MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON COMMERCE AND LABOR

Eightieth Session
May 13, 2019

The Committee on Commerce and Labor was called to order by Chair Ellen B. Spiegel at 12:33 p.m. on Monday, May 13, 2019, in Room 4100 of the Legislative Building, 401 South Carson Street, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/80th2019.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Ellen B. Spiegel, Chair
Assemblyman Jason Frierson, Vice Chair
Assemblyman Skip Daly
Assemblyman Chris Edwards
Assemblywoman Melissa Hardy
Assemblywoman Sandra Jauregui
Assemblyman Al Kramer
Assemblywoman Susie Martinez
Assemblyman William McCurdy II
Assemblywoman Dina Neal
Assemblywoman Jill Tolles
Assemblyman Steve Yeager

COMMITTEE MEMBERS ABSENT:

Assemblywoman Maggie Carlton (excused)

GUEST LEGISLATORS PRESENT:

Assemblywoman Sarah Peters, Assembly District No. 24
Senator Julia Ratti, Senate District No. 13

STAFF MEMBERS PRESENT:

Patrick Ashton, Committee Policy Analyst
Wil Keane, Committee Counsel
Karen Easton, Committee Secretary
Olivia Lloyd, Committee Assistant

OTHERS PRESENT:

Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry
Annette James, Lead Actuary, Division of Insurance, Department of Business and Industry
Genevieve Ramos, Director of Operations, Serenity Mental Health, LLC, Carson City, Nevada
Jesse A. Wadhams, representing Nevada Surplus Lines Association
Jeanette K. Belz, representing Liberty Mutual Insurance Company
C. Joseph Guild, representing State Farm Insurance Companies
Michael D. Hillerby, representing American Council of Life Insurers
Robert Giunta, Senior Deputy Attorney General, Fraud Control Unit for Insurance, Office of the Attorney General
Keith G. Hopkinson, representing Christian Healthcare Ministries, Barberton, Ohio
Nick Vander Poel, representing Samaritan Ministries
Tom Clark, representing Nevada Association of Health Plans
Catherine M. O'Mara, Executive Director, Nevada State Medical Association
Lesley R. Dickson, State Legislative Representative, Nevada Psychiatric Association
Cliff McCorkle, Private Citizen, Sparks, Nevada
Keith L. Lee, representing Nevada Association of Health Plans
Lea Tauchen, representing America's Health Insurance Plans

Chair Spiegel:
[Roll was taken and Committee rules and protocol were reviewed.] We will open the hearing on Senate Bill 86 (1st Reprint).

Senate Bill 86 (1st Reprint): Makes various changes relating to the regulation of insurers by the Division of Insurance of the Department of Business and Industry. (BDR 57-238)

Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry:
[Read from prepared testimony (Exhibit C).] I am here today to present Senate Bill 86 (1st Reprint), which is a bill that addresses a variety of topics related to insurance regulation.

Insurance is a $16.2 billion industry in Nevada. Due to the uniqueness of the risks and hazards in different areas of the country, Congress has always left the regulation of insurance up to the states. The Division of Insurance, Department of Business and Industry, regulates over 169,000 licensees, including 1,535 licensed admitted insurers and 203 captives that are authorized to engage in the business of insurance in Nevada.

The Division of Insurance is a consumer protection agency. Our mission is twofold: (1) to protect consumers in their insurance experiences; and (2) to maintain a stable and competitive insurance market. Insurance is a heavily regulated industry because of its potential financial risk and impact to consumers and businesses. It requires that Division staff have specialized knowledge of risk, finance, insurance contracts, fraud, and customer service. For purposes of regulating insurance alone, the Division is responsible for 59 chapters within the *Nevada Revised Statutes* (NRS) which are listed under Title 57. We have provided you with a listing of the 59 chapters in Title 57 (Exhibit D). We have also provided an explanation table for S.B. 86 (R1), which will provide you with a summary of the changes for each section of this bill, along with the corresponding rationale for each change (Exhibit E). I will provide you with a brief review of the changes being proposed in this bill and will be happy to answer any questions you may have.

Sections 1, 57, and 62 of the bill clarify that expenses incurred in examinations, which we do on companies for financial solvency reasons, are limited to "reasonable compensation and per diem." These changes also eliminate paying examination fees to assistants of the Commissioner and allow licensees to pay the examiner directly, under the oversight and approval of the Division. This will create additional efficiencies as compared to the current system where the Division pays the examiner directly and then seeks reimbursement from the examinee. If the examinee is insolvent, that reimbursement will never occur.

Sections 2, 3, 33, and 71 through 77 remove the requirements that physicians and osteopathic physicians report certain information regarding closed claims related to medical liability insurance to the Division of Insurance. The requirement to report this information to the state's licensing boards remains. Reporting of this information to the boards and the Division of Insurance is an unnecessary redundancy, given that the medical malpractice market has been stable since the early 2000s, and this additional reporting has no impact on the availability or affordability of this product.

Sections 4, 13, 17 through 20, 27, 28, 30, 31, 64, 70, and 78 eliminate the requirement that certificates of licensure, authority, or registration, which are issued by the Commissioner, are required to be surrendered or delivered to the Division of Insurance upon expiration, suspension, or termination. However, most of these licenses are no longer issued in hard copy with a seal, but are issued electronically as a pdf, so this requirement in the statutes is no longer practical.

Sections 5, 6, 32, 53, 56, 59, and 63 require certain insurers to file quarterly financial statements with the Commissioner. These are done in addition to the annual statements that are currently required. This is a requirement we are looking to do based on recommendations

from the National Association of Insurance Commissioners and because of our own experience. We are looking to see if we get more frequent updates as to the financial status of licensees. This will allow the Division to address financially troubled insurers earlier, and it will also allow us to step in and help the insurance company before they are in a financially insolvent position.

Sections 7 and 78 eliminate the countersignature requirement of NRS 680A.300, as there is no need to have a second signature of an additional licensed agent to write or place insurance or surety contracts. If you are licensed with the Division, then you have your license as required under these two sections.

Section 8 changes the annuity taxation in Nevada. After January 1, 2020, all money accepted by a life insurer pursuant to an annuity agreement will be subject to fully earned insurance premium tax upon receipt by the insurer. Currently, life insurance companies have the option to apply the premium tax at purchase—which is what we call front end—or at the time of annuitization—which is the back end—when annuity policies are sold. Annuity contracts are typically annuitized 20 or 30 years in the future and many policies are never annuitized. In our research we found that only 4 to 5 percent of these policies are ever annuitized. This change simplifies the statute so that all companies are subject to the same rules. Additionally, it would ensure that the state collects taxes that are actually due on annuity contracts and that the application of these rules is consistent with the rules that apply for other products sold by life insurance companies.

Sections 9 and 34 change the certificate of registration for service contract providers from one year to two years. It will also make a corresponding change of the initial registration and renewal of the certificate of registration from $1,000 to $2,000. It will increase the fee for the renewal of a certificate from $1,000 to $2,000 and require a provider to submit his or her application and fee for renewal no later than 60 days before his or her certificate expires. This is one of the particular types of companies where there is a lot of additional documentation. We are trying to give them a break on the regulatory oversight so they only have to do this every other year, rather than provide the documentation every year as required currently.

Section 10 corrects a reference in the statutes from NRS 682A.432 to 682A.434, as NRS 682A.436, subsection 4 currently cites the wrong statutory reference. The reference to the acquisition of real estate is applicable to the language in NRS 682A.434, which was added by Senate Bill 67 of the 78th Session.

Section 11 provides clarification that the financial statement provided by each applicant for a certificate of registration as an administrator must be reviewed by a certified public accountant and certified by an officer of the company. The current statute makes no mention of the financial statement requirement at the time of application. The Division needs this information to determine the financial wherewithal of the administrator, as they are financially responsible for handling all the claims of the administration and all the claims payments.

Section 12 requires the Commissioner to submit administrator applications to the Division of Industrial Relations (DIR) only if the applicant is seeking final approval by the DIR in order to administer workers' compensation claims. The statutes currently require the DIR to review all third-party administrator applications, even if the administrator will not be working with workers' compensation claims. This will speed up the transitioning and licensing oversight for those who do not do workers' compensation.

Section 14 eliminates the requirement to pay a filing fee when submitting the annual report of a third-party administrator. The Division believes that the cost associated with billing and collecting the current filing fee of $25 is equal to or greater than the cost of the filing fee itself. Section 14 also revises subsection 6 to amend the nature of the certification that an administrator will receive following their submission of an annual report. It is the Division's position that this certification process is to verify that the administrator is in compliance with Nevada's requirements and that any issue that the Division may have regarding the financial health of the administrator shall be handled separately and apart from this required activity. The whole idea is not to slow down their applications as they are coming in the door for a separate activity that we could talk to them about later.

Section 15 limits the requirement that adjusters maintain a place of business in Nevada to the Nevada resident adjusters. Adjusting claims is no longer solely a local business, as many insurance companies use electronic means to determine claim losses. I am sure you have all seen the opportunities for taking a picture of your car and having the claim adjusted in other states. We want to open the door to that opportunity for those companies that are able to do that, and to do it efficiently and quickly. This does not change the in-state office requirements placed on insurers or third-party administrators who adjust workers' compensation claims in Nevada under NRS 616B.027. That is the requirement under the Division of Industrial Relations, which needs a local presence to actually do their auditing.

Section 16 clarifies that administrator records are to be available for examination and shall be retained for at least three years "after the closure of the claim to which the records apply." The current statutory language is ambiguous as to the starting period of the three-year period for record retention. We are just trying to make it clear for us and for the carriers themselves.

Sections 21 through 26 of S.B. 86 (R1) authorize the Commissioner to designate an insurer which is domiciled in this state and meets certain requirements as a domestic surplus lines insurer and establishes certain requirements and limitations on the transaction of the business of insurance by and with a domestic surplus lines insurer. Under current law, any insurer domiciled in Nevada is considered an admitted or authorized insurer in Nevada, even though it may potentially operate as a nonadmitted insurer in another state. Allowing domestic surplus lines insurers to be formed in Nevada is both a business-friendly decision and one that enables the Commissioner to have more oversight over entities that choose to become a domiciled surplus lines insurer. So far, 12 states have enacted this legislation. As it stands right now, surplus lines insurers are not allowed to sell in the state that they are domesticated in; we wanted to be able to change that. There was a federal law that was enacted,

the Nonadmitted and Reinsurance Reform Act of 2010, which put some restrictions and financial thresholds. We believe it is reasonable to have them in the same state that they are able to sell in—we were trying to open the door for opportunities for companies to come to Nevada.

Section 26.5 corrects the Nevada statutes to reflect that a fee that can be charged by a surplus lines broker applies to surplus lines insurance from a nonadmitted carrier. This had been incorrectly referring to admitted carriers only, so it needed to be done for correctional purposes.

Section 29 authorizes the Commissioner to assess the cost for the review of a proposal to increase or decrease a rate against an insurer. Rate reviews—which is the term for determining premiums and how much the charges are—for individual and small employer health benefit plans have been paid by using rate review monies that came from the federal government under grants since the inception of the Patient Protection and Affordable Care Act. These grant monies are scheduled to expire this spring. At this time, the Division does not believe it is fully staffed to accommodate the current requirement. We are asking for outside actuarial services to continue in order to meet the statutory requirements to maintain our designation as an effective rate review state under the Affordable Care Act. We are choosing not to hire more staff at this time, but to make a request to have this external review done for the next two years until we have this done fully in-staff and with our fully trained people whom we have been working with.

An amendment to this section, made during the Senate Commerce and Labor Committee hearing on behalf of the Nevada Association of Health Plans, was intended to clarify that the ability to assess against an insurer for rate filings review was to be limited to an external actuarial review. The intent of that amendment was changed through the Legislative Counsel Bureau (LCB) Senate Amendment No. 4 to S.B. 86 (R1). The Division has proposed Amendment 1 to section 29 to help clarify that the ability to assess is only for outside, external reviews, and to also correct language that actuarial reviews relate to health insurance carrier filings only (Exhibit F).

Sections 35 through 38 authorize the Commissioner to issue a certificate of dormancy to a captive insurer that elects to cease transacting business in the state for a period of time, as long as they comply with certain requirements and conditions. We are hoping this will increase the appeal of Nevada in attracting additional captive insurance companies to domicile in Nevada. Sometimes they need to take a break or realign their business model. It continues their business process and their business authority while they are working on that.

Sections 39 through 44, 46, and 49 through 51 revise provisions governing captive insurers to distinguish between association captive insurers and state-chartered risk retention groups, for consistency with the accreditation standards of the National Association of Insurance Commissioners. Risk retention groups have a very specific set of guidelines for our financial

review and captive insurers have another distinctive review. A lot of it is because of whom they cover and whether they cover only those risks that are in the state or out of the state, their own risks or others risks.

In addition, section 44 creates statutory authority to allow surplus notes for maintaining capital and surplus for captives. These are allowed for traditional insurers, and we believe that there are perfectly reasonable financial alternatives, so we are trying to give them an extra alternative financial backstop for their use in their portfolios.

