ASSEMBLY BILL NO. 170–ASSEMBLYWOMEN SPIEGEL; AND CARLTON

FEBRUARY 18, 2019

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to health insurance coverage. (BDR 57-278)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
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 an insurer to authorize a service from an out-of-network provider in certain circumstances; requiring an insurer to offer health insurance coverage regardless of health status; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires an insurance carrier that offers coverage to small employer groups or individual markets to demonstrate the capacity of a network plan to deliver services adequately before making the network plan available for sale in this State. (NRS 687B.490) **Section 4** of this bill requires such an insurance carrier to authorize a person who is covered by the network plan of the carrier who is unable to obtain a covered service from an in-network provider to obtain the service from an out-of-network provider under the same conditions and with the same coverage as if the provider were an in-network provider in certain circumstances. **Sections 1-3, 5 and 6** of this bill make conforming changes.

Existing law prohibits an insurer from denying, limiting or excluding a benefit provided by a health care plan in certain limited circumstances, including when a person has contracted for a blanket policy of accident or health insurance or in certain cases relating to adoption. (NRS 689B.0265, 689B.500, 689C.190, 695A.159, 695B.193, 695C.173, 695F.480) The federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148, as amended) prohibits an insurer from establishing rules that limit eligibility for a health care plan based on certain health status factors, including, without limitation, preexisting conditions, claims history or genetic information of the insured and also prohibits an insurer from charging a higher premium, deductible or copay based on those health status factors. (42 U.S.C. § 300gg-4) **Sections 7, 12, 15, 19, 20, 24, 25 and 29-32** of this bill: (1) align Nevada law with federal law and require all insurers to offer health insurance coverage regardless of the health status of a person; and (2) prohibit an insurer from denying, limiting or excluding a benefit or requiring an insured to pay a higher

premium, deductible, coinsurance or copay based on the health status of the insured or the covered spouse or dependent of the insured. **Sections 9, 10, 12, 13, 16-18, 21, 23, 26, 27 and 35** of this bill remove partially duplicative provisions from existing law.

Existing law authorizes certain retired public officers and employees or the surviving spouse of such a retired officer or employee who is deceased to reinstate health insurance provided by the employer. If such an insurance plan is considered a grandfathered plan under the Patient Protection and Affordable Care Act, existing law authorizes such reinstatement to exclude claims for expenses for certain preexisting conditions. (NRS 287.0205) The Patient Protection and Affordable Care Act prohibits a grandfathered group plan from imposing such an exclusion. (42 U.S.C. §§ 300gg-3, 18011(a)(4)(B)) **Section 33** of this bill removes authorization for certain government insurance plans to exclude claims for preexisting conditions for reinstated coverage in conformance with federal law and **sections 12 and 31** of this bill. **Sections 11, 14, 22 and 35** of this bill remove other provisions of existing law that reference exclusions based on a preexisting condition. **Sections 8 and 28** of this bill make other conforming changes.

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

Section 1. Chapter 687B of NRS is hereby amended by adding thereto the provisions set forth as sections 2, 3 and 4 of this act.

Sec. 2. ***As used in this section and NRS 687B.470 to 687B.500, inclusive, and sections 3 and 4 of this act, unless the context otherwise requires, the words and terms defined in NRS 687B.470 and section 3 of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"Network plan" means a health benefit plan offered by a health carrier under which the financing and delivery of medical care, including, without limitation, items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.***

Sec. 4. ***1. A person covered by a network plan may request the health carrier that issued the network plan to obtain a covered service from an out-of-network provider under the same conditions and with the same coverage as if the provider were an in-network provider if the person is unable, after making a good faith effort, to obtain the service from an in-network provider who is qualified to perform the service:***

(a) At a location within 25 miles of his or her residence; and

(b) Within 30 days of requesting an appointment.

2. A request pursuant to subsection 1 must include, without limitation, evidence that the person made a good faith effort to obtain an appointment for the service from each in-network

provider who is qualified to perform the service within 25 miles of his or her residence.

