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Senate Bill No. 481–Committee on
Health and Human Services

CHAPTER.....

AN ACT relating to health insurance; establishing requirements for obtaining a certificate of authority for self-funded multiple employer welfare arrangements; establishing requirements for short-term limited duration medical plan cancellation and rescission; allowing certain consumers to purchase individual health insurance policies outside the rating area where they reside; revising provisions relating to health benefit plans that are not purchased on the Silver State Health Insurance Exchange; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law sets forth requirements for policies of health insurance which include a policy, contract, certificate, plan or agreement issued for the provision of, delivery of, arrangement for, payment for or reimbursement for any costs of a health care service for large and small employers. (Chapters 689B and 689C of NRS) Large employers and certain small employers have been able to participate in association health plans to provide policies of health insurance for their employees. Recent changes in the United States Department of Labor rules allow additional small employers to participate in certain association health plans. **Sections 1-5** of this bill define multiple employer welfare arrangements and establish requirements for a certificate of authority to be issued to a self-funded multiple employer welfare arrangement. **Sections 6 and 10** of this bill provide that only one policy of short-term health insurance may be issued to an insured during a 365-day period, except it may be extended to cover a period of hospitalization. **Section 7** of this bill: (1) requires a carrier issuing a health benefit plan that is not being purchased on the Silver State Health Insurance Exchange to provide on its enrollment Internet website and printed enrollment information a notice to inform consumers that consumers may be eligible for financial assistance with their health insurance premiums or other out-of-pocket expenses by enrolling on the Silver State Health Insurance Exchange; and (2) specifies the information to be provided in that notice. **Sections 8 and 9** of this bill establish the requirements for cancellation and rescission of a short-term limited duration medical plan. **Section 12** of this bill authorizes the Silver State Health Insurance Exchange to facilitate certain individuals purchasing individual health insurance policies in a manner which, in effect, will allow the individuals to purchase a plan from outside the rating area where they reside.

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

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

Section 1. Chapter 680A of NRS is hereby amended by adding thereto the provisions set forth as sections 2, 3 and 4 of this act.

Sec. 2. ***"Multiple employer welfare arrangement" has the meaning ascribed to it in 29 U.S.C. § 1002(40).***

Sec. 3. ***To the extent applicable and not inconsistent with federal law:***

1. The provisions of this chapter that govern domestic insurers, their business, capital and surplus requirements and the requirements for eligibility for a certificate of authority govern self-funded multiple employer welfare arrangements; and

2. A self-funded multiple employer welfare arrangement must comply with the criteria set forth in this chapter to qualify for a certificate of authority.

Sec. 4. ***The Commissioner may not issue a certificate of authority to a self-funded multiple employer welfare arrangement unless the arrangement establishes to the satisfaction of the Commissioner that the following requirements have been satisfied by the arrangement:***

1. The employers participating in the arrangement are members of a bona fide association;

2. The employers participating in the arrangement exercise control over the arrangement, as follows:

(a) Subject to paragraph (b) of this subsection, control exists if the board of directors of the bona fide association or the employers participating in the arrangement have the right to elect at least 75 percent of the individuals designated in the arrangement's organizational documents as having control over operations of the arrangement and individuals designated in the arrangement's organizational documents in fact exercise control over the operation of the arrangement; and

(b) The use of a third-party administrator to process claims and to assist in the administration of the arrangement is not evidence of the lack of control over the operation of the arrangement;

3. In this State, the arrangement provides only health care services;

4. In this State, the arrangement provides or arranges benefits for health care services in compliance with the provisions of this title that mandate particular benefits or offerings and with

provisions that require access to particular types or categories of health care providers and facilities;

5. The arrangement provides health care services to not less than 20 employers and not less than 75 employees;

6. The arrangement may not solicit participation in the arrangement from the general public. However, the arrangement may employ licensed insurance producers who receive a commission, unlicensed individuals who do not receive a commission, and may contract with a licensed insurance producer who may be paid a commission or other remuneration, for the purpose of enrolling and renewing the enrollments of employers in the arrangement;