Section 45 removes the requirement for an examination prior to the Commissioner suspending or revoking the license of a captive insurer and adds failure to pay taxes on premiums as one of the conditions for revocation. This is being done to make the process of restricting the insurance authority or revoking it altogether less onerous for captive companies that have simply chosen to wind down their business. While these insurers can still request a hearing, this eliminates the requirement to perform an examination on a carrier that has chosen to no longer do business in Nevada prior to suspending or revoking their license. The Division continues to perform financial analysis reviews throughout the process, but the insurer does not bear the additional examination expense if they maintain compliance through the entire full closure period. If they are trying to wind down, we are trying to help them so they do not have to use up their assets to pay for an examination that would not be required or necessary under the financial review that we currently perform on them.

Section 47 modifies the banking arrangements for captive insurers to include a state-chartered bank, state-chartered credit union, or a thrift company located in this state, along with a federally chartered bank with a branch located in Nevada. This language change will open up expanded banking options, which may help attract additional captives to our state.

Section 48 modifies the statutes so that a captive insurer, other than a state-chartered risk retention group, can pay certain dividends or make distributions with respect to its capital or surplus without approval from the Commissioner. Currently, the Division has to approve every dividend that a captive insurance company makes to its holders, while traditional insurance companies only require approval if the dividends are significant. This change will reduce current staff time in reviewing requests for small dividends and allow them to focus their review only for those dividend requests that are financially significant.

Sections 52, 54, 58, and 61 establish minimum capital requirements for nonprofit corporations for hospitals, medical and dental services, health maintenance organizations, and organizations that provide plans for dental care, and revise such requirements for prepaid limited health service organizations. The minimums will help ensure the financial stability of the companies doing the business of insurance in Nevada.

Section 55 of this bill provides that provisions governing rates and service organizations apply to health maintenance organizations (HMO). The statutes need to be modified to reflect that individual and small employer group HMO plans need to be subject to the standards and criteria under NRS Chapter 686B, Rates and Essential Insurance. Section 55.5 provides clarification that provisions governing portability and accountability of individual health benefit plans apply to health maintenance organizations. The idea is to try to pull the health maintenance organization under the same coverage and threshold that we do for any other kind of health plan. One of the reasons you will see that is, when we look at Senate Bill 87 (1st Reprint), we are talking about a guaranty association to cover any consumer who might be in one of those plans.

Section 60 clarifies the language in the statute to help make clear that the identified provisions apply to an agent or broker acting on behalf of a purchasing group, a member of a purchasing group under the group policy, or a risk retention group transacting insurance. This is a request from the industry; they believe the statutes were potentially misleading or hard to understand. As currently written, we agree the statutes could mistakenly be read to only apply to an agent or broker acting on behalf of a purchasing group. This is something we have done working with the industry itself to help make that clarification.

Sections 66 through 69 require the receiver of an insurer in receivership and each guaranty association which is affected by the delinquency proceedings to file certain financial reports as established or specified by the National Association of Insurance Commissioners. We do this so we can share all the information, especially when we are talking about a solvency with our fellow regulators. Very few companies only have consumers in one state. We want to make sure the consumers in every state have information and the regulators themselves can review that information. This was done in conjunction with the provisions to include references to the Insurer Receivership Model Act adopted by the National Association of Insurance Commissioners. This uniform language will provide efficiencies throughout the states for insurance companies to comply with laws and regulations in all the states where they do business. It will also make it easier to provide additional protections and lower rates for consumers in Nevada. Section 79 provides effective dates for this Act.

This concludes my introduction of S.B. 86 (R1) and I will be happy to answer any questions.

Assemblyman Kramer:
In section 1, you have a per diem allowance. I know there are places you can go to find out what a recommended per diem is; when federal employees go someplace, they are allowed a certain per diem. Do you prescribe to a table lookup for per diem?

Barbara Richardson:
The per diem is not only the government per diem, but we also use a per diem that is put out by the National Association of Insurance Commissioners that specifies what is allowed for determining the rate for compensation—it does not allow you to charge too high or too low. Those are all published in the *Market Regulation Handbook* and *The Oxford Handbook of Financial Regulation*.

Assemblyman Kramer:
I will assume that you abide by those and we are in good shape. Last year I took the Series 7 exam, so I am familiar with some of this. In section 8, I know that you are paying into an annuity, it can be converted to a savings account and thus is not an insurance product unless it is annuitized. This sounds like you are going to collect the insurance premium tax as it is paid in, thus having less money working for you going forward. In fact, you said 45 percent are never converted. Somebody is going to come back later and say, I want the tax back because it was not owed, yet the individual has lost the power of 3.5 percent of every payment put in, for all the time put in. This sounds very destructive to the individual who is buying an annuity. Can you comment on that, please?

Barbara Richardson:
You are right. It is very complicated and there are quite a few bits of moving parts. When we looked into this, we found that the 3.5 percent tax itself would not be taken out of the person's capital, but would be paid by the insurance carriers that are selling—much like the commission is currently paid. We looked at the Texas law, and we are potentially considering putting in an amendment to this particular section so the person's personal capital would not be affected by whether or not it was annuitized and whether or not the premium tax was paid. As it stands right now, that door is open to do exactly what you commented on. When we found that out, we went to start drafting—but we do not have that in front of you today.

Assemblyman Kramer:
That is major for me right now. You are talking about the difference between investing in a mutual fund and investing in an annuity—they both have their pluses and minuses. The way it is currently written, this would throw annuities out the door; they would no longer be feasible. In section 26, surplus lines of insurance with domestic—would you go to your notes again and please refresh my memory—it was not clear to me what that section is trying to do.

Barbara Richardson:
Currently, surplus lines companies are not allowed to be licensed in the same state where they sell the surplus lines products—except under the federal law, the Nonadmitted and Reinsurance Reform Act of 2010. They started making requirements on the solvency controls. Once they did that, quite a few states, including Nevada, said we should really look to find out if these solvency controls are in place. There is no reason why we could not allow them to sell to our consumers.

Assemblyman Kramer:
Did I hear you say what is in section 29 now is not how you are finishing it? You have an amendment to make so the "perform an actuarial review" is not on every rate change, but only on some. How did that work out?

Barbara Richardson:
It is not on every rate change; it is those rate changes that happen during that very limited time period—during the summer months when we are doing Affordable Care Act review.

Assemblyman Kramer:
And only health insurance?

Barbara Richardson:
Yes. That is why we are trying to be specific under the amendment. We believe it got confused as it came through the LCB process; but that was the agreement that we made.

Assemblywoman Neal:
In section 29, subsection 5, the pass-through where you are allowing the assessment against the insurer: Is this going to be a temporary pass-through until you get staff or is it going to be permanent?

Barbara Richardson:
The hope is that it will not be permanent. Every year we have been using our outside resources less and less; we are now in a peer review process. However, we still need to have that peer review done. I cannot tell you whether it will be two years or three years; that is the reason why we are uncomfortable making that determination.

Assemblywoman Neal:
In section 47, the state-charted bank and state-charted credit union, NRS 694C.310 says they need to make adequate arrangements with a bank for the transfer of money. Why do you need to expand the authority? Are they unable to currently do that?

Barbara Richardson:
I appreciate that question, specifically because it is something to do with the space. It has to do with the cannabis industry, and any kind of brand-new industries, they tend to try to stay in the state market. We have been working with the Division of Financial Institutions in the Department of Business and Industry and they are looking at ways to make the allowances on their side. Their banks have to have an insurance policy that covers them, and we have to have a policy that covers a portion of the banking piece. These are part of a two-level process in order to make the potential for using those banks available for non-federal-type industries.

Assemblywoman Neal:
Have you been documenting the type of transactions they are needing this for, since you mentioned marijuana?

Barbara Richardson:
Yes. This just happens to be a very large one, so that is why we have been focusing on it.

Assemblywoman Neal:
In section 48, you mentioned the captive insurer and the extraordinary dividends. What was happening with the current structure of dividends? Were they manipulating the law and paying dividends that they were not supposed to, so now you needed this carve-out to make sure you can do it here and there?

Barbara Richardson:
Actually they were not; they were fine. Sometimes we had to review a dividend for $15,000 back to its own parent company. We are talking very small; they are not financially significant; they do not harm the company. Captives are supposed to be insuring their own companies' risks. If they want to move small amounts that does not harm the captive insurance program itself or the carrier, it is their money—we sort of feel awkward trying to control those bits when it is really minimal payments.

Assemblyman Daly:
Can you give me a little more explanation on section 8 regarding the annuity? Are you trying to capture a date when the insurance company provides an annuity? There is a provision when they are supposed to pay taxes, but if it happens 20 or 30 years later when someone gets the annuity or begins payments, everyone has lost track of it and we are not sure if we are collecting everything that we should. Can you explain a little more of what you are trying to do? How it may benefit or impact the state? What happens if nobody ever gets to the annuity and they have already paid up front?

Barbara Richardson:
There are two ways to look at the annuity: Some people use it as a savings account and others use it as an annuity. There are times when you save for a long time period and it never annuitizes. If it never annuitizes and you paid your tax up front, there is a section of the tax code that allows you a refund. Trying to figure that out for the Department of Taxation was getting really rough—they could not figure it out because we are talking 20 to 30 years down the road. Then there were times when it actually annuitized but, depending on how you took the funds, you either took a little bit or you took it all in one shot, then trying to find a consumer to pay the premium tax. Having the Department of Taxation find that information many years down the road was extremely rough, especially since we found that only 4 to 5 percent were actually annuitizing. The idea is to try to get the information up front, have it part of the market strategy, the same type of overhead payment as you would for commissions or any kind of overhead cost when you purchase the product. It does not matter what the product is. We are concerned that not only do we not collect for our own state citizens, but should you move in from another state, there has been a claim that you will lose that money if you have a back-end tax collection. The problem is we do not pay income tax here, so there is nothing to tie it to, there is no way to know if that tax is actually being paid. It is just to clear up the tax implications.

Assemblyman Daly:
People will be paying this as they go as part of the premium, and it will be up to them at the end if they have something coming back to apply to whomever they need to—if they even know about it. In section 23, regarding the surplus lines insurer, if someone sells that kind of insurance and they are in Nevada, they can only sell it to other states, not in Nevada. Why was that a law? Is it like the Lloyd's of London insurance, unusual insurance, surplus stuff that nobody else would insure?

Barbara Richardson:
It is not just the ones that no one else will insure like Lloyd's, because Lloyd's is the most famous. There are lots of surplus lines companies and they do million-dollar homes, the homes in Incline Village that have problems getting fire insurance; they will do arenas in Las Vegas. Those can be done by the large surplus lines groups. One of the concerns is because they did not want to have a potential for the loss happening in the same state where the money was being held. Now that these new solvency and financial wherewithal requirements are put into place, you do not have that same fear anymore.

Assemblywoman Tolles:
Under section 11, I noticed that each applicant for a certificate of registration has to submit a financial statement. Previously it was certified by an officer, but it has been elevated to a level where it has to be reviewed by an independent certified public accountant. Could you give us more of the background for that change?

Barbara Richardson:
We were finding this particular type of administrator was very good at administering claims, but did not always have the understanding of the financial requirements that were necessary to hold enough secure funds in order pay the claims. As it turns out, they might be financially on the hook for anything that happens to the carrier—this was our way to help them easily qualify without having us make significant additional requirements on top of them. Having a certified public accountant (CPA) do that review was more fitting with the size of their business, their portfolio, and their risk capacity.

Assemblywoman Tolles:
In the process of making that determination, were there any concerns raised about the additional expense being incurred by having to hire a CPA?

Barbara Richardson:
I believe we did review it, and I think it was always a concern. But we also felt this was a better way than putting additional financial requirements on people who may not have needed it. There is usually a one size fits all, if you tell someone you have to hold $5 million, or you can get a CPA to say you only need $3 million. We just thought that was a better way to handle it.

Assemblyman Edwards:
When will you have the amendment? The session is almost over, and without the amendment to correct the situation with the annuities, I would definitely be a no. When might we see the amendment?

Barbara Richardson:
We had it Friday, but we did not make the 12 p.m. deadline, so we did not feel we should be bringing it forward. We can submit it anytime for you.

Chair Spiegel:
As soon as you can, please submit it.

Annette James, Lead Actuary, Division of Insurance, Department of Business and Industry:
I will discuss with you the amendment in section 8 (Exhibit G). Section 8.5 amends NRS 680B.027 in subsection 1 to reduce the tax rate for annuity contracts to 2 percent, but remain at 3.5 percent for all other products. Subsection 4 adds the following language:

> With respect to annuity contracts, the tax on net direct premiums and considerations shall be paid for by the life insurer providing such contracts and not netted against the premiums or considerations paid by the owner of the annuity. Nothing in this section prevents the insurer from including the cost of the tax on net direct premiums and considerations for annuities in the pricing of the annuity.