3. A health carrier that receives a request pursuant to subsection 1 may assist the person to obtain the service from an in-network provider. If by the end of the business day immediately following the request the health carrier:

(a) Schedules an appointment with an in-network provider located within 25 miles of the residence of the person and within 30 days, the health carrier is not required to approve the request. If approved, the person must not be required to pay more than he or she would pay to an in-network provider.

(b) Does not schedule an appointment with an in-network provider located within 25 miles of the residence of the person, the health carrier must approve the request and provide written authorization for the person to obtain the service from an out-of-network provider as described in subsection 1. The authorization must include, without limitation, a statement of any copay or coinsurance for which the person will be responsible.

4. A person who receives approval of a request pursuant to subsection 3 may present the written authorization to an out-of-network provider as proof of approval from the insurer. An out-of-network provider who receives such written authorization and provides the service to the person shall:

(a) Provide the service to the person and any care necessary during the acute phase of recovery from the service; and

(b) Bill the health carrier for any amount owed for the service after receiving any copay or coinsurance for which the person is responsible.

5. A health carrier that does not pay a bill submitted pursuant to subsection 4 within 30 days after receipt shall pay:

(a) The amount billed plus interest at a rate of the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date on which the payment was due, plus 1 percent; and

(b) Any costs incurred by the out-of-network provider to collect the amount due from the health carrier.

6. A person who receives a service from an out-of-network provider pursuant to subsection 4 is responsible to pay only the same amount for which he or she would otherwise pay had he or she obtained the service from an in-network provider. If a health carrier bills a person any additional amount, the person may refuse or may bring an action in a court of competent jurisdiction to recover from the health carrier:

(a) Any costs incurred by the person to prove that he or she is not responsible for the amount; and

(b) Such punitive damages as the court may award.

7. As used in this section:

(a) "In-network provider" means a provider of health care who is under contract to provide health care services as part of a network plan.

(b) "Out-of-network provider" means a provider of health care who is not under contract to provide health care services as part of a network plan.

Sec. 5. NRS 687B.470 is hereby amended to read as follows:

687B.470 1. ~~[As used in NRS 687B.470 to 687B.500, inclusive, "health]~~ ***"Health*** benefit plan" means a policy, contract, certificate or agreement offered by a carrier to provide for, deliver payment for, arrange for the payment of, pay for or reimburse any of the costs of health care services. Except as otherwise provided in this section, the term includes catastrophic health insurance policies and a policy that pays on a cost-incurred basis.

2. The term does not include:

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

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

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

(d) Workers' compensation or similar insurance;

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

(f) Credit insurance;

(g) Coverage for on-site medical clinics;

(h) Other similar insurance coverage specified pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits;

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

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

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

(a) Limited-scope dental or vision benefits;

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

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

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

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

(b) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

Sec. 6. NRS 687B.490 is hereby amended to read as follows:

687B.490 1. A carrier that offers coverage in the small employer group or individual market must, before making any network plan available for sale in this State, demonstrate the capacity to deliver services adequately by applying to the Commissioner for the issuance of a network plan and submitting a description of the procedures and programs to be implemented to meet the requirements described in subsection 2.

2. The Commissioner shall determine, within 90 days after receipt of the application required pursuant to subsection 1, if the carrier, with respect to the network plan:

(a) Has demonstrated the willingness and ability to ensure that health care services will be provided in a manner to ensure both availability and accessibility of adequate personnel and facilities in a manner that enhances availability, accessibility and continuity of service;

(b) Has organizational arrangements established in accordance with regulations promulgated by the Commissioner; and

(c) Has a procedure established in accordance with regulations promulgated by the Commissioner to develop, compile, evaluate and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its

services and such other matters as may be reasonably required by the Commissioner.

3. The Commissioner may certify that the carrier and the network plan meet the requirements of subsection 2, or may determine that the carrier and the network plan do not meet such requirements. Upon a determination that the carrier and the network plan do not meet the requirements of subsection 2, the Commissioner shall specify in what respects the carrier and the network plan are deficient.

4. A carrier approved to issue a network plan pursuant to this section must file annually with the Commissioner a summary of information compiled pursuant to subsection 2 in a manner determined by the Commissioner.

