordance with subsection 21 to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to subsection 41 regarding whether the recommended or requested health care service or treatment should be covered.

38. Except for an opinion provided pursuant to subsection 39, each clinical reviewer's opinion must be in writing and include the following:

(a) A description of the covered person's medical condition;

(b) A description of the indicators relevant to determine if there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(c) A description and analysis of any medical or scientific evidence considered in reaching the opinion;

(d) A description and analysis of any evidence-based standards used as a basis for the opinion; and

(e) Information concerning whether the reviewer's rationale for the opinion is based on the provisions of subsection 41.

39. For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no

event not more than 5 calendar days after being selected in accordance with subsection 21.

40. If the opinion provided pursuant to subsection 39 was not in writing, within 48 hours after providing that notice, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required pursuant to subsection 38.

41. In addition to the documents and information provided pursuant to subsections 10 and 26, each clinical reviewer, to the extent the information or documents are available and the reviewer considers them appropriate, shall consider the following in reaching an opinion:

(a) The covered person's medical records;

(b) The attending health care professional's recommendation;

(c) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative or the covered person's treating provider;

(d) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the health benefit plan; and

(e) Whether:

(1) The recommended or requested health care service or treatment has been approved by the Food and Drug Administration, if applicable, for the condition; or

(2) Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

42. Except as otherwise provided in subsection 43, within 20 days after receipt of the opinion of each clinical reviewer pursuant to subsection 41, the assigned independent review organization, in accordance with subsection 45 or 46, shall make a decision and provide written notice of the decision to the covered person, the covered person's authorized representative, if applicable, the health carrier and the Commissioner and include the information required pursuant to subsection 50.

43. For an expedited external review, within 48 hours after receipt of the opinion of each clinical reviewer pursuant to subsection 41, the assigned independent review organization, in accordance with subsection 45 or 46, shall make a decision and provide notice of the decision orally or in writing to the covered person, the covered person's authorized representative, if applicable, the health carrier and the Commissioner.

44. If the notice provided pursuant to subsection 43 was not in writing, within 48 hours after providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the covered person, the covered person's authorized representative, if applicable, the health carrier and the Commissioner and include the information required pursuant to subsection 50.

45. If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination.

46. If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination.

47. If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to subsection 45 or 46.

48. The additional clinical reviewer selected pursuant to subsection 47 shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to subsection 41.

49. The selection of an additional clinical reviewer pursuant to subsection 47 must not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers pursuant to subsection 42.

50. The independent review organization shall include in the notice provided pursuant to subsection 42 or 44:

(a) A general description of the reason for the request for external review;

(b) The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;

(c) The date the independent review organization was assigned by the Commissioner to conduct the external review;

(d) The date on which the external review was conducted;

(e) The date of the decision;

(f) The principal reason or reasons for the decision; and

(g) The rationale for the decision.

51. Upon receipt of a notice of a decision pursuant to subsection 42 or 44 reversing the adverse determination, the health carrier shall immediately approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination.

52. The assignment by the Commissioner of an approved independent review organization to conduct an external review in accordance with this section must be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service or treatment that is the subject of the adverse determination and other circumstances, including concerns regarding conflicts of interest pursuant to subsection 4 of section 9 of this act.

Sec. 108. *1. An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under federal or state law.*

2. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under federal or state law.

3. A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination for which the covered person has already received an external review decision.