Those are the two main changes; there was a small change in section 8, subsection 2, paragraph (b) to correct a typographical error—the word eligible was changed to ineligible. The point of that correction was to clarify that it is a front-end tax, and when the annuity is surrendered prior to annuitization or at end point, there is not an offset to the taxes.

Chair Spiegel:
We do not have a copy of what you are discussing. Once we get copies, we will come back to this so we can have a better understanding of what you are saying.

Assemblywoman Jauregui:
I share the same concerns as Assemblyman Kramer. In sections 36 and 37, regarding the dormant captive insurer, could you walk me through that? It looks like we are introducing a new line of insurance for those who are no longer practicing insurance. What do we currently do when insurers cease to sell all insurance products?

Barbara Richardson:
This is just for captives; they are insuring their own risks. Sometimes they decide for business purposes that they want to change the risks that they are setting up, or that they want to put it on hold for a couple of years and they want to try an alternate type of risk transfer method. For example, the Tycos of the world, they have insurance on top—that is a captive

piece of insurance. What we are finding is, if you wanted to hold and think of a way you wanted to move your business, you had to shut the entire business down, which meant going through an exam, there was additional cost, you had to wind down your business with all these additional requirements. A dormant clause lets you hold it out there—you have to pay all your taxes and fees, but you do not have to run down the business. If you start it back up the exact same way that we review it, if you start it up with additional types of risks, then we review it completely separately. It opens that door for allowing a hold pattern. There would not be new insurance; you would have to have actually already passed and become a captive insurer before you can even step into the dormant period.

Assemblywoman Jauregui:
The way it is worded, they would have to stop all insurance because it says, "ceased to transact the business of insurance."

Barbara Richardson:
They would stop. The Tycos would say, I am not going to do this type of insurance anymore, they would take that and hold it; but the company still exists so they do not have to go through that process.

Assemblywoman Jauregui:
Section 34 looks like it pertains to applicants who are sending their information with their application, and it appears you are doubling the application fee from $1,000 to $2,000. Can you explain why we are increasing it 100 percent?

Barbara Richardson:
Service contracts are the types of companies that are only licensed for a year, so they have to renew every year, so we are increasing it to $2,000 for their renewal.

Assemblywoman Jauregui:
Is that a 100 percent increase they have to pay every year?

Barbara Richardson:
No, they pay $2,000 for a two-year license instead of $1,000 for a one-year license.

Assemblywoman Neal:
In sections 52 and 54, both of these provisions are expanding the minimum capital requirements. Clearly there is something going on, because you are directing this to the HMO in section 54, and in section 52 you are addressing the minimum capital requirements for hospital, medical, and dental services. What was going on where you needed to get these additional protections? Was there some instability or occurrences that were happening where you said, We need to step in and fix this?

Barbara Richardson:
There was not great instability in the market. We were finding they could not be qualified under the guaranty association, which would create more protections for consumers.

We wanted to make sure all the companies were being treated equally, so when the consumers are under the guaranty association, they will be treated equally. The fear is if a company goes insolvent, all the companies that are paying in to taking care of the consumers under that insolvency are treated fairly and exactly the same. We made some adjustments to the HMO financial wherewithal and the financial oversight in order to put them in the same position.

Assemblywoman Neal:
Last session you had a big bill with a provision regarding insolvency, or trying to solve that problem. Is there an interrelationship to this provision similar to what you were trying to do last session?

Barbara Richardson:
Yes, this was the continuation of it. This bill and this section have to do with that. Also, Senate Bill 87 (1st Reprint), which actually fleshes out the rest of the guaranty association, is the final piece of that puzzle.

Chair Spiegel:
We were just given the memorandum from Ms. James regarding section 8 (Exhibit G). Could you please walk us through your memo, Ms. James?

Annette James:
There are three areas of the amendment. The first one indicates that the return of monies for an annuity due to the surrender of a policy will not constitute a return of premium. Secondly, we are suggesting the tax rate for annuities would be 2 percent instead of the 3.5 percent on other products. We looked at what the other states had for a premium tax on annuities and found the premium tax on annuities was consistently less than the premium tax on other products. The third section is where we indicate that the tax would not be paid for by the consumer; it would either be absorbed by the company or incorporated into the pricing. We looked at the other states that had annuity premium taxes. Florida was the one that used this approach, so it would not burden the consumer with the premium tax. With this amendment, when the tax is incurred by the company, it would not be passed on to the consumer. If you have $100,000 annuity purchased, the consumer would get the full benefit of that $100,000 instead of part of it being set aside to pay for the premium tax.

Barbara Richardson:
I wanted to clarify, when Ms. James said third section, it is subsection 4 of section 8.5, but it is the third change.

Chair Spiegel:
Could you please walk us through the fiscal impact of this change? It looks like you are dropping the rate, but perhaps you expect to collect it from more people. Could you just explain to us how that would work? Do you anticipate using some current data? How would you forecast it?

Annette James:
It is really difficult to answer your question. The data that we would need to do that calculation is not easily available from the Department of Taxation; but I can explain the moving parts. Right now it is 3.5 percent, but only upon annuitization. For deferred annuities, only 4 to 5 percent actually annuitize—that is a really small percentage. One hundred percent of the immediate annuities are taxed up front; there would be no change for those as far as the timing of the taxation. We came up with the 2 percent as a starting point because we recognized that if all of the deferred annuities are going to be taxed, the income to the state will be increased—anywhere from 1 to 2 percent would result in an increase in the money coming into the state. We did not have the actual data; we did some general calculations. It is our estimation that if it is 2 percent—even if it is a little less—it would result in an increase in the actual amounts collected by the state.

Assemblyman Kramer:
Your amendment says, "Total income derived from direct premiums written." If I am putting money into an annuity in the years before it is annuitized, how much of the money I am putting in is the premium?

Annette James:
The way it is defined in our statutes, the entire amount you put in to purchase that annuity is considered a premium—taxable income.

Assemblyman Kramer:
That means if I have a bank account and put money in every month, I do not pay anything to the state for the privilege of putting money into a bank account. Now you want me to pay 2 percent of that each month, for the life of the account I will be paying 2 percent to the state, which means the fund I have will be growing less. If I just took the money out and used it as deferred, part of it having taxes paid on it and part of it not having taxes paid on it, I would not pay any of the tax. Under your plan, at that time I would get a refund, somebody would get a refund of the 2 percent that had been paid in every year. You talk about trouble with calculating the amount. I think your trouble is still going to be there—I am not sure what it saves you. I think you are creating a product and you are driving it out of the market by saying it is much better to buy a mutual fund or a bank account rather than an annuity. I think you are just saying we do not want annuities anymore in this state. You are taking the benefit of increasing what you are paying into it away. If you take 2 percent off the top in earnings, some years that would be a negative amount. I just have a tough time seeing how you are promoting business.

Annette James:
There are a couple of pieces to your question that I would like to address. First, the tax right now on annuities is only for nonqualified annuities. Qualified annuities that are purchased using qualified money, or pretax money, like money from an individual retirement account or 401(k) or 403(b), the premium tax rate is zero—at least in Nevada. In other states, there is a tax; it depends on the state. In this state, only the nonqualified annuities are taxed.

Secondly, with this amendment we are trying to remove the burden from the consumer to pay the tax. This is similar to the Florida law that requires insurers to absorb the tax and include it in their pricing, if they so choose. If you refer to it as if it were a bank account, money would be taken off every month to pay the tax—that is what we are trying to avoid. Under the current law, that is what will happen—3.5 percent will be taken out of the account. Currently insurance companies can choose to pay it at the front end or at the back end. Those that choose to pay the tax at the front end, this is really no change, except the money is not coming out of the consumer's pocket. I hope that clarifies your question.

Barbara Richardson:
The best way I can describe it is it goes back to the commission; that commission is actually part of the requirement of the insurance carrier. It is not deducted from your initial payment. If you put $200,000 in, that is your capital, it stays $200,000. What this amendment is trying to do is treat the premium tax the same way that you would be treating the commissions. It would not come out of the initial dollar amount.

Assemblywoman Neal:
I understand that the change is not going to be passed on to the consumer. You said the tax can now be part of the pricing. If you calculated it out, what would be the price of the product itself? How much is the price going to increase?

Annette James:
It depends on how the carrier will handle the cost. It would be similar to how they handle commissions or any other overhead—that is all baked into the pricing. The way it is reflected in the actual cost of the product will be different depending on the carrier.

Assemblywoman Neal:
You talked about the timing of the tax. You said the only difference is that if you were already paying it on the front end you are not affected; you are affected if you were paying on the back end. Is that correct?

Annette James:
Partially. If you are paying on the front end right now, there are two things we are suggesting with this amendment. First, the tax will be reduced from 3.5 percent to 2 percent. Second, if you are paying on the front end and the annuity is surrendered, the amount of that annuity will be deducted from the premiums that would be taxable. With this amendment, since it is a front-end tax, the intent is to treat it as we do commissions—you do not get back the commission if the product is surrendered. On the back end there would be a change. They would now be paying it at issue instead of upon annuitization, and the 2 percent, instead of the 3.5 percent, would reflect the fact that the change from being able to offset the surrenders will in fact require a lower percentage to have the same cost.

Assemblywoman Neal:
The amount that we will collect on the 2 percent; it sounds like we are going to collect everything. What is still not clear is the amount that will drop into the bucket around

insurance premium tax—I did not hear that. Did the Department of Taxation come up with that number? Are you going to come up with that number soon? Are we going to know what is going into the bucket?

Annette James:
We came up with the 2 percent, but it could be lower. When we look at the tax rate that is charged for other states, the rate was between 1 percent and 2.35 percent —I think California is the highest at 2.35 percent on nonqualified annuities. We came up with 2 percent as a starting point for Nevada. We believe that you could go down to 1.5 percent, or even lower, yet still have an increase in the amount of money the state collects.

Chair Spiegel:
From any of the other states that are in your chart, such as Florida, have they been doing it similar to Nevada and then made the change, or is this how they have always been doing it?

Annette James:
Could you repeat the question?

Chair Spiegel:
I am looking at the chart in your memorandum regarding the premium tax on annuities by state. I was wondering if any of these other states had been structured as we are in Nevada, where it is paid on the back end, and then it made a shift to collecting it on the front end. If so, what states are those and what was the impact of those changes? Perhaps we could look at some comparables to try to get an assessment. We could reasonably assume if people in Nevada act like people in the other states, we would get collections from X percent more, and this is really the fiscal impact we could be looking at.

Annette James:
I do not have that information, but I am happy to get it and respond to you.

Assemblyman Edwards:
The more you have explained it, the more questions I have. It sounds as if you are saying we are going to tax this product at 3.5 percent from the beginning, and then we are going to tax it 2 percent as it develops over the years. Yes or no?

Annette James:
No. Let me try to explain again. Right now the state of Nevada taxes annuities, and the insurer can choose whether they are going to apply the tax on the front end or the back end.

Assemblyman Edwards:
Right now everybody is doing it on the back end.

Annette James:
Right now that is what is happening.

Assemblyman Edwards:
You also mentioned that 45 percent of these actually do annuitize, which is actually a pretty high percentage.

Annette James:
I said 4 to 5 percent, not 45 percent, of annuities actually annuitize; 95 to 96 percent do not.

Assemblyman Edwards:
So this bill is actually going to say, We know it is not going to annuitize, but we are going to tax you up front. It is kind of like walking into Walmart to buy a television; you do not actually buy the television, but you still get charged the tax. Right? Because you are collecting it up front, based on your expectation that you are going to annuitize it, but we know that 97 percent do not, so we are taxing that 97 percent on a product that they will never receive. I do not understand how that could possibly be fair in any world.

Annette James:
Let me try again. The way the annuities work is that you pay either through a single deposit or periodic deposits. You can decide to terminate that contract prior to annuitization, which means you get all your money back, plus all the interest or investment earned on the principal you put down.

Assemblyman Edwards:
But you do not get the interest you would have earned if you had not paid the tax, the 2 percent over the year. You are taking away 2 percent of the return on investment each year.

Annette James:
Right now, that would be the case. The amendment is intended to make sure that the consumer gets the full amount of the investment back. The 2 percent—or whatever this body decides is the right amount—premium tax that will be paid by the insurance company, not the consumer. If the consumer decides to surrender the policy or decides to annuitize, that consumer is in the same position because the amount of the premium tax would not be deducted from the principal.

Assemblyman Edwards:
Any company that would sell this product is going to include that 2 percent in the pricing of their premium, which means the consumer is paying it and the consumer is losing that buying power in the return on investment. Which essentially means we are going to destroy the annuity market in Nevada, because nobody in their right mind would buy a product like this.

Annette James:
I understand your concern. This is the approach that Florida has taken, and that is why we looked at this as a possible solution to some of the concerns that were raised about the consumer being negatively impacted.