5. The Commissioner shall, not less than once each year, or more often if deemed necessary by the Commissioner for the protection of the interests of the people of this State, make a determination concerning the availability and accessibility of the health care services of any network plan approved pursuant to this section.

6. The expense of any determination made by the Commissioner pursuant to this section must be assessed against the carrier and remitted to the Commissioner.

7. When making any determination concerning the availability and accessibility of the services of any network plan or proposed network plan pursuant to this section, the Commissioner shall consider services that may be provided through telehealth, as defined in NRS 629.515, pursuant to the network plan or proposed network plan to be available services.

8. As used in this section ~~[~~**:**

~~(a) "Network plan" has the meaning ascribed to it in NRS 689B.570.~~

~~(b) "Small]~~ **,** ***"small*** employer" has the meaning ascribed to it in NRS 689C.095.

Sec. 7. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer shall offer and issue a policy of health insurance to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. An insurer that offers or issues a policy of health insurance shall not:

(a) Deny, limit or exclude a benefit based on the health status of an insured; or

(b) Require an insured, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated insured or the covered dependent of such an insured who does not have such a health status.

3. An insurer that offers or issues a policy of health insurance shall not adjust a premium, deductible, copay or coinsurance for any insured on the basis of genetic information relating to the insured or the covered dependent of the insured.

Sec. 8. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~[.]~~ ***, and section 7 of this act.***

Sec. 9. NRS 689A.417 is hereby amended to read as follows:

689A.417 1. Except as otherwise provided in subsection 2, an insurer who provides health insurance shall not:

(a) Require an insured person or any member of the family of the insured person to take a genetic test;

(b) Require an insured person to disclose whether the insured person or any member of the family of the insured person has taken a genetic test or any genetic information of the insured person or a member of the family of the insured person; or

(c) Determine the rates or any other aspect of the coverage or benefits for health care provided to an insured person based on ~~[:~~

~~(1) Whether~~~~]~~ ***whether*** the insured person or any member of the family of the insured person has taken a genetic test ***.*** ~~[, or~~

~~(2) Any genetic information of the insured person or any member of the family of the insured person.]~~

2. The provisions of this section do not apply to an insurer who issues a policy of health insurance that provides coverage for long-term care or disability income.

3. As used in this section:

(a) "Genetic information" means any information that is obtained from a genetic test.

(b) "Genetic test" means a test, including a laboratory test that uses deoxyribonucleic acid extracted from the cells of a person or a diagnostic test, to determine the presence of abnormalities or deficiencies, including carrier status, that:

(1) Are linked to physical or mental disorders or impairments; or

(2) Indicate a susceptibility to illness, disease, impairment or any other disorder, whether physical or mental.

Sec. 10. NRS 689B.069 is hereby amended to read as follows:

689B.069 1. Except as otherwise provided in subsection 2, an insurer who provides group health insurance shall not:

(a) Require an insured person or any member of the family of the insured person to take a genetic test;

(b) Require an insured person to disclose whether the insured person or any member of the family of the insured person has taken a genetic test or any genetic information of the insured person or a member of the family of the insured person; or

(c) Determine the rates or any other aspect of the coverage or benefits for health care provided to an insured person based on ~~[:~~

~~(1) Whether]~~ ***whether*** the insured person or any member of the family of the insured person has taken a genetic test **.** ~~[; or~~

~~(2) Any genetic information of the insured person or any member of the family of the insured person.]~~

2. The provisions of this section do not apply to an insurer who issues a policy of group health insurance that provides coverage for long-term care or disability income.

3. As used in this section:

(a) "Genetic information" means any information that is obtained from a genetic test.

(b) "Genetic test" means a test, including a laboratory test that uses deoxyribonucleic acid extracted from the cells of a person or a diagnostic test, to determine the presence of abnormalities or deficiencies, including carrier status, that:

(1) Are linked to physical or mental disorders or impairments; or

(2) Indicate a susceptibility to illness, disease, impairment or any other disorder, whether physical or mental.