Sec. 109. *No independent review organization, clinical reviewer working on behalf of an independent review organization or employee, agent or contractor of an independent review organization is liable for damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to sections 102 to 112, inclusive, of this act, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.*

Sec. 110. *1. An independent review organization assigned pursuant to section 105, 106 or 107 of this act to conduct an external review shall maintain written records, aggregated for each state and for each health carrier, on all requests for which it conducted an external review during a calendar year and, upon request, submit a report to the Commissioner in a format specified by the Commissioner.*

2. The report must include, aggregated for each state and for each health carrier:

(a) The total number of requests for external review;

(b) The number of requests for external review resolved and, of those resolved, the number upholding the adverse determination and the number reversing the adverse determination;

(c) The average length of time for resolution;

(d) A summary of the types of coverages or cases for which an external review was sought;

(e) The number of external reviews that were terminated as the result of a reconsideration by the health carrier of its adverse determination after receipt of additional information from the covered person or the covered person's authorized representative pursuant to subsection 18 of section 105 of this act and subsection 32 of section 107 of this act; and

(f) Any other information the Commissioner may request or require.

3. An independent review organization shall retain the written records required pursuant to this section for at least 3 years.

4. Each health carrier shall maintain written records, aggregated for each state and for each type of health benefit plan offered by the health carrier, on all requests for external review for which the health carrier receives notice from the Commissioner and, upon request, submit a report to the Commissioner in a format specified by the Commissioner.

5. The report must include, aggregated for each state and for each type of health benefit plan:

(a) The total number of requests for external review;

(b) Of the total number of requests for external review, the number of requests determined to be eligible for external review; and

(c) Any other information the Commissioner may request or require.

6. A health carrier shall retain the written records required pursuant to this section for at least 3 years.

Sec. 111. ***The health carrier against which a request for an external review or an expedited external review is filed shall pay the costs of the services provided by an independent review organization.***

Sec. 112. ***1. A health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.***

2. The description required by subsection 1 must be in a format prescribed by the Commissioner.

3. The description required by subsection 1 must include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination with the Commissioner. The statement may explain that external review is available when the adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. The statement must include the telephone number and address of the Commissioner.

4. In addition to the requirements of subsection 3, the statement must inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

Sec. 113. NRS 695G.010 is hereby amended to read as follows:

695G.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 695G.020 to ~~[695G.080,]~~ ***695G.070,*** inclusive, ***and sections 71 to 101, inclusive, of this act*** have the meanings ascribed to them in those sections.

Sec. 114. NRS 695G.012 is hereby amended to read as follows:

695G.012 "Adverse determination" means a determination ~~[of a managed care organization to deny all or part of a service or procedure that is proposed or being provided to an insured on the basis that it is not medically necessary or appropriate or is experimental or investigational. The term does not include a determination of a managed care organization that such an allocation is not a covered benefit.]~~ ***by a health carrier or utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of***

care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.

Sec. 115. NRS 695G.014 is hereby amended to read as follows:

695G.014 "Authorized representative" means ~~[a]~~ ***:***

1. A person ~~[who has obtained the consent of an insured]~~ ***to whom a covered person has given express written consent*** to represent ~~[him or her]~~ ***the covered person*** in an external review ~~[of a final adverse determination conducted pursuant to NRS 695G.241 to 695G.310, inclusive.]~~ ***;***

2. A person authorized by law to provide substituted consent for a covered person; or

3. A family member of a covered person or the covered person's treating provider only when the covered person is unable to provide consent.

Sec. 116. NRS 695G.018 is hereby amended to read as follows:

695G.018 ~~["External]~~ ***"Independent*** review organization" means an ~~[organization]~~ ***entity*** that:

1. Conducts an ***independent*** external review of ~~[a final]~~ ***an*** adverse determination; and

2. Is certified by the Commissioner in accordance with ~~[NRS 683A.371.]~~ ***sections 8 and 9 of this act.***

Sec. 117. NRS 695G.210 is hereby amended to read as follows:

695G.210 1. ~~[Except as otherwise provided in NRS 695G.300, a]~~ ***A*** system for resolving complaints created pursuant to NRS 695G.200 must include, without limitation, an initial investigation, a review of the complaint by a review board and a procedure for appealing a determination regarding the complaint. The majority of the members of the review board must be insureds who receive health care services from the managed care organization.