Assemblyman Edwards:
I think this is going to grossly negatively impact any consumer, because the tax is paid up front and paid each year. Their buying power is lost, there is no real benefit to the actual consumers trying to save for their retirement. This is going to destroy the annuity market here in Nevada. It will probably destroy the annuity market in Florida, too, if this is what they are doing. The economics just do not work out.

Barbara Richardson:
I understand what you are saying. Right now the 3.5 percent is taken out of the consumer's investment. What we are trying to do is stop that from happening. I know it sounds like the 2 percent would still adjust the price, but in fact it adjusts it much smaller across the entire market. It is much like when you buy life insurance products, the person who sells them can earn anywhere from 7 to 10 percent, or sometimes 45 percent; but no consumer feels it because of the way the pricing works—there is such a broad base. If we can require the carriers to make it as part of their operational costs, which is what we are intending to do, then the consumer should not feel the bite. I understand it feels awkward, but it has to do with the huge risk that we are talking about.

Assemblyman Edwards:
It feels flawed. The operational costs of any company are going to be borne by the price that they put on their product—which means the price is going to go up and the consumers are going to lose. No matter how you slice it, the consumer ultimately will pay the tax. It cannot simply be shifted to the company. The economics you are working with just do not add up.

Chair Spiegel:
I think we are ready for testimony in support. Is there anyone to testify in support of S.B. 86 (R1)? [There was no one.] Is there anyone to testify in opposition to S.B. 86 (R1)?

Assemblywoman Sarah Peters, Assembly District No. 24:
I have a friendly amendment to Senate Bill 86 (1st Reprint) that I would like to present (Exhibit H). This amendment adds a reporting provision to Nevada state law which would require insurers to demonstrate compliance with an existing federal law passed in 2008—the Mental Health Parity and Addiction Equity Act of 2008, also known as the federal parity law. This law requires insurers to cover illnesses of the brain, such as depression or addiction, no more restrictively than other illnesses such as heart disease or cancer. You may ask yourself, why do we need a new law about a law that is already in place? I do not know about you, but I got a number of phone calls from people who said it is very unclear what is covered, what is not covered, what you have to fight for, what should already be there—this is especially a problem in mental health.

Submitted to the Nevada Electronic Legislative Information System (NELIS) is a handout describing seven common parity violations a patient may face from their insurance company when seeking treatment for behavioral health conditions (Exhibit I). These can include higher copays and deductibles for behavioral health providers, charging more for a mental

health prescription, or refusing to cover residential behavioral health treatment as recommended by a doctor. We hope that requiring these analyses to be reported will provide the state with confidence that its insurers are meeting stipulations of a law that is essential to addressing the opioid crisis and rising suicide deaths, which claim over 300 American lives each day.

Currently, the Division of Insurance can only investigate complaints of parity violations if a patient or family member submits a report of a suspected violation to the Division. You have to know there may be a problem, how to report that problem, whom to report it to, and defend your report—that is a lot for a layperson to take on. This reactive approach to enforcement leads to delays in care and can cause some patients to give up on treatment altogether. When you ignore mental health treatment, you risk lives.

A federal judge found widespread noncompliance in his ruling involving United Behavioral Health just two months ago. I submitted a copy of an article from *The New York Times* reporting that Judge Spero found United had discriminated against persons with mental illness and substance abuse disorders by restricting access to care with internal policies infected by financial interest (Exhibit J). With this amendment, we are simply asking for a proactive approach—requiring documentation that insurers are in compliance with the current federal law. You may hear from insurers that they are already in compliance with the Mental Health Parity and Addiction Equity Act and this reporting requirement is unnecessary.

A few months ago, a friend of mine who is a constituent came to me. She moved to Nevada approximately ten years ago with her two children. She left an abusive relationship in which her daughter had been sexually molested by her father. Her daughter has been in and out of therapy most of her life. Last year, her daughter went to her mother and said, I am no longer Maggie, I am Max, I am more comfortable being a male than I am being a female and I want you to respect that. During this time, she had also experienced depression, anxiety, attempted suicide, self-harm, suicidal ideation, bulimia—all of which she asked to get treatment for. Her mother went through the process and called her insurance company. She went through the process of calling her therapist and tried to get her daughter the treatment she needed to help restart her life as Max. She was told that she had one choice in Reno, and that one choice was not particularly well suited for lesbian, gay, bisexual, transgender youth. She was afraid to send her daughter there, her daughter who already had trauma to her body. Her mother found a place in California that was highly recommended to parents of transgender children and wanted to send her daughter there. She petitioned, but was continually told, only if the doctor says she needs to be admitted—which only occurs if that child is under extreme duress—then she could get ten days. After the ten days, the doctor would have to call the insurance company and justify keeping her longer. All Max wanted was to be able to restart their life, to figure out how to deal with depression, anxiety, and self-harm. Her mother was trying as hard as she could. Her mother decided to send her

daughter to this place, and after a lot of work she managed to get an outpatient waiver; not everybody has that in them. This woman is amazing, she works in social services, so she knows the process. It was hard for her to watch her daughter hurt herself. Going through this process caused her own depression, anxiety, and mental health care needs.

I am particularly passionate about this issue. My grandfather moved to Nevada in the 1970s, specifically because of the mental health care crisis. There is still a crisis. Despite the federal act being passed in 2008, we still see disparities. I imagined Max's mother going through this process. I thought, Would she have to go through this process if she had been hit by a car? If Max had been hit by a car, debilitated, her legs broken, and she needed to go into an in-care facility where someone could help her get back on her feet, there would be no question as to how long that would take. The fact that she has to justify being in a facility for more than ten days to get coverage is not parity. If it takes a doctor to determine whether a child needs care or not and to have to justify it over and over again, that is not parity.

I jumped into my grandfather's connection to this. He specialized in treating patients with addiction issues. He was also a professor at the University of Nevada School of Medicine where he taught generations of doctors. If you have gone to a doctor in the Reno/Sparks area who graduated from the University of Nevada between 1976 and 2007, they would have been taught by my grandfather. He was battling the same issues that we are battling today: access to health care, parity to health care, ensuring that our health care providers are treated equitably.

This amendment is a small step. No patient should be denied coverage by their insurance company simply because their disease is in the brain. This proactive approach simply asks that insurers, already subject to regulation by the Division of Insurance, demonstrate their compliance with the Mental Health Parity and Addiction Equity Act by submitting this annual report. This is one small step towards ensuring parity in Nevada. Mental Health America lists Connecticut, Maryland, Minnesota, Vermont, and Oregon as the five states with the best parity laws. This comparative analysis approach has been enacted over the last year in virtually identical pieces of legislation in Colorado, the District of Columbia, Delaware, Illinois, New Jersey, and Tennessee. In all of those states, the insurance industry dropped opposition to the legislation. I would also add that most states have some additional parity laws, and some go even further than the federal law.

This amendment would not add additional requirements on insurers beyond demonstrating compliance with existing federal law. If you like, I can walk through the new sections proposed in the amendment or stand for questions.

Chair Spiegel:
Yes, please walk us through your amendment.

Assemblywoman Peters:
The first part of the amendment [page 1, (Exhibit H)] details the reporting required by insurers. Subsection 1 adds individual and small employers to the types of insurance plans that must comply with the Mental Health Parity and Addiction Equity Act of 2008. These insurers are already subject to the oversight of the Division of Insurance; this clarifies that they must comply with the Parity Act as well.

Subsection 2 inclusive, states that these insurers must submit a report on or before March 1 of each year to the Division of Insurance with information on their process for determining medical necessity for mental health and addiction treatment as well as for medical and surgical benefits. This ensures that the determination of necessity for mental health care is not more restrictive than the determinations used for medical and surgical benefits. In paragraph (b), the insurers must also identify any non-quantitative treatment limitations placed on mental health and addiction treatments as compared with any non-quantitative limits on medical or surgical treatments. Non-quantitative treatment limits include policies like fail first, which means you have to try one option and not get better on that option, or step therapy for medications, requiring prior authorization, determining reimbursement rates, and formulary designs for prescription drugs. These policies, typically used to control costs, can still be used by insurers so long as they are doing so fairly, without discriminating against mental or behavioral health by placing more limits and restrictions on those treatments.

The amendment further requires that the insurers analyze and report the results of their analysis showing that the criteria for medical necessity and non-quantitative treatment limits are applied equally across mental health, addiction, medical, and surgical benefits. Finally, the section requires that the insurer disclose these findings showing they are in compliance with the federal Parity Act.

The second part of the amendment [page 2, (Exhibit H)] outlines the duties of the Commissioner of Insurance in ensuring these reports are completed. We also ask that the Commissioner submit a report and presentation to the Legislative Committee on Health Care no later than June 30, 2021, discussing the methodology used by the Commissioner to determine compliance with the federal Parity Act, compliance with this new section, and any educational or corrective action taken to ensure compliance.

In closing, I would like to add that the December 2017 Milliman Research Report on disparities in network use and provider reimbursement rates found that there is value to insurers and patients in having health plans conduct a detailed assessment to ensure compliance with the Mental Health Parity and Addiction Equity Act. Conducting and reporting such an analysis will ensure patients have the coverage they paid for and are entitled to through their insurance contract, help reduce barriers to mental health care,

provide a higher level of customer satisfaction for insurance companies, and ensure a healthier population which will reduce costs of care in the long run. One last note, the amendment was developed in collaboration with the Division of Insurance. They are neutral but have no objections to the amendment and are available to answer questions you might have.

Assemblyman Kramer:
As I read the amendment (Exhibit H), some of the terms used are not very familiar to me. In subsection 2, paragraph (a), "A description of the process used to develop or select the medical necessity criteria for mental health or addiction benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits." We are doing an annual report and describing the process for the mental health side and the medical and surgical benefit side, it is identification of all non-quantitative treatment limitations that are applied to both, and that there be no separate non-quantitative treatment limitations for the mental health side. Is that a statement, or is that a measurement?

Assemblywoman Peters:
It is a statement.

Assemblyman Kramer:
So paragraph (a) is something you have to do, and paragraph (b) is a qualifying statement on paragraph (a). Then it says for each of the criteria described in (a), and again for the non-quantitative treatment limitations which you cannot have for mental health, it says, give me the necessary criteria, the processes, strategies, evidentiary standards, or other factors. Is that something that will change as time goes on, or is that fairly static once it is identified?

Assemblywoman Peters:
That is a really good question, but I am not personally in the field, but I do work in data quite frequently.

Barbara Richardson:
Medical necessity is actually a term of art in the field. It actually can change but it changes in general; the whole block changes. It is not something that changes from day to day, it changes across the board with medical.

Assemblyman Kramer:
This looks like each company is going to develop what their criteria is for both mental health and medical surgical, and make a statement as to where they are. I do not see where there is a moving document that changes once this is done. Having created this and disclosed it to everyone, I do not see how it would change from year to year unless they went in and revamped their program. It does not look like it counts people, the number of occurrences, how many people have applied, or how many people have been rejected, based on this criteria. How would this reporting affect an individual?

Assemblywoman Peters:
This amendment is to look at parity; how the two processes compare what the determination for necessary care is. It is also an annual report. If those determinations change, we would see it in the next annual report. I have a friend who can tell us how this works on the clinical side.

Genevieve Ramos, Director of Operations, Serenity Mental Health, LLC, Carson City, Nevada:
I am a licensed marriage and family therapist, a clinical alcohol and drug counselor, as well as the director of operations for Serenity Mental Health. I just wanted it to be clear that I am very qualified to speak on this topic. Currently, the federal Parity Act states that the medical and surgical approvals must be compared to the mental health treatment approvals. However, the mental health treatment evidence-based practice approaches and standard of practice are not outlined as a comparison to current medical and surgical. For example, there is a face-to-face individual mental health treatment provided when someone walks into a clinic—they ask for a diagnosis, a therapeutic approach, and assistance to help with a problem. Is that comparative to a primary care doctor, where you get the flu and you are able to go to your primary care doctor anytime you are ill, you have the flu, a cold, or a nodule you want looked at? We have evidence-based practices in mental health that have no identified comparison such as is it considered primary care, is the hospital inpatient center considered an emergency. What is considered an emergency? These things are not outlined; therefore, insurance companies do not have very good policies in place for those of us in the mental health field who are looking for a treatment to be approved based on our clinical judgment. Where do we go, whom do we ask, how do we fight for our patients' needs and rights if those things are not identified? Initiating this policy would assist in opening that conversation to determine these factors. Right now, with their being undetermined, patients have nowhere to go to ask these questions; clinicians have nowhere to go to fight for rights.

There was a 12-year-old foster child who needed emergency medicine based on a homicidal ideation as well as homicidal action. At this point, the child should have been hospitalized, but insurance denied treatment. The parents contacted the outpatient clinic, which happened to be Serenity Mental Health. They had questions but did not know where to go. They wanted to file a complaint and advocate for this foster child who desperately needed an inpatient facility, but the insurance was denying it. Providers are regularly providing free services. There are no regulations except for our ethical dilemmas. This amendment would provide a regulation where we would know whom to go to for assistance when these situations happen.