7. The arrangement has been in existence and operated actively for a continuous period of not less than 10 years as of December 31, 2018, except for an arrangement that has been in existence and operated actively since December 31, 2015, and is sponsored by an association that has been in existence more than 25 years;

8. The arrangement is not organized or maintained solely as a conduit for the collection of premiums and the forwarding of premiums to an insurance company; and

9. The arrangement has aggregate stop loss coverage, with an attachment point of 120 percent of expected claims.

Sec. 5. NRS 680A.010 is hereby amended to read as follows:

680A.010 As used in this Code, unless the context otherwise requires, the words and terms defined in NRS 680A.020 to 680A.050, inclusive, ***and section 2 of this act*** shall have the meanings ascribed to them in NRS 680A.020 to 680A.050, inclusive ~~[.]~~ ***, and section 2 of this act.***

Sec. 6. NRS 687B.470 is hereby amended to read as follows:

687B.470 1. As used in NRS 687B.470 to 687B.500, inclusive, "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]~~ ***which is:***

(1) Issued to provide coverage that does not result in an individual being covered by one or more short-term health insurance policies for more than 185 days in a 365-day period, but such coverage may be extended to provide coverage until the end of a period of hospitalization for a condition which the person covered by the policy is hospitalized on the day coverage would have otherwise ended; and

(2) Nonrenewable or is extended to provide coverage for the period of hospitalization; 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,]~~ ***TRICARE,*** 10 U.S.C. §§ 1071 et seq.; and

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

Sec. 7. NRS 687B.480 is hereby amended to read as follows:

687B.480 1. All health benefit plans must be made available in the manner required by 45 C.F.R. § 147.104.

2. In addition to the requirements of subsection 1, any health benefit plan for individuals that is not purchased on the Silver State Health Insurance Exchange established by NRS 695I.210:

(a) Must be made available for purchase at any time during the calendar year;

(b) Is subject to a waiting period of not more than 90 days after the date on which the application for coverage was received;

(c) Is effective upon the first day of the month immediately succeeding the month in which the waiting period expires; and

(d) Is not retroactive to the date on which the application for coverage was received.

3. Except as otherwise provided in this subsection, a carrier offering a health benefit plan for individuals that is not being purchased on the Silver State Health Insurance Exchange established by NRS 695I.210 must include on its enrollment Internet website and printed enrollment information a notice to inform consumers that consumers may be eligible for financial assistance with their health insurance premiums or other out-of-pocket expenses by enrolling on the Silver State Health Insurance Exchange established by NRS 695I.210. A carrier is not required to provide the notice required by this subsection if such financial assistance is not available. The notice required by this subsection must contain the following statement:

> ***You can also enroll in a health insurance plan for you and your family through the Silver State Health Insurance Exchange (Nevada's state-based health insurance exchange). The Silver State Health Insurance Exchange allows you to get quotes from different insurance companies that are available on the Exchange. You can compare different plans, get quotes and find out if you qualify for financial assistance. The Silver State Health Insurance***

Exchange is the only way to receive financial assistance for your health insurance. You can enroll online by visiting www.nevadahealthlink.com or by calling 800-547-2927 TTY 711.

4. The Commissioner may adopt regulations to carry out the provisions of subsection 3, including, without limitation, regulations to require additional information to be provided in the notice required by subsection 3.

Sec. 8. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. A short-term limited duration medical plan shall not be cancelled by the carrier during the coverage period except for the following:

(a) Nonpayment of premium;

(b) Violation of published policies of the carrier approved by the Commissioner;

(c) Failure of a member to pay any deductible or copayment amount owed to the carrier and not the provider of health care services;

(d) Members committing fraudulent acts as to the carrier;

(e) A member's material breach of the medical plan; or

(f) Change or implementation of federal or state laws that no longer permit the continued offering of such coverage.

2. Except as otherwise provided in subsections 3 and 4, a short-term limited duration medical plan must not be rescinded by the carrier during the coverage period except for nonpayment of premium.