Sec. 11. NRS 689B.275 is hereby amended to read as follows:

689B.275 1. An insurer shall provide to each policyholder, or producer of insurance acting on behalf of a policyholder, on a form approved by the Commissioner, a summary of the coverage provided by each policy of group or blanket health insurance offered by the insurer. The summary must disclose any:

(a) Significant exception, reduction or limitation that applies to the policy;

(b) Restriction on payment for care in an emergency, including related definitions of emergency and medical necessity;

(c) Right of the insurer to change the rate of premium and the factors, other than claims experienced, which affect changes in rate;

(d) Provisions relating to renewability; ***and***

(e) ~~[Provisions relating to preexisting conditions; and~~

~~(f)]~~ Other information that the Commissioner finds necessary for full and fair disclosure of the provisions of the policy.

2. The language of the disclosure must be easily understood. The disclosure must state that it is only a summary of the policy and that the policy should be read to ascertain the governing contractual provisions.

3. The Commissioner shall not approve a proposed disclosure that does not satisfy the requirements of this section and of applicable regulations.

4. In addition to the disclosure, the insurer shall provide information about guaranteed availability of basic and standard plans for benefits to an eligible person.

5. The insurer shall provide the summary before the policy is issued.

Sec. 12. NRS 689B.500 is hereby amended to read as follows:

689B.500 ~~[A carrier that issues a group health plan or coverage under blanket accident and health insurance or group health insurance shall not deny, exclude or limit a benefit for a preexisting condition.]~~

1. A carrier shall offer and issue a policy of group health insurance to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. A carrier that offers or issues a policy of group health insurance shall not:

(a) Deny, limit or exclude a benefit based on the health status of an insured; or

(b) Require an insured, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance

based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated insured or the covered dependent of such an insured who does not have such a health status.

3. A carrier that offers or issues a policy of group health insurance shall not adjust a premium, deductible, copay or coinsurance for any insured on the basis of genetic information relating to the insured or the covered dependent of the insured.

Sec. 13. NRS 689B.550 is hereby amended to read as follows:

689B.550 1. A carrier shall not place any restriction on a person or a dependent of the person as a condition of being a participant in or a beneficiary of a policy of blanket accident and health insurance or group health insurance that is inconsistent with the provisions of this chapter.

2. A carrier that offers coverage under a policy of blanket accident and health insurance or group health insurance pursuant to this chapter shall not establish rules of eligibility ~~[,]~~ ***which conflict with the provisions of NRS 689B.500,*** including rules which define applicable waiting periods, for the initial or continued enrollment under a group health plan offered by the carrier that are based on the following factors relating to the employee or a dependent of the employee:

(a) Health status.

(b) Medical condition, including physical and mental illnesses, or both.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions which arise out of acts of domestic violence.

(h) Disability.

3. Except as otherwise provided in NRS 689B.500, the provisions of subsection 1 do not:

(a) Require a carrier to provide particular benefits other than those that would otherwise be provided under the terms of the blanket health and accident insurance or group health insurance or coverage; or

(b) Prevent a carrier from establishing limitations or restrictions on the amount, level, extent or nature of the benefits or coverage for similarly situated persons.

4. As a condition of enrollment or continued enrollment under a policy of blanket accident and health insurance or group health insurance, a carrier shall not require an employee to pay a premium or contribution that is greater than the premium or contribution for a

similarly situated person covered by similar coverage on the basis of any factor described in subsection 2 in relation to the employee or a dependent of the employee.

5. This section does not:

(a) Restrict the amount that an employer or employee may be charged for coverage by a carrier;

(b) Prevent a carrier from establishing premium discounts or rebates or from modifying otherwise applicable copayments or deductibles in return for adherence by the insured person to programs of health promotion and disease prevention; or

(c) Preclude a carrier from establishing rules relating to employer contribution or group participation when offering health insurance coverage to small employers in this state.

Sec. 14. NRS 689C.159 is hereby amended to read as follows:

689C.159 The provisions of NRS 689C.156 ~~[and 689C.190]~~ do not apply to health benefit plans offered by a carrier if the carrier makes the health benefit plan available in the small employer market only through a bona fide association.