2. Except as otherwise provided in subsection 3, a review board shall complete its review regarding a complaint or appeal and notify the insured of its determination not later than 30 days after the complaint or appeal is filed, unless the insured and the review board have agreed to a longer period.

3. If a complaint involves an imminent and serious threat to the health of the insured, the managed care organization shall inform the insured immediately of the right of the insured to an expedited review of the insured's complaint. If an expedited review is required, the review board shall notify the insured in writing of its determination within 72 hours after the complaint is filed.

4. Notice provided to an insured by a review board regarding a complaint must include, without limitation, an explanation of any further rights of the insured regarding the complaint that are available under the health care plan of the insured.

Sec. 118. NRS 695G.230 is hereby amended to read as follows:

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

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

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

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

2. If a managed care organization denies coverage of a health care service to an insured, including, without limitation, a health maintenance organization that denies a claim related to a health care plan pursuant to NRS 695C.185, it shall notify the insured in writing within 10 working days after it denies coverage of the health care service of:

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

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

(c) The right of the insured to:

(1) File a written complaint and the procedure for filing such a complaint;

(2) Appeal ~~[a final]~~ ***an*** adverse determination pursuant to ~~[NRS 695G.241 to 695G.310,]~~ ***sections 102 to 112,*** inclusive ~~[;]~~ ***, of this act;***

(3) Receive an expedited external review of ~~[a final]~~ ***an*** adverse determination if the managed care organization receives proof from the insured's provider of health care that failure to proceed in an expedited manner may jeopardize the life or health of the insured, including notification of the procedure for requesting the expedited external review; and

(4) Receive assistance from any person, including an attorney, for an external review of ~~[a final]~~ ***an*** adverse determination; and

(d) The telephone number of the Office for Consumer Health Assistance.

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

Sec. 119. NRS 695H.090 is hereby amended to read as follows:

695H.090 1. An application for registration to engage in business as a medical discount plan must be submitted on a form prescribed by the Commissioner. The form must be signed by an officer or an authorized representative of the applicant. Except as otherwise provided in this section, the application must be accompanied by:

(a) A registration fee of $500 and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110.

(b) A copy of the organizational documents of the applicant, if any.

(c) A list of names, addresses, positions of employment and biographical information of each person who is responsible for conducting the business activities of the medical discount plan of the applicant, including, but not limited to, all members of the board of directors, board of trustees, officers and managers. The list must set forth the extent and nature of any contracts or other agreements between any person who is responsible for conducting the business activities of the applicant and the medical discount plan, including disclosure of any possible conflicts of interest.

(d) A complete biographical statement, on a form prescribed by the Commissioner, describing the facilities, employees and services that will be offered by the applicant.

(e) A copy of all forms used for contracts between the applicant and networks of providers of health care regarding the provision of health care or medical services to members.

(f) A copy of the most recent financial statements of the applicant, audited by an independent certified public accountant.

(g) A description of the method of marketing proposed by the applicant.

(h) A description of the procedures for making a complaint to be established and maintained by the applicant.

(i) Any other information required by the Commissioner.

2. Each person who registers a medical discount plan must renew the registration ~~[annually]~~ ***on or*** before ~~[the registration expires.]~~ ***March 1 of each year.*** Except as otherwise provided in this section, an application to renew the registration must include:

(a) An annual renewal fee of $500 and, in addition to any other fee or charge, all applicable fees required pursuant to NRS 680C.110; and

(b) Any information set forth in subsection 1 that the Commissioner requires to be included in the application.

3. An administrator or insurer that registers a medical discount plan is not required to pay the fees for registering or renewing the registration of the medical discount plan pursuant to this section.

4. The Commissioner shall, by regulation, designate the provisions of subsection 1 that shall be deemed satisfied by an administrator, insurer or affiliate of an insurer that has complied with substantially similar requirements pursuant to other provisions of this title.