Assemblyman Kramer:
That is the crux of what I am asking. What does this provide? It looks to me like this provides for every person providing health care; they would have to say this is how we treat these types of symptoms. If you came in with a broken leg, you would do this; if you came in with depression, you would do this. Each category of symptoms would be broken down. Is that what this does?

Assemblywoman Peters:
The determination for qualifications of necessary coverage does occur based on what is needed. If I have pneumonia, I need a prescription for an antibiotic so I can get better. The broader qualifications of that may look different when they are written. I am not entirely sure how the industry already qualifies these non-quantitative treatment limitations. I am not sure it is going to be as specific as if someone comes in feeling sad they will get XYZ versus someone who comes in with a cough gets XYZ. I think it will be a little broader than that, but it would definitely create a comparative.

Assemblyman Kramer:
That is part of what I am asking. After this is developed, would the list of symptoms and treatments remain the same going forward? From what I see, the annual report does not count people or incidences, so it is kind of like you develop a treatment strategy and unless something changes. Why is that an annual report requirement?

Assemblywoman Peters:
This is to develop a baseline of the comparisons. In the best-case scenario, they would be equitable to meet the federal Parity law. As a body, we and the Commissioner can decide that they are adequate and we really need to be addressing something different. As cited in Judge Spero's findings, we do not see parity in the way that mental health and physical health are treated through our insurance companies. This is trying to get to a potential issue, but we may have to address the bigger picture. The insurance companies may say they are in compliance. Right now I do not see anything that suggests that they are in compliance. I do not have access to any of that information—this would give us access to that information.

Assemblyman Kramer:
I accept what you are saying. I think once this is decided by someone, it really would not change, so the need for annual reports is not there. In subsection 1, it refers to NRS 689A, 689B, 689C, 695A, 695B, 695C, or 695F. Those are all private insurance companies. I do not see NRS 695I, Public Employees' Benefits Program, or self-insureds—those three groups are the majority of the people in this state. Is this likely to be the most intensive group of people you are talking about, and the ones you want to know most about, is why you want to go after them? Is there some reason that segment of Nevada are the ones you want the baseline on and not anyone else?

Chair Spiegel:
Can we have the Commissioner come up and answer some of these questions?

Barbara Richardson:
The bulk of the different plans you are speaking of are the Employee Retirement Income Security Act (ERISA) plans, so they are outside of our requirement. By focusing on the carriers that we are talking about, we are going to get the bulk of the carriers who are selling in the state. For example, Anthem sells to the small group, they sell to large groups, they sell to all the different ERISA plans. If you can figure out what they are using as a baseline, you can get a pretty good idea of what they are doing in the ERISA market, even if you are not in

the ERISA market or actually asking for any information in the ERISA market. This would give a pretty good baseline set of data. The other question was whether or not once this is said and done, would it need to continue? We have seen more and more treatment plans coming out across the board, either on mental health or opioid addictions and also by physicians, like surgeries—they change more rapidly than they did in the past. I would suggest having the annual reports, given how quickly and intricate our new potential treatments have been. Maybe ten years from now we will want one biennially.

Genevieve Ramos:
The purpose of this is to construct oversight and have enforcement—continuity through the insurance companies. It is to assist the patient by simplifying some of the language as well as ensuring there is clarification and consistency. If you can go to your primary care doctor 12 times a year, you should be able to go to your therapist or psychotherapist 12 times a year—easy language clarification and continuity. Right now there are some insurance companies in Nevada that allow you unlimited access to your primary care doctor for any reason you choose to wake up in the morning and go. Mental health is different; there are limits, requirements, and prior authorization processes in place through some of the insurance companies, that are not congruent with the medical side. In mental health, we are required to prove over and over not only why the service is needed, but what we are performing behind closed doors, which should be considered confidential. If you want to go to a medical doctor for treatment, you are able to go and get that treatment—most insurance companies allow that; it is not that way with mental health.

Chair Spiegel:
We have several more bills and a very big work session, and there are at least three more amendments to this bill to discuss. I would like to close this part. I encourage anyone on this Committee to reach out to the stakeholders with any questions. I would like to go in the following order for the rest of the amendments to this bill. We will start with the proposed amendment from the Nevada Surplus Lines Association, then Liberty Mutual, and I think there is one more; then we hear from the health care sharing ministries. I ask everyone to be as brief as possible. If anyone has any general comments, we can take those as well. But I would like to encourage people to stick to two minutes or less, unless you are presenting an amendment.

Jesse A. Wadhams, representing Nevada Surplus Lines Association:
Our amendment is on NELIS (Exhibit K). We spoke with the Commissioner and her staff, and they have been tremendous to work with on this issue. This would amend NRS 685A.075 to clarify the fees charged on filings by brokers by the Nevada Surplus Lines Association. It would put a fee structure not to exceed the Commissioner's recommended amount. It also deals with the board of directors appointment process, and those directors would still serve at the pleasure of the Commissioner of Insurance. The Nevada Surplus Lines Association is a nonprofit entity that essentially helps regulate and administer the nonadmitted market in the state of Nevada, it is a bit of an adjunct, but it is a private entity. These amendments are just some cleanup and technical issues. We appreciate the Commissioner and her staff having been amenable to them.

Chair Spiegel:
Just to confirm, is this a friendly amendment?

Jesse Wadhams:
I sure hope so. We have an email indicating that it is.

Jeanette K. Belz, representing Liberty Mutual Insurance Company:
Our amendment deals with the fraud assessment, which amends NRS Chapter 679B. The amendment is available on NELIS (Exhibit L). The assessment has not been raised since 2001, when the current structure became law as a result of passage of Assembly Bill 134 of the 71st Session from Assemblymen Dini and Perkins. The assessment is currently distributed 15 percent to the Division of Insurance and 85 percent to the Insurance Fraud Unit in the Office of the Attorney General. Fraud costs a great deal of money; nationally, it is $40 billion a year just for property and casualty, costing the average U.S. family about $400 to $700 per year in the form of increased premiums. The National Health Care Anti-Fraud Association estimates, conservatively, that health care fraud is about $68 billion annually. The Insurance Information Institute reports that one in ten Americans who have ever had auto insurance provided false information when buying insurance. The National Conference of State Legislatures had an article this morning about state fraud efforts, not just what are called hard fraud—those are rings of complex schemes that are carried out by organized fraud rings—but also soft fraud, small opportunistic transgressions that happen every day. Samples of fraud are fraudulent claims, exaggerated claims, disaster fraud, personal injury fraud schemes—like slip and falls, staged accidents, et cetera. I submitted a handout of headlines from the state of Nevada in terms of insurance fraud (Exhibit M). There is everything from distributing controlled substances without a medical purpose, fake pedestrian crashes, faking receipts for flood claims, and inflated claims submitted by a chiropractor. If you have any questions, Bob Giunta from the Office of the Attorney General is in Las Vegas and can describe their activities. Commissioner Richardson was the director of operations and fraud for 12 years in the New Hampshire Insurance Department before coming to Nevada, and she understands the importance of this effort. Naturally, the Division of Insurance and the Attorney General's Office are neutral, but this is considered a friendly amendment.

C. Joseph Guild, representing State Farm Insurance Companies:
The State Farm Insurance Companies supported the increases in 2001 and it supports this idea today.

Michael D. Hillerby, representing American Council of Life Insurers:
I think I was the one other amendment that you mentioned. At the risk of drawing the Committee's ire, the amendment is on section 8 of the bill regarding annuity taxes (Exhibit N). American Council of Life Insurers (ACLI) has a long history of supporting the Division of Insurance's omnibus bills; but for section 8, we would be happily supporting S.B. 86 (R1). The proposed language in the bill and, as nearly as I could follow, the proposed amendment which we just had explained, both represent significant tax increases on savings in this state. It is a major change to taxation, it is not a bookkeeping effort, it is

not simply keeping better track of—it changes what is taxable. The insurance premium tax in Nevada is 3.5 percent—that is the highest in the United States. For those of you who do not spend your mornings in the Assembly Committee on Ways and Means, you might be surprised to find that the fourth-largest revenue stream to the state budget is the insurance premium tax—netting more than the live entertainment, real property transfer, and commerce taxes combined. It is the tax almost no one knows they pay.

Only seven states currently tax annuity contracts. West Virginia passed a law last year, lowering their tax rate and phasing out the annuity tax, and Maine is considering a bill now to get rid of the tax on annuities. So only seven states currently tax annuities at all. I can simplify that entire debate: we should not be taxing savings; it is a bad idea, but we do. The mechanism now is it is taxed when it is annuitized. The reason companies currently have the option in the *Nevada Revised Statutes* whether to pay up front when the deposit is made or when it is annuitized is to actually pay the premium tax when the taxable event occurs. If you pay it on the back end, the 3.5 percent comes out of the larger amount, after the deposit has earned interest in all those years. If you pay it up front and it does not annuitize, right now insurers are able to take that as a return premium credit on their tax returns, which are filed either quarterly or annually, depending on the size of the company.

In 2016, ACLI members paid more than $547 million in annuity benefits to Nevadans. The average household income of an annuity holder is $64,000; more than a third of annuity holders make less than $50,000. I offer those statistics because we have had bills this session trying to encourage savings opportunities for Nevadans, pointing out that many Nevadans do not have access to 401(k)s and other employer-sponsored retirement plans. We think making a savings product like this even less attractive is a very bad idea. With the taxation paid on the back end, Nevadans have the full benefit of the amount of their deposit, the interest it earns, the growth while it is there, whether it annuitizes and they take payments, or they withdraw that.

Our amendment would simply delete section 8, which would leave the law as it is and allow companies to continue to pay, making the taxable event when it is annuitized. We would love to participate in a discussion lowering or perhaps doing away with that tax rate entirely, given how unfriendly it is to Nevada savers, but I understand where we are at this point in the session.

Robert Giunta, Senior Deputy Attorney General, Fraud Control Unit for Insurance, Office of the Attorney General:

I wanted to speak in reference to Ms. Belz's amendment. I know the hour is late and you have listened to a lot. I just wanted to give you my perspective as the prosecutor for insurance fraud. I think you are in a unique situation where an additional assessment is being requested by individuals on whom the assessment is being levied (Exhibit O). I believe that indicates the importance of this amendment. I have been with the Insurance Fraud Control Unit and Workers' Compensation Fraud Unit on and off for 12 years. When I started in 2007, the average insurance fraud case was an individual who was enticed by a new-car smell, he bought the car, he could not afford it, and when he discovers he cannot afford it,

he drives it off a cliff or burns it in the desert. When he was caught, there was a very good chance he was going to fess up and acknowledge his bad act, and, if possible, repay whatever cost came to the insurance company.

In the last few years, we have encountered syndicates which are preying on Nevada drivers, especially commercial policies which typically carry limits of about $1 million or higher. I am sure you have all heard about the swoop and squat, and other ways to manufacture an accident, organizing numerous people in several vehicles. They are usually carried out by groups of individuals who, when they learn the game and how the game is played, form their own group, thereby putting other Nevada drivers at risk. As you might imagine, these cases are extremely convoluted; there are very many moving parts. You have complicated drivers, passengers, attorneys, cappers, medical providers, and these cases require significant manpower to prosecute. Professional criminals are not usually the least bit remorseful and they are not cooperative. Since 2015 we have been averaging 120 to 150 referrals from the insurance companies a month; the majority of those are done in the south to get away from the manpower problems.

Chair Spiegel:
We are starting to run out of time. Can you send us your testimony and wrap up now, and we will get everything in the record.

Robert Giunta:
Certainly, I will send that. I just wanted you to know that we have a significant manpower shortage. With the staged accidents, we are having to make a decision. We have the guns and better argument: Do we prosecute staged accidents or do we prosecute the smaller cases that we have been handling, about 40 to 50 a year? I will present that by virtue of my testimony and I thank you for your time.

Chair Spiegel:
Thank you very much. We appreciate what you do to help protect the citizens of Nevada. We will now move on to the health care sharing ministries presentation of the potential amendments to this bill.

Keith G. Hopkinson, representing Christian Healthcare Ministries, Barberton, Ohio:
We have been working diligently with the lobby team as well as the Division of Insurance to address our concerns. The original version of this amendment was particularly onerous to almost all of the sharing ministries. We got all of that resolved; the Division of Insurance has a close version of what you now see (Exhibit P). There is a conceptual agreement among the ministries that this works fine for us—we are fine with the transparency that the Division of Insurance is seeking, as well as the registration provision. We are hopeful that the Division will see it as fine as well. We are reasonably confident. The only caveat is we want to have a little more time to make sure if they have any concerns with language, we will be able to address that in the next 24 hours. We have moved remarkably well to a positive place in the last three and a half hours.

Chair Spiegel:
We are having trouble seeing the amendment. If you could talk us through it really fast, because we are almost out of time.