Sec. 15. NRS 689C.190 is hereby amended to read as follows:

689C.190 ***1.*** A carrier ~~[serving small employers]~~ that issues a health benefit plan shall ~~[not deny, exclude or limit a benefit for a preexisting condition.]~~ ***offer and issue a health benefit plan to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:***

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. A carrier that offers or issues a health benefit plan shall not:

(a) Deny, limit or exclude a benefit based on the health status of an insured; or

(b) Require an insured, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated insured or the covered dependent of such an insured who does not have such a health status.

3. A carrier that offers or issues a health benefit plan shall not adjust a premium, deductible, copay or coinsurance for any

insured on the basis of genetic information relating to the insured or the covered dependent of the insured.

Sec. 16. NRS 689C.193 is hereby amended to read as follows:

689C.193 1. A carrier shall not place any restriction on a small employer or an eligible employee or a dependent of the eligible employee as a condition of being a participant in or a beneficiary of a health benefit plan that is inconsistent with NRS 689C.015 to 689C.355, inclusive.

2. A carrier that offers health insurance coverage to small employers pursuant to this chapter shall not establish rules of eligibility ~~[,]~~ ***which conflict with the provisions of NRS 689C.190,*** including, but not limited to, rules which define applicable waiting periods, for the initial or continued enrollment under a health benefit plan offered by the carrier that are based on the following factors relating to the eligible employee or a dependent of the eligible employee:

(a) Health status.

(b) Medical condition, including physical and mental illnesses, or both.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions which arise out of acts of domestic violence.

(h) Disability.

3. Except as otherwise provided in NRS 689C.190, the provisions of subsection 1 do not require a carrier to provide particular benefits other than those that would otherwise be provided under the terms of the health benefit plan or coverage.

4. As a condition of enrollment or continued enrollment under a health benefit plan, a carrier shall not require any person to pay a premium or contribution that is greater than the premium or contribution for a similarly situated person covered by similar coverage on the basis of any factor described in subsection 2 in relation to the person or a dependent of the person.

5. Nothing in this section:

(a) Restricts the amount that a small employer may be charged for coverage by a carrier;

(b) Prevents a carrier from establishing premium discounts or rebates or from modifying otherwise applicable copayments or deductibles in return for adherence by the insured person to programs of health promotion and disease prevention; or

(c) Precludes a carrier from establishing rules relating to employer contribution or group participation when offering health insurance coverage to small employers in this State.

6. As used in this section:

(a) "Contribution" means the minimum employer contribution toward the premium for enrollment of participants and beneficiaries in a health benefit plan.

(b) "Group participation" means the minimum number of participants or beneficiaries that must be enrolled in a health benefit plan in relation to a specified percentage or number of eligible persons or employees of the employer.

Sec. 17. NRS 689C.198 is hereby amended to read as follows:

689C.198 1. Except as otherwise provided in subsection 2, a carrier serving small employers shall not:

(a) Require an insured person or any member of the family of the insured person to take a genetic test;

(b) Require an insured person to disclose whether the insured person or any member of the family of the insured person has taken a genetic test or any genetic information of the insured person or a member of the family of the insured person; or

(c) Determine the rates or any other aspect of the coverage or benefits for health care provided to an insured person based on ~~[~~:

~~(1) Whether]~~ ***whether*** the insured person or any member of the family of the insured person has taken a genetic test ***.*** ~~[; or~~

~~(2) Any genetic information of the insured person or any member of the family of the insured person.]~~

2. The provisions of this section do not apply to a carrier serving small employers who issues a policy of health insurance that provides coverage for long-term care or disability income.

3. As used in this section:

(a) "Genetic information" means any information that is obtained from a genetic test.

(b) "Genetic test" means a test, including a laboratory test that uses deoxyribonucleic acid extracted from the cells of a person or a diagnostic test, to determine the presence of abnormalities or deficiencies, including carrier status, that:

(1) Are linked to physical or mental disorders or impairments; or

(2) Indicate a susceptibility to illness, disease, impairment or any other disorder, whether physical or mental.