Sec. 120. NRS 695H.180 is hereby amended to read as follows:

695H.180 A person who violates any provision of this chapter or an order or regulation of the Commissioner issued or adopted pursuant thereto may be assessed an administrative penalty by the Commissioner of not more than $2,000 for each act or violation ***.*** ~~[, not to exceed an aggregate amount of $10,000 for violations of a similar nature. For the purposes of this section, violations shall be deemed to be of a similar nature if the violations consist of the same or similar conduct, regardless of the number of times the conduct occurred.]~~

Sec. 121. NRS 697.173 is hereby amended to read as follows:

697.173 1. Except as otherwise provided in subsection ~~[2,]~~ ***4,*** a person is entitled to receive, renew or hold a license as a bail enforcement agent if the person:

(a) Is a natural person not less than 21 years of age.

(b) Is a citizen of the United States or is lawfully entitled to remain and work in the United States.

(c) Has a high school diploma or a general equivalency diploma or has an equivalent education as determined by the Commissioner.

(d) Has ~~[submitted to the Commissioner a report of an investigation of the criminal history of the person from the Central Repository for Nevada Records of Criminal History which indicates that the person possesses the qualifications for licensure as a bail enforcement agent.]~~ ***complied with the requirements of subsection 4 of NRS 697.180.***

(e) Has submitted to the Commissioner the results of an examination conducted by a psychiatrist or psychologist licensed to practice in this state which indicate that the person does not suffer from a psychological condition that would adversely affect the ability of the person to carry out his or her duties as a bail enforcement agent.

(f) Has passed any written examination required by this chapter.

(g) Submits to the Commissioner the results of a test to detect the presence of a controlled substance in the system of the person that was administered no earlier than 30 days before the date of the application for the license which do not indicate the presence of any controlled substance for which the person does not possess a current and lawful prescription issued in the name of the person.

(h) Successfully completes the training required by NRS 697.177.

2. A person is not entitled to receive, renew or hold a license of a bail enforcement agent if the person:

(a) Has been convicted of a felony in this state or of any offense committed in another state which would be a felony if committed in this state; or

(b) Has been convicted of an offense involving moral turpitude or the unlawful use, sale or possession of a controlled substance.

Sec. 122. NRS 697.180 is hereby amended to read as follows:

697.180 1. A written application for a license as a bail agent, general agent, bail enforcement agent or bail solicitor must be filed with the Commissioner by the applicant, accompanied by the applicable fees. The application form must:

(a) Include the social security number of the applicant; ***and***

(b) ~~[Be accompanied by a complete set of the applicant's fingerprints which the Commissioner may forward to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report; and~~

~~(c)]~~ Require full answers to questions reasonably necessary to determine the applicant's:

(1) Identity and residence.

(2) Business record or occupations for not less than the 2 years immediately preceding the date of the application, with the name and address of each employer, if any.

(3) Prior criminal history, if any.

2. The Commissioner may require the submission of such other information as may be required to determine the applicant's qualifications for the license for which the applicant applied.

3. The applicant must verify his or her application. An applicant for a license under this chapter shall not knowingly misrepresent or withhold any fact or information called for in the application form or in connection therewith.

4. Each applicant must, as part of his or her application and at the applicant's own expense:

(a) Arrange to have a complete set of his or her fingerprints taken by a law enforcement agency or other authorized entity acceptable to the Commissioner; and

(b) Submit to the Commissioner:

(1) A completed fingerprint card and written permission authorizing the Commissioner to submit the applicant's fingerprints to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary; or

(2) Written verification, on a form prescribed by the Commissioner, stating that the fingerprints of the applicant were taken and directly forwarded electronically or by another means to the Central Repository and that the applicant has given written permission to the law enforcement agency or other authorized entity taking the fingerprints to submit the fingerprints to the Central Repository for submission to the Federal Bureau of Investigation for a report on the applicant's background and to such other law enforcement agencies as the Commissioner deems necessary.