Nick Vander Poel, representing Samaritan Ministries:
Health care ministries are operating in Nevada and are recognized under the United States Code. In this industry there are bad actors—in southern Nevada there is activity preying on individuals. Working with the Division of Insurance, we came up with language that would define what a health care ministry is and it can be regulated by the Division of Insurance. It gives the Division a little more teeth to go after the bad actors in Nevada. This is a registration with the state and we believe it is a step in the right direction. They are recognized by the federal government under a 501(c)(3) operation, but registering with the state of Nevada will give us a little more oversight. They will undergo a utilization review at the Division of Insurance. They will have to submit the total number of enrolled members, distribution of members by age, county, and gender. If there is a group that does enroll with the state of Nevada, then they will be subject to the Commissioner and the Division going after them.

Chair Spiegel:
I have not seen this, but I received 40 to 50 phone calls this morning from people who are members of a competing health care ministry. They all said that if this bill, this amendment, or one of the amendments, or some version goes through, they will be out of business. What I would like to know is, why are they saying that? How does this differ? What exactly are you trying to achieve that would allow good players who are providing a service to people, who are competitors but are still providing a service and fulfilling their role, how would they still be able to be in the market?

Keith Hopkinson:
In the original version of the amendment that the ministries saw on Friday, section 1 had 16 provisions that essentially defined what the sharing ministries were and what all the criteria were that they had to meet in order to be a sharing ministry in Nevada. It was so onerous in language that all of the ministries but one would not have been able to comply.

The ministries are all complying with the federal requirements and the ability to have independent audits, but some of the additional criteria that were in there would completely change the way they would have to operate, and the ability to do that when operating nationally was extraordinarily difficult and would not have been possible. This version of the amendment now does, it still uses the definition, but what it does more appropriately is to rely on the definition in the Affordable Care Act. That is something that is working everywhere in the country, and everybody knows what that is. We are incorporating that by reference; there is a notice requirement for Nevada applicants. It would lay out and make it clear that you are signing up for something as a member that is not insurance and your recourse is a consequence. We are fine with that kind of notice requirement; ministries do that in a lot of states. In Nevada that is fine as well.

And the other piece—and this is new for Nevada and the ministries—is a registration. We would be required to register and disclose the number of members, where they are located, their ages, and that is information we have. When we receive informal requests from departments, it is something that we can do. The original amendment would have had a registration requirement, but the provisions and the definition would have meant there was nobody left in Nevada to even register. We are providing a very beneficial and helpful need for many of the Nevada residents, we want to be here, and we want to be reasonable and transparent, and we think we are in a really good place for the Division as well.

Chair Spiegel:
I would like to ask the Insurance Commissioner: Is this a friendly amendment, and are you good with version three?

Barbara Richardson:
We have not seen version three yet, so I cannot say yes. But version two was fine and we have talked to the group, so we understand where they are heading; it appears we are all heading in the same direction. I just have not seen the actual verbiage to say yes.

Chair Spiegel:
You will get us version three and we will take it from there. Is there anybody who wishes to testify in opposition to S.B. 86 (R1)? [There was no one.] Is there anyone to testify in neutral?

Tom Clark, representing Nevada Association of Health Plans:
We are in neutral on S.B. 86 (R1) as it is written. We worked with the Insurance Commissioner on the minor amendment that was presented on the Senate side, and it has been cleaned up over here. We are neutral on the bill as a whole. We are very much in opposition to the amendment brought forward by Assemblywoman Peters. We received that amendment on Friday, and it is comprehensive. It is not simple, the reporting that is required in that amendment requires an analysis and the reporting for insurance companies that are already compliant with the federal act. We do report to the Division of Insurance and to the federal agencies that we are compliant. Her amendment creates a lot of questions about mental health and parity as a whole. We agree that conversation does need to take place. We do not necessarily have time this legislative session to go into all the details, all of the questions that are brought forward by the amendment itself. We look forward to having a conversation about this in the interim, whatever avenue that may take. It is very important that all insurers are at the table, not just the 20 percent of the insurers that are compelled by the amendment brought forward by Assemblywoman Peters.

Catherine M. O'Mara, Executive Director, Nevada State Medical Association:
We are neutral on the underlying bill, but we also have some comments about Assemblywoman Peters' amendment; however, we are in support of that amendment. The issue of whether there should be parity between mental health and other medical coverage has already been settled, it is a matter of federal law—it was passed in 2008 and it is called the Mental Health Parity and Addiction Equity Act. We are not talking about

whether or not there should be parity; we are talking about are we going to be able to look and determine that we are offering parity in our state. This body has done a lot of work in this session and in earlier sessions to reduce the stigma of mental health and substance abuse disorders. I started looking at the access to the covered care issue; this is a piece of that.

The federal government is also still looking at this issue, so those of you concerned that not all the health plans will be covered, the federal government is looking at things such as ERISA plan compliance. In fiscal year 2017, the United States Department of Labor, Employee Benefits Security Administration, conducted 187 investigations of these plans and found 92 violations—they were not actually offering parity. In December 2016, the 21st Century Cures Act created an action plan for enhanced enforcement of mental health and substance use disorders. Almost ten years after the federal law [Mental Health Parity and Addiction Equity Act of 2008], there seems to be agreement by states and the federal government that we are not really enforcing the law that was passed. If you visit paritytrack.org/anniversary you see what the Nevada scorecard is on parity—we score a 54 out of 100. One of the things that is recommended is, does the state statute require health insurance and benefit plans to submit reports demonstrating how they comply with the federal parity law or any state parity statutes? We are failing because we do not ask for any of those things. The parity track tool was created by the Kennedy-Satcher Center for Mental Health Equity and the Satcher Health Leadership Institute.

Another thing we should be doing is strengthening the enforcement and compliance activities by empowering our regulatory agencies to enforce the parity laws, including the state and federal law. We are not asking for a new mandate on coverage. If a plan covers mental health, then they are already covered. We are not asking them to cover something they are not willing to cover. But if they cover mental health, then they should be applying the same rules across the board that they do for their non-mental health coverage. All we are asking for is an annual report that says, We have looked at how we assess medical necessity, which is basically prior authorization; we are looking at how we assess that for our surgical and medical and we are looking at how we assess it for mental health. The answer should be, this is how we do it for medical and surgical, and for mental health, the answer should be the same. If they do that every year, we can ensure that they are complying. It will help all of us make sure that we are following the current law.

Lesley R. Dickson, State Legislative Representative, Nevada Psychiatric Association:
I am here to support Assemblywoman Peters' amendment to S.B. 86 (R1). I think it is important to start collecting data about whether these companies are really enforcing parity laws across the board. My experience as a clinician is that they are not. I have patients who are substance abuse disorder patients and have a lot of trouble getting good mental care for their disorder, both in terms of treatment, visits, and medication. We are really in support of this amendment. [(Exhibit Q) is a letter submitted in support of S.B. 86 (R1).]

Cliff McCorkle, Private Citizen, Sparks, Nevada:
I am here to support the concept of allowing ministry sharing programs to continue. If you adopt the amendment prepared by Mr. Hopkinson, it sounds like that will take care of some of the concerns which caused the 50 phone calls this morning. That is why I came today. I have been part of a ministry sharing program for 15 years, and it has worked wonderfully for me and my family. Your goal is to protect the public, and I am a typical public and I found no problems with it at all. I would just encourage you not to overregulate that part of the insurance industry, because it is not insurance. I support the amendments that are going to be made to what caused the alarm to raise in the first place.

Assemblywoman Tolles:
I just wanted to acknowledge former Nevada State Senator Cliff McCorkle.

[(Exhibit R) and (Exhibit S) were submitted as letters in support of S.B. 86 (R1).]

Chair Spiegel:
We will close the hearing on S.B. 86 (R1) and open the hearing on Senate Bill 87 (1st Reprint).

Senate Bill 87 (1st Reprint): Revises provisions governing the Nevada Life and Health Insurance Guaranty Association. (BDR 57-219)

Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry:
[Read from prepared testimony (Exhibit T).] I am here to present Senate Bill 87 (1st Reprint). This is a bill that addresses the Nevada Life and Health Insurance Guaranty Association. The Nevada Life and Health Insurance Guaranty Association's primary purpose is to protect policy or contract owners, insureds, beneficiaries, health care providers, annuitants, payees, and assignees against certain losses, both in terms of paying claims and continuing coverage. This might happen if they otherwise lost their insurance due to an impairment or insolvency of an insurer.

This change to the *Nevada Revised Statutes* (NRS) is intended to update the Nevada Life and Health Insurance Guaranty Association, Model 520—this is a generic model that we pick up from the National Association of Insurance Commissioners (NAIC). We try to use models when there is going to be consistency for consumers and protections across state lines. This is going to provide additional consumer protections to Nevada policyholders by including long-term care insurance within the Guaranty Fund protections; and it will broaden the number of carriers participating in the fund by including health maintenance organizations (HMOs), along with insurers licensed under NRS Chapter 695B, as a part of the insurers participating in the Guaranty Association Fund.

As reflected in the bill's Legislative Counsel's Digest, numerous sections of the bill add language to standardize the definition of the term "health benefit plan," and clarify provisions relating to the Association apply equally, whether or not the coverage or benefits are established through a policy or a contract, and clarify that the provisions relating to the Association apply only to the insurers that are members of the Association.

I will provide you with a brief review of the changes being proposed in this bill and will be happy to answer any questions you may have. We have also provided an explanation table for S.B. 87 (R1), which will provide you with a summary of the changes for each section of this bill, along with the corresponding rationale for each change (Exhibit U).

Sections 1 and 44 through 47 standardize the term "health benefit plan" for certain purposes. To provide for standardization, the definition of health benefit plan in section 44, which applies to NRS 689A.540, is being replaced with the definition in NRS 687B.470. All references to NRS 689A.540 are being replaced with the NRS Chapter 687B definitions. The idea is to make sure, when you read through the chapters, they all mean consistently the same thing so they are easier for the consumers and for the insurance carriers to understand.

Sections 2 and 3 introduce a new section to NRS Chapter 686C, which clarifies that a life insurance policy or annuity contract that contains a rider for long-term care is still deemed to be treated as a life insurance or annuity contract. It shall not be treated as long-term care insurance by virtue of the rider.

Section 4 clarifies the term "health maintenance organization" has the meaning as defined in NRS 695C.030; again, this is for standardization purposes.

Section 6 clarifies that this chapter applies to life insurance, health insurance, and annuity policies or contracts. It also spells out beneficiaries, assignees, payees, and providers of health care rendering services are included regardless of where they reside. Basically, if you buy your program in one state, you can still get benefits in another state or if you move here from another state. That is the idea of having it connected to where you reside.

Section 7 requires the Guaranty Association to cover a portion of a policy or contract that provides long-term care benefits or other health insurance benefits regardless of whether the portion of the policy or contract would otherwise be eligible for certain exemptions. Section 7 also provides that the Association does not cover a policy or contract for Medicaid benefits.

Sections 8, 10, and 14 require a health maintenance organization that operates in this state to be a member of the Association. Sections 14 and 33 of this bill also revise the names of the accounts maintained by the Association. This is where we pick up the last piece where we did not have the HMOs covered by the Guaranty Association. This will pull them under that for protections for the consumers in Nevada.

Section 15 expands the board of directors of the Association to not less than 7 and no more than 11. This is being done to mirror the NAIC model, but mostly to reflect the inclusion of HMOs, because we believe that they warrant additional input on the board and they warrant additional seats to do so.

Sections 16 and 17 add the act of "reissuing" a policy or contract to the actions that can be taken by the Association if a member insurer is impaired or insolvent. This is in addition to the ability to guarantee, assume, or reinsure the policies or contracts already contained in the statutes. This is to allow, especially if you are in a long-term care product, you to actually purchase another one once it is moved into an insolvency area; for protections so you can actually move from one carrier who may be insolvent to a solvent carrier, and that opens the door for the ability.

Sections 18 and 19 clarify that, if the Association issues alternative substitute coverage for the policies or contracts of an insolvent or impaired insurer, the alternative policy or contract must be issued at actuarially justified rates. They want to make sure you do not end up in the same death spiral of fees increasing that really cause the original insurer to go impaired.

Sections 19 and 20 remove a requirement that certain alternative policies, contracts, or substitute coverage issued by the Association must be approved by a court in the insolvent or impaired insurer's state. Courts have not been involved in approving alternative policies or contracts or approving the Association's guaranteeing, assuming, reissuing, or reinsuring a policy or contract. This has all been done by the guaranty associations under the jurisdiction of the Commissioner of Insurance, and once the company is insolvent, through a court action.

Section 25 provides that limitations on the obligations of the Association apply to health benefit plans, which are policies, contracts, certificates, or agreements offered by a carrier to provide for, deliver payment for, arrange the payment of, pay for, or reimburse any of the costs of health care services.

Section 26 authorizes the Association to file for actuarially justified rates or premium increases for any policy for which the Association provides coverage. They would be coming back to the Division of Insurance to show the new coverage would require a change in either the increase or the policy benefits they are going to be asking for the members who might have policies or contracts who had come from insolvent insurers.