Sec. 18. NRS 689C.220 is hereby amended to read as follows:

689C.220 A carrier serving small employers shall not charge adjustments in rates for ~~[claim experience, health status and]~~ duration of coverage ***or any reason prohibited by NRS 689C.190*** to individual employees or dependents. Any such adjustment must be

applied uniformly to the rates charged for all employees and dependents of a small employer.

Sec. 19. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. A society shall offer and issue a benefit contract to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. A society that offers or issues a benefit contract shall not:

(a) Deny, limit or exclude a benefit based on the health status of an insured; or

(b) Require an insured, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated insured or the covered dependent of such an insured who does not have such a health status.

3. A society that offers or issues a benefit contract shall not adjust a premium, deductible, copay or coinsurance for any insured on the basis of genetic information relating to the insured or the covered dependent of the insured.

Sec. 20. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

1. An insurer shall offer and issue a contract for hospital or medical service to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. An insurer that offers or issues a contract for hospital or medical service shall not:

(a) Deny, limit or exclude a benefit based on the health status of an insured; or

(b) Require an insured, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated insured or the covered dependent of such an insured who does not have such a health status.

3. An insurer that offers or issues a contract for hospital or medical service shall not adjust a premium, deductible, copay or coinsurance for any insured on the basis of genetic information relating to the insured or the covered dependent of the insured.

Sec. 21. NRS 695B.193 is hereby amended to read as follows:

695B.193 1. All individual and group service or indemnity-type contracts issued by a nonprofit corporation which provide coverage for a family member of the subscriber must as to such coverage provide that the health benefits applicable for children are payable with respect to:

(a) A newly born child of the subscriber from the moment of birth;

(b) An adopted child from the date the adoption becomes effective, if the child was not placed in the home before adoption; and

(c) A child placed with the subscriber for the purpose of adoption from the moment of placement as certified by the public or private agency making the placement. The coverage of such a child ceases if the adoption proceedings are terminated as certified by the public or private agency making the placement.

➥ The contracts must provide the coverage specified in subsection 3, and must not exclude premature births.

2. The contract may require that notification of:

(a) The birth of a newly born child;

(b) The effective date of adoption of a child; or

(c) The date of placement of a child for adoption,

➥ and payments of the required fees, if any, must be furnished to the nonprofit service corporation within 31 days after the date of birth, adoption or placement for adoption in order to have the coverage continue beyond the 31-day period.

3. The coverage for newly born and adopted children and children placed for adoption consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center under major medical

policies, and with respect to basic policies to the extent such costs are charged by the treatment center.

4. ~~[A corporation shall not restrict the coverage of a dependent child adopted or placed for adoption solely because of a preexisting condition the child has at the time the child would otherwise become eligible for coverage pursuant to that contract. Any provision relating to an exclusion for a preexisting condition must comply with NRS 689C.190.~~

~~5.]~~ For covered services provided to the child, the corporation shall reimburse noncontracted providers of health care to an amount equal to the average amount of payment for which the organization has agreements, contracts or arrangements for those covered services.

Sec. 22. NRS 695B.2555 is hereby amended to read as follows:

695B.2555 A converted contract ~~[must not exclude a preexisting condition not excluded by the group contract, but a converted contract]~~ may provide that any hospital, surgical or medical benefits payable under it may be reduced by the amount of any benefits payable under the group contract after his or her termination. A converted contract may provide that during the first contract year the benefits payable under it, together with the benefits payable under the group contract, must not exceed those that would have been payable if the subscriber's coverage under the group contract had remained in effect.

Sec. 23. NRS 695B.317 is hereby amended to read as follows:

695B.317 1. Except as otherwise provided in subsection 2, a corporation that provides health insurance shall not:

(a) Require an insured person or any member of the family of the insured person to take a genetic test;

(b) Require an insured person to disclose whether the insured person or any member of the family of the insured person has taken a genetic test or any genetic information of the insured person or a member of the family of the insured person; or

(c) Determine the rates or any other aspect of the coverage or benefits for health care provided to an insured person based on ~~[:~~

~~(1) Whether]~~ ***whether*** the insured person or any member of the family of the insured person has taken a genetic test **.** ~~[; or~~

~~(2) Any genetic information of the insured person or any member of the family of the insured person.]~~

2. The provisions of this section do not apply to a corporation that issues a policy of health insurance that provides coverage for long-term care or disability income.

