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AN ACT relating to insurance; requiring certain insurers to allow certain persons who are less than 65 years of age to purchase a Medicare supplemental policy that the insurer makes available for purchase to new insureds who are 65 years of age or older; imposing certain restrictions on the limitations, terms and conditions such an insurer may impose and the premiums such an insurer may charge for such policies to persons who are less than 65 years of age; requiring such an insurer to establish certain open enrollment periods for the purchase of a Medicare supplemental policy; prohibiting an insurer from imposing an exclusion of certain benefits with respect to a Medicare supplemental policy issued during an open enrollment period; and providing other matters properly relating thereto.

Legislative Counsel’s Digest:

Existing federal law establishes the Medicare program, which is a public health insurance program for persons 65 years of age or older and specified persons with disabilities or end-stage renal disease who are less than 65 years of age. (42 U.S.C. §§ 1395 et seq.) Existing federal law defines the term “Medicare supplemental policy” to mean a policy offered by a private insurer that is primarily designed to pay expenses not reimbursed under Medicare because of certain limitations under Medicare. Existing federal law requires the issuance of a Medicare supplemental policy under certain circumstances but does not require a private insurer to sell or issue a Medicare supplemental policy to a person who is less than 65 years of age and enrolled in Medicare on the basis of a disability or end-stage renal disease. (42 U.S.C. § 1395ss)

Section 4 of this bill requires an insurer that offers a Medicare supplemental policy in this State, including an insurer that provides coverage to state and local government employees, to allow a person who is less than 65 years of age and enrolled in Medicare on the basis of a disability or end-stage renal disease to purchase any Medicare supplemental policy that the insurer offers to new insureds in this State who are 65 years of age or older. **Section 4** imposes certain limitations on the premium rate that such an insurer may charge such persons for a Medicare supplemental policy and prohibits insurers from imposing additional limitations, terms or conditions on such persons with respect to the policy that the insurer would not impose on persons who are 65 years of age or older.

Existing law requires an insurer offering a Medicare supplemental policy to annually offer an open enrollment period for persons currently covered by a Medicare supplemental policy, during which the insurer is prohibited from taking certain actions with respect to the issuance or effectiveness of, or price charged for, a policy offered to a person during the open enrollment period. (NRS 687B.352) **Section 4** requires an insurer to establish a similar open enrollment period which allows an eligible person who is less than 65 years of age to purchase a Medicare supplemental policy during a 6-month period commencing on the first day of the first month during which the person enrolled in coverage under Part B of Medicare, which provides coverage for certain medically necessary services provided outside



of a hospital. During that open enrollment period, **section 4** prohibits an insurer from taking certain actions with respect to the issuance or effectiveness of a policy offered to the person. **Section 4** also prohibits an insurer from imposing an exclusion of benefits under a Medicare supplemental policy during that open enrollment period based on a preexisting condition. **Section 6** of this bill adds a similar prohibition with regard to the open enrollment period established under existing law which will apply to both persons who are 65 years of age or older and persons who are less than 65 years of age and suffering from a disability or end-stage renal disease. **Section 10** of this bill requires an insurer to establish a similar open enrollment period, which commences on October 1, 2025, and remains open through April 1, 2026, for persons who are: (1) less than 65 years of age; (2) suffering from a disability or end-stage renal disease; and (3) enrolled in coverage under Part B of Medicare as of October 1, 2025, on the basis of the disability or end-stage renal disease.

Sections 7-9 of this bill establish the applicability of **section 4** to: (1) a hospital or medical services corporation; and (2) state and local governments that offer insurance to employees. **Section 3** of this bill defines the term “Medicare supplemental policy” to have the same meaning as is ascribed to it in federal regulations, and **section 2** of this bill establishes the applicability of that definition. **Sections 5 and 6** of this bill make conforming changes to remove duplicative language from other existing provisions.

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

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

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

Sec. 2. *As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 687B.015 and section 3 of this act have the meanings ascribed to them in those sections.*

Sec. 3. *“Medicare supplemental policy” has the meaning ascribed to it in 42 C.F.R. § 403.205.*

Sec. 4. 1. *An insurer that offers any Medicare supplemental policy for delivery in this State shall allow a person who is less than 65 years of age and eligible for and enrolled in Medicare on the basis of a disability or end-stage renal disease to purchase any Medicare supplemental policy that the insurer offers to new insureds in this State who are 65 years of age or older.*

2. An insurer shall not impose any limitation, term or condition relating to coverage, benefits, protections, policies or procedures with respect to a Medicare supplemental policy issued to a person who is less than 65 years of age pursuant to subsection 1 if the limitation, term or condition is not imposed with respect to



a Medicare supplemental policy offered by the insurer to a person who is 65 years of age or older.