Section 32 prescribes the manner in which the Association is required to calculate the amount of a Class B assessment for long-term care insurance written by an impaired or insolvent insurer and allocate such an assessment among the accounts of the Association. Subsection 7 also includes the formulas for determining if an insurer is considered to primarily provide life insurance and annuities or primarily provide health insurance. The reason for these Class B assessments is these are the assessments that go against the healthy insurance carriers in the state that are members of the Association to help offset the claims that would fall under an insolvent carrier.

Section 36 authorizes a member insurer that is exempt from its liability for premium tax to recoup its assessments by imposing a surcharge on premiums. This is for the very few nonprofit companies that we have. They do not pay taxes the same way the other ones do. Their Class B assessment is treated slightly different. We just want to make sure that they are recouping what their payment and assessments are in an equal manner.

Section 37 requires the plan of operation for the Association to include certain provisions relating to the recoupment of assessments. The plan must establish a period of time over which the insurer determines whether they have recouped an excess amount pursuant to section 36 and remit any excess amount to the Association.

Section 48.5 repeals the requirement that nonprofit corporations for hospital, medical, and dental services, and HMO licensees carry a reinsurance policy to protect insureds and members in the event of a carrier insolvency, since this bill includes them as member insurers in the Nevada Life and Health Guaranty Association. This is where we will be lowering the solvency requirements on the HMOs because they are now going to be members. They had to hold a certain amount of additional equity in state in order to protect against a particular insolvency. We all experienced the Nevada Health CO-OP failure. When it went down, there was not enough money in that financial security in order to pay the bills. This would support the consumers in Nevada much better. Section 48.5 also repeals the requirement for HMOs to prepare a plan for continuation of benefits due to insolvency, since insolvencies will be covered by the Guaranty Association with the passage of this bill.

Sections 48 and 49 are the effective date of this bill, which is January 1, 2020.

That concludes my testimony for this bill, and I am happy to answer any questions.

Assemblyman Daly:
Is long-term health insurance or those types of premiums covered under this default or deficiency provision?

Barbara Richardson:
I just want to make sure I am understanding you. Are you talking about long-term care insurance should you be in a long-term facility or long-term nursing care?

Assemblyman Daly:
Yes.

Barbara Richardson:
That is exactly one of the open doors that this particular bill would be allowing, long-term care. We do see a change in the market there and we want to make sure the consumers are protected.

Assemblyman Daly:
So it would be covered under this?

Barbara Richardson:
Yes.

Assemblyman Daly:
On the membership where it says you are only allowed to participate if you a member, I think there was some language that says everybody has to be a member. Is that correct?

Barbara Richardson:
Basically everybody does have to become a member. There is no way around it, unless you are only selling ERISA [Employee Retirement Income Security Act] plans, those plans that are not in the general market. We are looking for any carriers that are in an admitted market to be in this.

Chair Spiegel:
Is there any testimony in support of S.B. 87 (R1)?

Keith L. Lee, representing Nevada Association of Health Plans:
Our association consists of those commercial entities that write health insurance that covers 20 percent of Nevadans. We are here in support of this. We worked with the Insurance Commissioner during the interim; it is a good bill, and it fills in a couple of the gaps that were out there that we all had to experience some rough time for, so we support this bill.

Lea Tauchen, representing America's Health Insurance Plans:
We would like to place our support on the record and give our thanks to the Insurance Commissioner and her staff for the work they did on this issue.

Michael D. Hillerby, representing American Council of Life Insurers:
We enthusiastically support S.B. 87 (R1).

Chair Spiegel:
Is there anyone who wishes to testify in opposition to S.B. 87 (R1)? [There was no one.] Is there anyone to testify in neutral? [There was no one.] I will close the hearing on S.B. 87 (R1) and open the hearing on Senate Bill 481 (1st Reprint).

Senate Bill 481 (1st Reprint): Revises provisions relating to health insurance. (BDR 57-788)

Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry:
[Read from prepared testimony (Exhibit V).] Senate Bill 481 (1st Reprint) was designed by the Legislative Committee on Health Care, and we worked with Senator Ratti. I will go over some of the information in the bill, and if you have questions, please let me know. Senate Bill 481 (1st Reprint) contains various policy initiatives for legislative consideration that are intended to provide additional protections for Nevada's health insurance consumers.

Consumer protection is the overriding policy for the Nevada Division of Insurance. The language in this bill provides the Legislature some policy options that are intended to increase consumer protections in the Nevada health insurance markets.

Sections 1 through 5 provide language concerning self-funded multiple employer welfare arrangements, also known as MEWAs. The Trump Administration's association health plan (AHP) regulations, issued by the Department of Labor, created a new category of association health plans, which fall under the MEWA definitions. The new regulations broadened the definition of the AHPs, and it provides the ability for an association to offer an association health plan if they fit this broader category. Plans can either be fully insured through an insurer that is licensed and regulated by the Division of Insurance, or as of this past April 1, they can also be self-funded plans. There has been a significant change in the standing for the AHPs on the federal side, because there is a case, *New York v. United States Department of Labor* [Civ. Action 18-1747], which has challenged the Department of Labor law. However, the Department of Labor has put out a "do not enforce" notice, so we are still standing as if the association health plans are a category under the MEWAs that are appropriate and can be used going forward with some restrictions in the Nevada market.

Nevada currently has 13 fully insured AHPs approved in the state. These plans have been providing additional options and the potential for lower rates for many of Nevada's small business employers. This recent ruling by a U.S. Federal District Court for the District of Columbia judge questioned the legality of some of the expansion of eligible groups under the new federal AHP regulation, and that ruling is currently under appeal. As the Department of Labor just recently moved to appeal the decision, we will be waiting for the courts to see where it falls out.

Sections 1-5 of this bill only address self-funded types of AHPs. Although self-funded plans must obtain certificates of authority from the Division of Insurance, they are not directly regulated by us, and these types of arrangements have historically created major problems for consumers and providers due to fraud and insolvency issues that we have seen.

Under this bill, a self-funded MEWA would be required to have a minimum of 20 employers and not less than 75 employees. In addition, to help protect against fraud and solvency concerns, we are recommending that only very experienced, long-standing associations be available to start these types of self-funded plans in Nevada. These types of plans are proposed to be limited to arrangements that have already been in existence and continuously operated for a period of ten years or have been in existence and operated continuously since December 31, 2015, and would be sponsored by an association that has been in existence for 25 years. The idea is not to shut off the market for the self-funded but to make the threshold a little higher than those that are in the fully insured market. We have quite a few that are in the fully insured market.

Sections 6 and 10 of this bill allow consumers to purchase one short-term, limited-duration health insurance policy with a 185-day maximum coverage limit in any 365-day period. Short-term, limited-duration plans have historically been available to provide consumers

health insurance for the "gap" periods when they were in between plans. Short-term plans were not designed to serve as a replacement for health benefit plans, as they do not provide guaranteed issue, they exclude preexisting conditions, and do not cover many benefits included in Affordable Care Act (ACA)-compliant plans. To ensure that these plans remained for short-term use only, the ACA limited the duration of short-term, limited-duration plans to 90 days; however, a recent federal ruling changed the maximum duration of these types of policies to 364 days. In addition, the new rule allows consumers two renewals of the policy, effectively now providing three years of coverage under a plan intended for short-term use.

Nevada currently limits short-term policies to 185 days under *Nevada Administrative Code* 689A.434, but this bill language will provide statutory authority and prohibit the practice of immediately moving to a new policy at the end of the 185-day expiration period. What we were seeing is people jumping from one short-term plan to another short-term plan, and if they had any issues or any health concerns in between, they were then canceled the second time around for having a preexisting condition. We are trying to stop that and allow people to be thinking about what they should be choosing for their second term if they still need a short-term plan.

Section 7 requires health insurers selling individual health benefit plans that are not being sold through the Silver State Health Insurance Exchange to include a notice informing consumers they may be eligible for financial assistance only through policies sold through the state's exchange. Our concern is we do know a lot of people are buying off-exchange, which is a viable market; we just want to make sure they know there is an opportunity for financial assistance of some sort if they do choose the exchange product. We are just concerned that the people do not understand the market and we want to make sure they have the opportunity to know that is a potential for them. The notice must be provided to consumers on the carriers' enrollment Internet websites and printed enrollment information. This is to help raise consumer awareness of subsidies prior to purchasing health insurance through an off-exchange carrier.

Sections 8 and 9 propose to limit a carrier's ability to cancel short-term, limited-duration policies once they have been issued. As discussed, short-term, limited-duration policies have created challenges for consumers when insurers cancel a policy and deny the claim after a claim is filed, using the preexisting conditions exclusion in the contract. We have seen this, usually the second time they purchase a short-term contract, not the first time.

Finally, section 12 expands the exchange's powers related to facilitating the purchase and sale of qualified health plans by allowing certain consumers to purchase individual health insurance policies outside of the rating area where they reside if they obtain their health care services in a different service area. For example, currently the cost of insurance in most counties is approximately double the cost of insurance in Clark County. For residents who choose to drive to Clark County or Reno to receive their medical care, this could provide an option to make the purchase of insurance an affordable option. We are looking at getting down to the ZIP Code for rating areas to help facilitate that opportunity.

That concludes my testimony for this bill, and I am happy to answer any questions.

Assemblywoman Tolles:
I noticed there is a bifurcated implementation timeline: sections 1 through 5 are to be effective July 1, 2019, and sections 6 through 10, January 1, 2020. I just need a little clarification on when we are implementing these, July 1, 2019, or January 1, 2020? My question is specifically connected to section 4, because I had questions about the time frame for implementation for certification.

Barbara Richardson:
We did have it bifurcated because some of them can take effect immediately and some of them you need to have the insurance carriers put new policies forward. There has to be some time for review and to make sure the consumers understand the change in the market. What we were trying to do was make any corrections that we could that did not harm the market, consumers, or the carriers all at once.

Assemblywoman Tolles:
Section 4 says the Commissioner of Insurance may not issue a certificate of authority to a self-funded multiple employer welfare arrangement unless they have established, to the satisfaction of the Commissioner, the following requirements. There is a list of nine requirements in order for the Commissioner to provide them a certificate of authority. If I look at the time frame at the end of this bill, it says that sections 1 through 5 are effective July 1, 2019. Is that just beginning when it can start implementation, or if they have to satisfy all those requirements by July 1, 2019, in order to receive that certificate from the Commissioner? Would that time line be problematic?

Barbara Richardson:
As the federal law was built, April 1 was when they could first start applying. It opened the door; we have not had any applications. Between April 1 and up to two weeks ago, there was the door that was open, but the court case has shut that door down at this point until the action has been completed. The only thing that is happening is that the Department of Labor is not enforcing, but they have said they will not allow any new applications for anybody who is not already in the association health plan space. We have plenty of time to review and get everything settled should they alter their look and to get them moving forward.

Assemblyman Daly:
My question was with section 4, subsection 7, regarding the arrangement being in existence for ten years. Is that part of the door that has been closed off? Would it not allow anyone to start up in this business unless they partnered in with someone who is already existing?

Barbara Richardson:
According to the federal requirements right now, no. Nobody can start in, even with these potential exceptions. They have to wait until the court opens the door. Currently the fight is over whether or not you can have association health plans of these types at all.

Assemblyman Daly:
In section 7, subsection 3, it says you might be able to receive assistance from the Silver State Health Insurance Exchange, but in that paragraph it says you have to do a notice. Then it says you are not required to provide this notice if they are not going to be eligible for reimbursement. How is that going to work? Who is going to know and when? Or is it just going to be a matter of their income is too high, we know they are not going to get reimbursement. How is the carrier supposed to know?

Barbara Richardson:
We found that the carriers were not asking that question; this will trigger them to ask the question regarding whether or not you already do not qualify. At that point, if you do not qualify, you move straight ahead. If you do qualify, they give you information to look at the exchange plans.

Chair Spiegel:
Welcome, Senator Ratti.

Senator Julia Ratti, Senate District No. 13:
I did not want my absence to be interpreted as a lack of enthusiasm for these two bills you are about to hear. If the Commissioner did not already mention it, S.B. 481 (R1) was work that the Division of Insurance did upon the request of the Legislative Committee on Health Care. In this very fluid environment where there have been lots of changes at the federal level rolling back some protections, we did ask that the Commissioner go back with her team and bring forward some recommendations that would, in this particular bill, really protect consumers. What has survived the legislative process to date are the ones that we think are essential to make sure that there are good protections in place in the insurance market for consumers. Knowing that you have had a long day and there are lots of bills processed this week, I did not want my absence to be a lack of enthusiasm. I am here presenting this on behalf of the Legislative Committee on Health Care. We collectively believe in this bill.

Chair Spiegel:
Thank you, Senator. As a member of that Committee, I appreciate this as well. Is there any testimony in support of S.B. 481 (R1)? [There was none.] Is there any testimony in opposition to S.B. 481 (R1)? [There was none.] Is there anyone in the neutral position?