3. Except as provided in subsection 4 of this section, no oral or written misrepresentation or warranty made by the person applying for coverage or on his or her behalf in the process of applying for a short-term limited duration medical plan shall be deemed material or allow the carrier to rescind the medical plan, unless the misrepresentation or warranty is made to deceive.

4. In any application for a short-term limited duration medical plan made in writing by a person, all statements in the application by the person shall, in the absence of fraud, be deemed representations and not warranties. The falsity of any such statement shall not bar the right to recovery under the contract unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the carrier.

5. When cancellation or rescission is for nonpayment of premium, the carrier must notify the member in writing 10 days

prior to the cancellation or rescission that his or her short-term limited duration medical plan will be cancelled, unless payment is made prior to the cancellation date. When cancellation is for any other reason allowed under subsection 1, the carrier must notify the member in writing 20 days prior to the cancellation date. The notice must specifically state the reason or reasons for the cancellation. The written communications required by this subsection must be phrased in simple language that is readily understood.

Sec. 9. NRS 689A.040 is hereby amended to read as follows:

689A.040 1. Except as otherwise provided in subsection 2, each such policy delivered or issued for delivery to any person in this State must contain the provisions specified in NRS 689A.050 to 689A.170, inclusive, ***and section 8 of this act,*** in the words in which the provisions appear, except that the insurer may, at its option, substitute for one or more of the provisions corresponding provisions of different wording approved by the Commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Each such provision must be preceded individually by the applicable caption shown or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve.

2. If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the Commissioner, may omit from the policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of a provision in such a manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

Sec. 10. NRS 689A.540 is hereby amended to read as follows:

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

2. The term does not include:

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

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

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

(d) Workers' compensation or similar insurance;

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

(f) Credit insurance;

(g) Coverage for on-site medical clinics;

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

(i) Coverage under a short-term health insurance policy ~~[; and]~~ ***which is:***

(1) Issued to provide coverage that does not result in an individual being covered by one or more short-term health insurance policies for more than 185 days in a 365-day period, but such coverage may be extended to provide coverage until the end of a period of hospitalization for a condition which the person covered by the policy is hospitalized on the day coverage would have otherwise ended; and

(2) Nonrenewable or is extended to provide coverage for the period of hospitalization; and

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

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

(a) Limited-scope dental or vision benefits;

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

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

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

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

(b) Hospital indemnity or other fixed indemnity insurance.

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

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

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

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

Sec. 11. (Deleted by amendment.)

Sec. 12. NRS 695I.210 is hereby amended to read as follows:

695I.210 1. The Exchange shall:

(a) Create and administer a health insurance exchange;

(b) Facilitate the purchase and sale of qualified health plans ~~[;]~~ ***consistent with established patterns of care within the State;***

(c) Provide for the establishment of a program to assist qualified small employers in Nevada in facilitating the enrollment of their employees in qualified health plans offered in the small group market;

(d) Make only qualified health plans available to qualified individuals and qualified small employers on or after January 1, 2014; and

(e) Unless the Federal Act is repealed or is held to be unconstitutional or otherwise invalid or unlawful, perform all duties that are required of the Exchange to implement the requirements of the Federal Act.

2. The Exchange may:

(a) Enter into contracts with any person, including, without limitation, a local government, a political subdivision of a local government and a governmental agency, to assist in carrying out the duties and powers of the Exchange or the Board; and

(b) Apply for and accept any gift, donation, bequest, grant or other source of money to carry out the duties and powers of the Exchange or the Board.

3. The Exchange is subject to the provisions of chapter 333 of NRS.

Sec. 13. 1. This section and sections 1 to 5, inclusive, of this act become effective on July 1, 2019.

2. Sections 6 to 10, inclusive, of this act become effective on July 1, 2019, for the purposes of adopting regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act, and on January 1, 2020, for all other purposes.

3. Section 12 of this act becomes effective on July 1, 2019, for the purposes of adopting regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act, and on January 1, 2021, for all other purposes.

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