3. As used in this section:

(a) "Genetic information" means any information that is obtained from a genetic test.

(b) "Genetic test" means a test, including a laboratory test that uses deoxyribonucleic acid extracted from the cells of a person or a diagnostic test, to determine the presence of abnormalities or deficiencies, including carrier status, that:

(1) Are linked to physical or mental disorders or impairments; or

(2) Indicate a susceptibility to illness, disease, impairment or any other disorder, whether physical or mental.

Sec. 24. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health maintenance organization shall offer and issue a health care plan to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. A health maintenance organization that offers or issues a health care plan shall not:

(a) Deny, limit or exclude a benefit based on the health status of an enrollee; or

(b) Require an enrollee, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated enrollee or the covered dependent of such an enrollee who does not have such a health status.

3. A health maintenance organization that offers or issues a health care plan shall not adjust a premium, deductible, copay or coinsurance for any enrollee on the basis of genetic information relating to the enrollee or the covered dependent of the enrollee.

Sec. 25. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this title

except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694 to 695C.1698, inclusive, 695C.1708, 695C.1731, 695C.17345, 695C.1735, 695C.1745 and 695C.1757 ***and section 24 of this act*** apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 26. NRS 695C.173 is hereby amended to read as follows:

695C.173 1. All individual and group health care plans which provide coverage for a family member of the enrollee must as to such coverage provide that the health care services applicable for children are payable with respect to:

(a) A newly born child of the enrollee from the moment of birth;

(b) An adopted child from the date the adoption becomes effective, if the child was not placed in the home before adoption; and

(c) A child placed with the enrollee for the purpose of adoption from the moment of placement as certified by the public or private agency making the placement. The coverage of such a child ceases if the adoption proceedings are terminated as certified by the public or private agency making the placement.

➥ The plans must provide the coverage specified in subsection 3, and must not exclude premature births.

2. The evidence of coverage may require that notification of:

(a) The birth of a newly born child;

(b) The effective date of adoption of a child; or

(c) The date of placement of a child for adoption,

➥ and payments of the required charge, if any, must be furnished to the health maintenance organization within 31 days after the date of birth, adoption or placement for adoption in order to have the coverage continue beyond the 31-day period.

3. The coverage for newly born and adopted children and children placed for adoption consists of preventive health care services as well as coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center under major medical policies, and with respect to basic policies to the extent such costs are charged by the treatment center.

4. ~~[A health maintenance organization shall not restrict the coverage of a dependent child adopted or placed for adoption solely because of a preexisting condition the child has at the time the child would otherwise become eligible for coverage pursuant to that plan. Any provision relating to an exclusion for a preexisting condition must comply with NRS 689B.500 or 689C.190, as appropriate.~~

~~5.]~~ For covered services provided to the child, the health maintenance organization shall reimburse noncontracted providers of health care to an amount equal to the average amount of payment for which the organization has agreements, contracts or arrangements for those covered services.

Sec. 27. NRS 695C.207 is hereby amended to read as follows:

695C.207 1. A health maintenance organization shall not:

(a) Require an enrollee or any member of the family of the enrollee to take a genetic test;

(b) Require an enrollee to disclose whether the enrollee or any member of the family of the enrollee has taken a genetic test or the genetic information of the enrollee or a member of the family of the enrollee; or

(c) Determine the rates or any other aspect of the coverage or benefits for health care provided to an enrollee based on ~~[:~~

~~(1) Whether]~~ ***whether*** the enrollee or any member of the family of the enrollee has taken a genetic test **.** ~~[; or~~

~~(2) Any genetic information of the enrollee or any member of the family of the enrollee.]~~

2. As used in this section:

(a) "Genetic information" means any information that is obtained from a genetic test.