5. The Commissioner may:

(a) Unless the applicant's fingerprints are directly forwarded pursuant to subparagraph (2) of paragraph (b) of subsection 4, submit those fingerprints to the Central Repository for submission to the Federal Bureau of Investigation and to such other law enforcement agencies as the Commissioner deems necessary;

(b) Request from each such agency any information regarding the applicant's background as the Commissioner deems necessary; and

(c) Adopt regulations concerning the procedures for obtaining this information.

Sec. 123. NRS 223.580 is hereby amended to read as follows:

223.580 On or before February 1 of each year, the Director shall submit a written report to the Governor, and to the Director of the Legislative Counsel Bureau for transmittal to the appropriate committee or committees of the Legislature. The report must include, without limitation:

1. A statement setting forth the number and geographic origin of the written and telephonic inquiries received by the Office for Consumer Health Assistance and the issues to which those inquiries were related;

2. A statement setting forth the type of assistance provided to each consumer and injured employee who sought assistance from the Director, including, without limitation, the number of referrals made to the Attorney General pursuant to subsection 7 of NRS 223.560;

3. A statement setting forth the disposition of each inquiry and complaint received by the Director; and

4. A statement setting forth the number of external reviews conducted by ~~[external]~~ ***internal*** review organizations pursuant to ~~[NRS 695G.241 to 695G.310,]~~ ***sections 102 to 112,*** inclusive, ***of this act,*** and the disposition of ~~[each of]~~ those reviews as reported pursuant to ~~[NRS 695G.310.]~~ ***section 110 of this act.***

Sec. 124. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 689B.255, 695G.150, 695G.160, 695G.164, 695G.1645, 695G.170, 695G.171, 695G.173, 695G.177, 695G.200 to 695G.230, inclusive, ~~[695G.241 to 695G.310,]~~ ***and sections 102 to 112,*** inclusive, ***of this act*** and 695G.405, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 125. NRS 422.273 is hereby amended to read as follows:

422.273 1. For any Medicaid managed care program established in the State of Nevada, the Department shall contract only with a health maintenance organization that has:

(a) Negotiated in good faith with a federally-qualified health center to provide health care services for the health maintenance organization;

(b) Negotiated in good faith with the University Medical Center of Southern Nevada to provide inpatient and ambulatory services to recipients of Medicaid; and

(c) Negotiated in good faith with the University of Nevada School of Medicine to provide health care services to recipients of Medicaid.

➥ Nothing in this section shall be construed as exempting a federally-qualified health center, the University Medical Center of Southern Nevada or the University of Nevada School of Medicine from the requirements for contracting with the health maintenance organization.

2. During the development and implementation of any Medicaid managed care program, the Department shall cooperate with the University of Nevada School of Medicine by assisting in the provision of an adequate and diverse group of patients upon which the school may base its educational programs.

3. The University of Nevada School of Medicine may establish a nonprofit organization to assist in any research necessary for the development of a Medicaid managed care program, receive and accept gifts, grants and donations to support such a program and

assist in establishing educational services about the program for recipients of Medicaid.

4. For the purpose of contracting with a Medicaid managed care program pursuant to this section, a health maintenance organization is exempt from the provisions of NRS 695C.123.

5. The provisions of this section apply to any managed care organization, including a health maintenance organization, that provides health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program pursuant to a contract with the Division. Such a managed care organization or health maintenance organization is not required to establish a system for conducting external reviews of ~~[final]~~ adverse determinations in accordance with chapter 695B, 695C or 695G of NRS. This subsection does not exempt such a managed care organization or health maintenance organization for services provided pursuant to any other contract.

6. As used in this section, unless the context otherwise requires:

(a) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(b) "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

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

Sec. 126. NRS 616A.235 is hereby amended to read as follows:

616A.235 ~~["External]~~ ***"Independent*** review organization" means an organization which has been issued a certificate pursuant to NRS 616A.469 that authorizes the organization to conduct external reviews for the purposes of chapters 616A to 617, inclusive, of NRS.