3. An insurer shall not charge a person described in subsection 1:

(a) For a Standardized Benefit Plan A, Plan B or Plan D Medicare supplemental policy, a premium rate that exceeds the premium rate that the insurer would charge a person who is exactly 65 years of age for the same Medicare supplemental policy.

(b) For a standardized benefit plan not described in paragraph (a), a premium rate that exceeds 200 percent of the premium rate that the insurer would charge a person who is exactly 65 years of age for the same Medicare supplemental policy.

4. An insurer shall offer to a person who is less than 65 years of age and eligible to purchase a Medicare supplemental policy pursuant to subsection 1 an open enrollment period commencing on the first day of the first month that the person enrolled in coverage pursuant to Medicare Part B, 42 U.S.C. §§ 1395j et seq., and remaining open for at least 6 months thereafter, during which the person may purchase any Medicare supplemental policy made available by the insurer to new insureds in this State.

5. During the open enrollment period offered pursuant to subsection 4, an insurer shall not:

(a) Deny or condition the issuance or effectiveness of a Medicare supplemental policy based on the health status, claims experience, receipt of health care or medical condition of a person described in subsection 4; or

(b) Impose an exclusion of benefits provided under the Medicare supplemental policy based on a preexisting medical condition of a person described in subsection 4.

6. As used in this section, "standardized benefit plan":

(a) Means a Medicare supplemental policy with a particular package of benefits as required by federal law; and

(b) Includes, without limitation, any Medicare supplemental policy designated as Standardized Benefit Plan A to N, inclusive, any high deductible version of any such plan and any other standardized package of benefits for Medicare supplemental policies that may be established by federal law.

Sec. 5. NRS 687B.015 is hereby amended to read as follows:

687B.015 ~~{As used in this chapter, unless the context otherwise requires, "binder"}~~ **"Binder"** means an oral or written contract for temporary insurance which is used when a policy is not immediately issued to evidence that the coverage attaches at a specified time and continues until the policy is issued or the risk is declined.



Sec. 6. NRS 687B.352 is hereby amended to read as follows:

687B.352 1. An insurer that issues a Medicare supplemental policy shall offer to a person currently insured under any such policy an annual open enrollment period commencing with the first day of the birthday month of the person and remaining open for at least 60 days thereafter, during which the person may purchase any Medicare supplemental policy made available by the insurer in this State that includes the same or lesser benefits. Innovative benefits, as described in 42 U.S.C. § 1395ss(p)(4)(B), must not be considered when determining whether a Medicare supplemental policy includes the same benefits as or lesser benefits than another such policy.

2. During the open enrollment period offered pursuant to subsection 1, an insurer shall not ~~deny~~:

(a) *Deny* or condition the issuance or effectiveness, or discriminate in the price of coverage, of a Medicare supplemental policy based on the health status, claims experience, receipt of health care or medical condition of a person described in subsection 1 ~~H~~; or

(b) *Impose an exclusion of benefits provided under the Medicare supplemental policy based on a preexisting medical condition of a person described in subsection 1.*

3. At least 30 days before the beginning of the open enrollment period offered pursuant to subsection 1 but not more than 60 days before the beginning of that period, an insurer that issues a Medicare supplemental policy shall notify each person to whom the open enrollment period applies of:

(a) The dates on which the open enrollment period begins and ends and the rights of the person established by the provisions of this section; and

(b) Any modification to the benefits provided by the policy under which the person is currently insured or adjustment to the premiums charged for that policy.

4. An insurer or other person or entity shall not vary the commission associated with the purchase of Medicare supplemental policies during the open enrollment period offered pursuant to subsection 1, pay differential commissions associated with the purchase of Medicare supplemental policies during that open enrollment period or otherwise treat Medicare supplemental policies purchased during that open enrollment period differently for the purposes of commission for any reason, including, without limitation:

(a) Because the Medicare supplemental policy was purchased during the open enrollment period offered pursuant to subsection 1;



(b) Because the Medicare supplemental policy is classified as guaranteed issue under 42 U.S.C. § 1395ss or any other applicable federal or state law or regulations; or

(c) Because of the health status, claims experience, receipt of health care or medical condition of the insured.