(b) "Genetic test" means a test, including a laboratory test which uses deoxyribonucleic acid extracted from the cells of a person or a

diagnostic test, to determine the presence of abnormalities or deficiencies, including carrier status, that:

(1) Are linked to physical or mental disorders or impairments; or

(2) Indicate a susceptibility to illness, disease, impairment or any other disorder, whether physical or mental.

Sec. 28. 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, ***and section 24 of this act,*** or 695C.207;

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

(d) The Commissioner certifies that the health maintenance organization:

(1) Does not meet the requirements of subsection 1 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 adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(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 or creditors or to the general public;

(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. 29. Chapter 695F of NRS is hereby amended by adding thereto a new section to read as follows:

1. A prepaid limited health service organization shall offer and issue evidence of coverage to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. A prepaid limited health service organization that offers or issues evidence of coverage shall not:

(a) Deny, limit or exclude a benefit based on the health status of an enrollee; or

(b) Require an enrollee, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated enrollee or the covered dependent of such an enrollee who does not have such a health status.

3. A prepaid limited health service organization that offers or issues evidence of coverage shall not adjust a premium, deductible, copay or coinsurance for any enrollee on the basis of genetic information relating to the enrollee or the covered dependent of the enrollee.

Sec. 30. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

1. A managed care organization shall offer and issue a health care plan to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. A managed care organization that offers or issues a health care plan shall not:

(a) Deny, limit or exclude a benefit based on the health status of an insured; or

(b) Require an insured, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated insured or the covered dependent of such an insured who does not have such a health status.

3. A managed care organization that offers or issues a health care plan shall not adjust a premium, deductible, copay or coinsurance for any insured on the basis of genetic information relating to the insured or the covered dependent of the insured.

Sec. 31. NRS 287.010 is hereby amended to read as follows:

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

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

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

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 687B.408, 689B.030 to 689B.050, inclusive, ~~[and]~~ 689B.287 ***and 689B.500*** apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378 and 689B.03785 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.

(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation,

political subdivision, public corporation or other local governmental agency of the State of Nevada.

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

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.

4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.

5. A contract that is entered into pursuant to subsection 3:

(a) Must be submitted to the Commissioner of Insurance for approval not less than 30 days before the date on which the contract is to become effective.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

6. As used in this section, "legal services organization" means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.

Sec. 32. 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 687B.409, 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and section 30 of this act*** in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 33. Section 15 of chapter 453, Statutes of Nevada 2011, at page 2746, is hereby amended to read as follows:

Sec. 15. 1. This section and sections 4 and 12 of this act become effective on July 1, 2011.

2. Sections 1, 2, 3, 5 to 11, inclusive, 13 and 14 of this act become effective on October 1, 2011.

3. Section 4.5 of this act becomes effective on ~~[the date on which the provisions of the Patient Protection and Affordable Care Act, Public Law 111-148, cease to allow a grandfathered health plan to exclude claims for preexisting medical conditions.]~~ ***January 1, 2020.***

Sec. 34. The provisions of sections 4, 7, 12, 15, 19, 20 and 24 of this act apply to any contract, agreement, network plan, policy of health insurance, policy of group health insurance, health benefit plan, benefit contract, contract for hospital or medical service and health care plan that is delivered, issued for delivery or renewed on or after January 1, 2020.

Sec. 35. NRS 689A.523, 689A.585, 689B.450, 689C.082, 695A.159 and 695F.480 are hereby repealed.

Sec. 36. ***This act becomes effective:***

1. Upon passage and approval for the purpose of performing any preparatory administrative tasks that are necessary to carry out the provisions of this act; and

2. On January 1, 2020, for all other purposes.

LEADLINES OF REPEALED SECTIONS

689A.523 “Exclusion for a preexisting condition” defined.
689A.585 “Preexisting condition” defined.
689B.450 “Preexisting condition” defined.
689C.082 “Preexisting condition” defined.
695A.159 Society prohibited from restricting coverage of child based on preexisting condition when person who is eligible for group coverage adopts or assumes legal obligation for child.

695F.480 Organization prohibited from restricting coverage of child based on preexisting condition if person who is eligible for group coverage adopts or assumes legal obligation for child.

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