Sec. 127. NRS 616A.469 is hereby amended to read as follows:

616A.469 1. The Commissioner may issue certificates authorizing qualified ~~[external]~~ ***independent*** review organizations to conduct external reviews for the purposes of chapters 616A to 617, inclusive, of NRS. If the Commissioner issues such certificates and the Commissioner determines that an ~~[external]~~ ***independent*** review organization is qualified to conduct external reviews for the purposes of chapters 616A to 617, inclusive, of NRS, the Commissioner shall issue a certificate to the ~~[external]~~ ***independent*** review organization that authorizes the organization to conduct such external reviews in accordance with the provisions of NRS 616C.363 and the regulations adopted by the Commissioner.

2. The Commissioner may adopt regulations setting forth the procedures that an ~~[external]~~ ***independent*** review organization must follow to be issued a certificate to conduct external reviews. Any regulations adopted pursuant to this section must include, without limitation, provisions setting forth:

(a) The manner in which an ~~[external]~~ ***independent*** review organization may apply for a certificate and the requirements for the issuance and renewal of the certificate pursuant to this section;

(b) The grounds for which the Commissioner may refuse to issue, suspend, revoke or refuse to renew a certificate issued pursuant to this section;

(c) The manner and circumstances under which an ~~[external]~~ ***independent*** review organization is required to conduct its business; and

(d) Any applicable fees for issuing or renewing a certificate of an ~~[external]~~ ***independent*** review organization pursuant to this section.

3. A certificate issued pursuant to this section expires 1 year after it is issued and may be renewed in accordance with regulations adopted by the Commissioner.

4. Before the Commissioner may issue a certificate to an ~~[external]~~ ***independent*** review organization, the ~~[external]~~ ***independent*** review organization must:

(a) Demonstrate to the satisfaction of the Commissioner that it is able to carry out, in a timely manner, the duties of an ~~[external]~~ ***independent*** review organization as set forth in NRS 616C.363 and the regulations adopted by the Commissioner. The demonstration must include, without limitation, proof that the ~~[external]~~ ***independent*** review organization employs, contracts with or otherwise retains only persons who are qualified because of their education, training, professional licensing and experience to perform the duties assigned to those persons; and

(b) Provide assurances satisfactory to the Commissioner that the ~~[external]~~ ***independent*** review organization will:

(1) Conduct external reviews in accordance with the provisions of NRS 616C.363 and the regulations adopted by the Commissioner;

(2) Render its decisions in a clear, consistent, thorough and timely manner; and

(3) Avoid conflicts of interest.

5. For the purposes of this section, an ~~[external]~~ ***independent*** review organization has a conflict of interest if the ~~[external]~~ ***independent*** review organization or any employee, agent or contractor of the ~~[external]~~ ***independent*** review organization who conducts an external review has a professional, familial or financial

interest of a material nature with respect to any person who has a substantial interest in the outcome of the external review, including, without limitation:

(a) The claimant;

(b) The employer; or

(c) The insurer or any officer, director or management employee of the insurer.

6. The Commissioner shall not issue a certificate to an ~~[external]~~ ***independent*** review organization that is affiliated with:

(a) An organization for managed care which provides comprehensive medical and health care services to employees for injuries or diseases pursuant to chapters 616A to 617, inclusive, of NRS;

(b) An insurer;

(c) A third-party administrator; or

(d) A national, state or local trade association.

7. An ~~[external]~~ ***independent*** review organization which is certified or accredited by an accrediting body that is nationally recognized shall be deemed to have satisfied all the conditions and qualifications required for the ~~[external]~~ ***independent*** review organization to be issued a certificate pursuant to this section.