5. An insurer or other person or entity must treat the purchase of a Medicare supplemental policy during the open enrollment period offered pursuant to subsection 1 in the same manner as the renewal of a Medicare supplemental policy for all purposes relating to the payment of a commission.

~~¶6.—As used in this section, “Medicare supplemental policy” has the meaning ascribed to it in 42 C.F.R. § 403.205 and additionally includes policies offered by public entities that otherwise meet the requirements of that section.†~~

Sec. 7. NRS 695B.320 is hereby amended to read as follows:

695B.320 1. Nonprofit hospital and medical or dental service corporations are subject to the provisions of this chapter, and to the provisions of chapters 679A and 679B of NRS, subsections 2, 4, 17, 18 and 30 of NRS 680B.010, NRS 680B.025 to 680B.060, inclusive, chapter 681B of NRS, NRS 686A.010 to 686A.315, inclusive, 686B.010 to 686B.175, inclusive, 687B.010 to 687B.040, inclusive, 687B.070 to 687B.140, inclusive, 687B.150, 687B.160, 687B.180, 687B.200 to 687B.255, inclusive, 687B.270, 687B.310 to 687B.380, inclusive, *and section 4 of this act*, 687B.410, 687B.420, 687B.430, 687B.500 and chapters 692B, 692C, 693A and 696B of NRS, to the extent applicable and not in conflict with the express provisions of this chapter.

2. For the purposes of this section and the provisions set forth in subsection 1, a nonprofit hospital and medical or dental service corporation is included in the meaning of the term “insurer.”

Sec. 8. NRS 287.010 is hereby amended to read as follows:

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

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



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

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 439.581 to 439.597, inclusive, 686A.135, 687B.352, 687B.408, 687B.692, 687B.723, 687B.725, 687B.805, 689B.030 to 689B.0317, inclusive, paragraphs (b) and (c) of subsection 1 of NRS 689B.0319, subsections 2, 4, 6 and 7 of NRS 689B.0319, 689B.033 to 689B.0369, inclusive, 689B.0375 to 689B.050, inclusive, 689B.0675, 689B.265, 689B.287 and 689B.500 **and section 4 of this act** apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and 689B.500 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.

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

2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the



group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.

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

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

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

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

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

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

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

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

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

Sec. 9. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 439.581 to 439.597, inclusive, 686A.135, 687B.352, 687B.409, 687B.692, 687B.723, 687B.725, 687B.805, 689B.0353, 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.1635, 695G.164, 695G.1645, 695G.1665, 695G.167,



695G.1675, 695G.170 to 695G.1712, inclusive, 695G.1714 to 695G.174, inclusive, 695G.176, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, 695G.405 and 695G.415, *and section 4 of this act*, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 10. 1. In addition to the open enrollment period described in subsection 4 of section 4 of this act, an insurer that offers any Medicare supplemental policy for delivery in this State as of October 1, 2025, shall offer to a person who is less than 65 years of age and is eligible for and enrolled in coverage pursuant to Medicare Part B, 42 U.S.C. §§ 1395j et seq., on October 1, 2025, on the basis of a disability or end-stage renal disease, an open enrollment period commencing on October 1, 2025, and remaining open through April 1, 2026.

2. During the open enrollment period offered pursuant to subsection 1, an insurer shall not:

(a) Deny or condition the issuance or effectiveness of a Medicare supplemental policy based on the health status, claims experience, receipt of health care or medical condition of a person described in subsection 1; or

(b) Impose an exclusion of benefits provided under the Medicare supplemental policy based on a preexisting medical condition of a person described in subsection 1.

3. As used in this section:

(a) “Insurer” has the meaning ascribed to it in NRS 679A.100 and additionally includes:

(1) A governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides Medicare supplemental policies through a self-insurance reserve fund pursuant to NRS 287.010; and

(2) The Public Employees’ Benefits Program.

(b) “Medicare supplemental policy” has the meaning ascribed to it in 42 C.F.R. § 403.205.

Sec. 11. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