Keith L. Lee, representing Nevada Association of Health Plans:
We are here in neutral. We have worked with the Legislative Committee on Health Care; we worked with the Division of Insurance on this bill. It is a good bill; go forward with it.

Chair Spiegel:
We will close the hearing on S.B. 481 (R1) and open the hearing on Senate Bill 482 (1st Reprint).

Senate Bill 482 (1st Reprint): Revises provisions relating to health insurance. (BDR 57-531)

Senator Julia Ratti, Senate District No. 13:
The next bill we are presenting, Senate Bill 482 (1st Reprint), is a bit of a companion to Senate Bill 481 (1st Reprint). This bill, however, focuses on market stabilization. What do we need to do to stabilize the insurance market in Nevada? I think we are all well aware of the problem. This is an area where lots of changes at the federal level are creating some instability at the state level and putting us in a position where we are always trying to react. We all remember the very trying times in 2017 of the bare counties, where 15 of our 17 counties were facing a situation where they may have no insurance carriers on the exchange. I think everybody in this room wants to make sure that does not happen again and Nevada has the most stable health insurance market possible. This was one of the many issues addressed by the Legislative Committee on Health Care as well, and there has been some work going all the way back to 2015 to initiate very comprehensive studies to look at anything that Nevada could do to address stabilizing the market.

The "Market Options Study: Final Report," prepared by Wakely Consulting Group in particular (Exhibit W), came back midway through this session. There were good results, and we have some initial reactions to it. We were not prepared to jump right in with some of the bigger concepts that would help stabilize the market, something like a reinsurance pool or insurance wraps. They could still be promising, so the fact that they are not in this bill does not mean that they are not promising practices; it just means that we are not quite ready to pull that trigger. They do come with significant expenses, and we felt it would be appropriate to be thoughtful with doing more analysis. That could not be accomplished in the timeline of a 120-day legislative session.

With that said, there are still some things that we can do to stabilize the market. Just to give you a sense of what we are talking about, after the implementation of the Patient Protection and Affordable Care Act (ACA) in 2014, enrollment in the state's individual health benefit plans increased from 77,617 in 2013 to 116,131 in 2014—that is a very significant increase in the number of individuals who are served. It peaked in 2016 with 143,257; we almost doubled from where we were in 2013. Unfortunately, with some of the instability we are seeing in the market, we have now taken a dip, and in 2019 there were about 114,000 lives covered. We are still above where we were at the beginning of the ACA implementation, but we are starting to see a dip. Again, lots of different changes at the federal level.

Senate Bill 482 (1st Reprint) seeks to address some of those issues. First, it gives the Division of Insurance within the Department of Business and Industry the opportunity to do reciprocal licenses with border states. This may help in future situations where we have parts of the state that may not have access to insurance. For example, if you are in Wendover, there might be some opportunities in Utah that they should be able to take advantage of. I will let the Commissioner of Insurance explain it in more detail, but that is the concept, that is sections 1 and 2.

Section 45 allows for the application for an ACA Section 1332 waiver for Medicare. This could be used for reinsurance; it could also be used for other innovations. The state needs permission to apply for the waiver, and basically this opens the door for there to be work done during the interim. It would allow the Commissioner to come back to the Legislative Commission during the interim if there was a compelling reason, working with the Governor and the Legislative Branch through the Legislative Commission, to pursue an innovation waiver. Again, with lots of different changes in this market, waiting a full two years to have the opportunity for the full Legislature to be in session again is probably not going to make much sense. This is an area where we all have to be comfortable with a little uncertainty because this enables the application of that waiver; but we do not know what that waiver would look like today.

Section 56 removes the ability of individual plans to be purchased outside of the open enrollment window. This is a problem because as we are working to set up a state exchange and working to stabilize that exchange, make sure it is financially viable and financially sustainable, if you have individual plans that are off the exchange where individuals can purchase those plans at any time, not just during open enrollment, the incentive to make sure that you are making that decision during the open enrollment period becomes less. You can just go buy a plan anywhere, and we really do need to have a sustainable number of people participating in our own exchange if we are going to keep it viable and be able to keep providing insurance for everybody in the future. We stepped away from saying that all individual plans have to go through the exchange. But we are asking that they do have the same open enrollment period so it is not an unintended incentive not to get on the exchange because you can make your insurance decisions at a different time of year. It is intended to be a market stabilization tool.

I think that is everything I wanted to make you aware of. We do have a full Health and Human Services Committee meeting in the Senate. I am going to excuse myself and turn you back over to Barbara Richardson from the Division of Insurance. If you have any general questions you would like to ask me, I am here presenting on behalf of the Legislative Committee on Health Care and the Senate Health and Human Services Committee.

[(Exhibit X) was written testimony submitted but not presented.]

Chair Spiegel:
Thank you. Does the Committee have any questions? I do not see any questions. Is there anyone to testify in support of S.B. 482 (R1)? [There was no one.] Is there anyone to testify in opposition to S.B. 482 (R1)? [There was no one.] Is there anyone to testify in neutral to S.B. 482 (R1)?

Keith L. Lee, representing Nevada Association of Health Plans:
We appear neutral on this bill. We worked with Senator Ratti and the Legislative Committee on Health Care and the Insurance Commissioner to get where we are today.

Chair Spiegel:
We will close the hearing on S.B. 482 (R1). We will take a 30-second recess before we start the work session. That means you can stand up, but you cannot leave. We will now open our work session.

Senate Bill 88 (1st Reprint): Revises provisions governing producers of insurance and other persons regulated by the Commissioner of Insurance. (BDR 57-220)

Patrick Ashton, Committee Policy Analyst:
Senate Bill 88 (1st Reprint) revises provisions concerning certain fees collected by the Commissioner of Insurance of the Department of Business and Industry for issuing and renewing appointments, certificates, and licenses (Exhibit Y). Additionally, the bill revises licensing requirements for adjusters and eliminates various provisions related to prelicensing requirements and licensing of associate adjusters. There were no amendments to this bill.

Chair Spiegel:
Are there any questions on the bill? [There were none.] I will entertain a motion to do pass.

> ASSEMBLYWOMAN JAUREGUI MADE A MOTION TO DO PASS SENATE BILL 88 (1ST REPRINT).
>
> ASSEMBLYWOMAN TOLLES SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMEN CARLTON, FRIERSON, KRAMER, AND NEAL WERE ABSENT FOR THE VOTE.)

I will assign the floor statement to Assemblywoman Jauregui. We will now open the work session on Senate Bill 192 (1st Reprint).

Senate Bill 192 (1st Reprint): Revises provisions relating to health care. (BDR 53-781)

Patrick Ashton, Committee Policy Analyst:
Senate Bill 192 (1st Reprint) establishes the minimum level of health benefits an employer must make available to an employee and his or her dependents in order to determine whether the employer can pay the lower minimum wage established in the *Nevada Constitution* (Exhibit Z). In addition, the bill requires a hospital to provide notice of a patient's right to:

1. Make a complaint to certain persons and entities; and

2. Designate a caregiver to whom the hospital must provide instructions concerning aftercare.

There were no amendments to this bill.

Chair Spiegel:
Are there any questions or comments on S.B. 192 (R1)?

Assemblyman Edwards:
In Committee I will be voting no on this, but I may change my vote on the floor.

Chair Spiegel:
I will entertain a motion to do pass.

> ASSEMBLYMAN YEAGER MOVED TO DO PASS SENATE BILL 192 (1ST REPRINT).
>
> ASSEMBLYMAN DALY SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMAN EDWARDS VOTED NO. ASSEMBLYMEN CARLTON, FRIERSON, KRAMER, AND NEAL WERE ABSENT FOR THE VOTE.)

I will assign the floor statement to Assemblyman Yeager. We will now open the work session on Senate Bill 436 (1st Reprint).

Senate Bill 436 (1st Reprint): Revises provisions relating to professional entities. (BDR 7-1147)

Patrick Ashton, Committee Policy Analyst:
Senate Bill 436 (1st Reprint) adds chiropractic to the list of professional services that can be included in a professional entity comprised of persons engaged in rendering more than one type of professional service relating to homeopathy, medicine, osteopathy, or psychology (Exhibit AA). The bill also clarifies that no practitioner in a professional entity described in the bill may render service beyond the scope of his or her licensed authority or influence or interfere with the health care decisions of another practitioner within the same group. There were no amendments to this bill.

Chair Spiegel:
Are there any questions or comments on Senate Bill 436 (1st Reprint)? [There were none.] I will entertain a motion to do pass.

> ASSEMBLYMAN YEAGER MOVED TO DO PASS SENATE BILL 436 (1ST REPRINT).
>
> ASSEMBLYMAN EDWARDS SECONDED THE MOTION.
>
> THE MOTION PASSED. (ASSEMBLYMEN CARLTON, DALY, FRIERSON, AND NEAL WERE ABSENT FOR THE VOTE.)

I will assign the floor statement to Assemblyman Edwards. We are done with our work session. Is there any public comment? [There was none.] The meeting is adjourned [at 3:37 p.m.].

RESPECTFULLY SUBMITTED:

_____
Karen Easton
Committee Secretary

APPROVED BY:

_____
Assemblywoman Ellen B. Spiegel, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is written testimony presented by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry, regarding Senate Bill 86 (1st Reprint).

Exhibit D is a copy of the "Title 57—Insurance" page from the *Nevada Revised Statutes*, submitted by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry.

Exhibit E is a document titled "Section by Section Explanation for S.B. 86 – Regulation of Insurers, 2019 Legislative Session," submitted by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry.

Exhibit F is a proposed amendment to Senate Bill 86 (1st Reprint), dated May 1, 2019, presented by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry.

Exhibit G is a memorandum and proposed amendment to Senate Bill 86 (1st Reprint), presented by Annette James, Lead Actuary, Division of Insurance, Department of Business and Industry.

Exhibit H is a proposed amendment to Senate Bill 86 (1st Reprint), presented by Assemblywoman Sarah Peters, Assembly District No. 24.

Exhibit I is a document titled "Common Parity Violations," presented by Assemblywoman Sarah Peters, Assembly District No. 24.

Exhibit J is a copy of an article from *The New York Times* titled, "Mental Health Treatment Denied to Customers by Giant Insurer's Policies, Judge Rules," dated March 5, 2019, submitted by Assemblywoman Sarah Peters, Assembly District No. 24.

Exhibit K is a proposed amendment to Senate Bill 86 (1st Reprint), presented by Jesse A. Wadhams, representing Nevada Surplus Lines Association.

Exhibit L is a proposed amendment to Senate Bill 86 (1st Reprint), presented by Jeanette K. Belz, representing Liberty Mutual Insurance Company.

Exhibit M is a collection of news articles regarding insurance fraud, submitted by Jeanette K. Belz, representing Liberty Mutual Insurance Company.

Exhibit N is a proposed amendment to Senate Bill 86 (1st Reprint), presented by Michael D. Hillerby, representing American Council of Life Insurers.

Exhibit O is written testimony dated May 15, 2019, submitted by Robert Giunta, Senior Deputy Attorney General, Fraud Control Unit for Insurance, Office of the Attorney General.

Exhibit P is a proposed amendment to Senate Bill 86 (1st Reprint), presented by Keith G. Hopkinson, representing Christian Healthcare Ministries, Barberton, Ohio.

Exhibit Q is a letter dated May 12, 2019, to Chair Spiegel and the Assembly Committee on Commerce and Labor, authored by Lesley R. Dickson, State Legislative Representative, Nevada Psychiatric Association, in support of Senate Bill 86 (1st Reprint).

Exhibit R is a letter dated May 11, 2019, to the Assembly Committee on Commerce and Labor, authored by Saul Levin, Chief Executive Officer and Medical Director, American Psychiatric Association, in support of Senate Bill 86 (1st Reprint).

Exhibit S is testimony dated May 13, 2019, submitted by Robin Reedy, Executive Director, National Alliance on Mental Illness Nevada, in support of Senate Bill 86 (1st Reprint).

Exhibit T is written testimony presented by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry, regarding Senate Bill 87 (1st Reprint).

Exhibit U is a document titled "Section by Section Explanation for S.B. 87 – Guaranty Association 2019 Legislative Session," submitted by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry.

Exhibit V is written testimony presented by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry, regarding Senate Bill 481 (1st Reprint).

Exhibit W is a copy of a document dated March 31, 2019, titled "Market Options Study: Final Report," prepared by Wakely Consulting Group for the Division of Insurance, Department of Business and Industry.

Exhibit X is written testimony submitted by Barbara D. Richardson, Commissioner of Insurance, Division of Insurance, Department of Business and Industry, regarding Senate Bill 482 (1st Reprint).

Exhibit Y is the Work Session Document for Senate Bill 88 (1st Reprint), presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit Z is the Work Session Document for Senate Bill 192 (1st Reprint), presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.

Exhibit AA is the Work Session Document for Senate Bill 436 (1st Reprint), presented by Patrick Ashton, Committee Policy Analyst, Research Division, Legislative Counsel Bureau.