Sec. 128. NRS 616B.691 is hereby amended to read as follows:

616B.691 1. ~~[For the purposes of chapters 612 and 616A to 617, inclusive, of NRS, an]~~ ***An*** employee leasing company which complies with the provisions of NRS 616B.670 to 616B.697, inclusive, shall be deemed to be the employer of the employees it leases to a client company. ***The provisions of this subsection apply only for the purposes of chapters 612 and 616A to 617, inclusive, of NRS.***

2. ~~[If an employee leasing company complies with the provisions of subsection 3, the]~~ ***An*** employee leasing company shall be deemed to be ~~[the]~~ ***an*** employer of its leased employees for the purposes of ***offering,*** sponsoring and maintaining any benefit plans ***.*** ~~[, including, without limitation, for the purposes of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 et seq.]~~ ***The provisions of this subsection do not affect the employer-employee relationship that exists between a leased employee and a client company.***

3. An employee leasing company shall not offer ***, sponsor or maintain for*** its ***leased*** employees any self-funded ~~[industrial]~~ insurance program. An employee leasing company shall not act as a self-insured employer or be a member of an association of self-insured public or private employers pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS ~~[.]~~ ***or title 57 of NRS.***

4. If an employee leasing company fails to:

(a) Pay any contributions, premiums, forfeits or interest due; or

(b) Submit any reports or other information required,

➥ pursuant to this chapter or chapter 612, 616A, 616C, 616D or 617 of NRS, the client company is jointly and severally liable for the contributions, premiums, forfeits or interest attributable to the wages of the employees leased to it by the employee leasing company.

Sec. 129. NRS 616C.360 is hereby amended to read as follows:

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

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

3. If there is a medical question or dispute concerning an injured employee's condition or concerning the necessity of treatment for which authorization for payment has been denied, the appeals officer may:

(a) Order an independent medical examination and refer the employee to a physician or chiropractor of his or her choice who has demonstrated special competence to treat the particular medical condition of the employee, whether or not the physician or chiropractor is on the insurer's panel of providers of health care. If the medical question concerns the rating of a permanent disability, the appeals officer may refer the employee to a rating physician or chiropractor. The rating physician or chiropractor must be selected in rotation from the list of qualified physicians or chiropractors maintained by the Administrator pursuant to subsection 2 of NRS 616C.490, unless the insurer and the injured employee otherwise agree to a rating physician or chiropractor. The insurer shall pay the costs of any examination requested by the appeals officer.

(b) If the medical question or dispute is relevant to an issue involved in the matter before the appeals officer and all parties agree to the submission of the matter to an ~~[external]~~ ***independent*** review organization, submit the matter to an ~~[external]~~ ***independent*** review organization in accordance with NRS 616C.363 and any regulations adopted by the Commissioner.

4. The appeals officer may consider the opinion of an examining physician or chiropractor, in addition to the opinion of an authorized treating physician or chiropractor, in determining the compensation payable to the injured employee.

5. If an injured employee has requested payment for the cost of obtaining a second determination of his or her percentage of

disability pursuant to NRS 616C.100, the appeals officer shall decide whether the determination of the higher percentage of disability made pursuant to NRS 616C.100 is appropriate and, if so, may order the insurer to pay to the employee an amount equal to the maximum allowable fee established by the Administrator pursuant to NRS 616C.260 for the type of service performed, or the usual fee of that physician or chiropractor for such service, whichever is less.

6. The appeals officer shall order an insurer, organization for managed care or employer who provides accident benefits for injured employees pursuant to NRS 616C.265 to pay to the appropriate person the charges of a provider of health care if the conditions of NRS 616C.138 are satisfied.

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

8. Except as otherwise provided in subsection 9, the appeals officer shall render a decision:

(a) If a transcript is ordered within 7 days after the hearing, within 30 days after the transcript is filed; or

(b) If a transcript has not been ordered, within 30 days after the date of the hearing.

9. The appeals officer shall render a decision on a contested claim submitted pursuant to subsection 2 of NRS 616C.345 within 15 days after:

(a) The date of the hearing; or

(b) If the appeals officer orders an independent medical examination, the date the appeals officer receives the report of the examination,

➥ unless both parties to the contested claim agree to a later date.

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

Sec. 130. NRS 616C.363 is hereby amended to read as follows:

616C.363 1. Not later than 5 business days after the date that an ~~[external]~~ ***independent*** review organization receives a request for an external review, the ~~[external]~~ ***independent*** review organization shall:

(a) Review the documents and materials submitted for the external review; and

(b) Notify the injured employee, his or her employer and the insurer whether the ~~[external]~~ ***independent*** review organization needs any additional information to conduct the external review.

2. The ~~[external]~~ ***independent*** review organization shall render a decision on the matter not later than 15 business days after the date that it receives all information that is necessary to conduct the external review.

3. In conducting the external review, the ~~[external]~~ ***independent*** review organization shall consider, without limitation:

(a) The medical records of the insured;

(b) Any recommendations of the physician of the insured; and

(c) Any other information approved by the Commissioner for consideration by an ~~[external]~~ ***independent*** review organization.

4. In its decision, the ~~[external]~~ ***independent*** review organization shall specify the reasons for its decision. The ~~[external]~~ ***independent*** review organization shall submit a copy of its decision to:

(a) The injured employee;

(b) The employer;

(c) The insurer; and

(d) The appeals officer, if any.

5. The insurer shall pay the costs of the services provided by the ~~[external]~~ ***independent*** review organization.

6. The Commissioner may adopt regulations to govern the process of external review and to carry out the provisions of this section. Any regulations adopted pursuant to this section must provide that:

(a) All parties must agree to the submission of a matter to an ~~[external]~~ ***independent*** review organization before a request for external review may be submitted;

(b) A party may not be ordered to submit a matter to an ~~[external]~~ ***independent*** review organization; and

(c) The findings and decisions of an ~~[external]~~ ***independent*** review organization are not binding.

Sec. 131. NRS 683A.371, 683A.373, 684A.155, 686A.225, 689A.360, 689A.625, 689C.105, 695G.016, 695G.070, 695G.080, 695G.241, 695G.251, 695G.261, 695G.271, 695G.280, 695G.290, 695G.300 and 695G.310 are hereby repealed.

Sec. 132. 1. This act becomes effective:

(a) Upon passage and approval for the purpose of adopting regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On October 1, 2011, for all other purposes.

2. Sections 23, 24, 25, 45, 47, 59, 60 and 122 of this act expire by limitation on the date on which the provisions of 42 U.S.C. § 666 requiring each state to establish procedures under which the state has authority to withhold or suspend, or to restrict the use of professional, occupational and recreational licenses of persons who:

(a) Have failed to comply with a subpoena or warrant relating to a proceeding to determine the paternity of a child or to establish or enforce an obligation for the support of a child; or

(b) Are in arrears in the payment for the support of one or more children,

➥ are repealed by the Congress of the United States.

LEADLINES OF REPEALED SECTIONS

683A.371 Certification; conflicts of interest; annual list.

683A.373 Submission of annual list to Office for Consumer Health Assistance.

684A.155 Limited license: Commissioner authorized to issue to adjuster licensed in adjoining state; terms; powers.

686A.225 Certain insurers to retain adjuster who resides in this State.

689A.360 Filing of rates.

689A.625 Supplemental coverage not health benefit plan if individual carrier files annual certification with Commissioner.

689C.105 "Supplemental coverage" defined.

695G.016 "Clinical peer" defined.

695G.070 "Provider of health care" defined.

695G.080 "Utilization review" defined.

695G.241 Adverse determination deemed final for purpose of submitting to external review organization.

695G.251 Request for review; assignment of external review organization; provision of documents relating to adverse determination to external review organization.

695G.261 Review of documents by external review organization; decision of external review organization.

695G.271 Expedited approval or denial of request.

695G.280 Basis for decision of external review organization.

695G.290 Decision in favor of insured binding on managed care organization; limitation of liability; cost for external review organization.

695G.300 Submission of complaint of insured to external review organization.

695G.310 Annual report; requirements.