

SENATE BILL NO. 235—COMMITTEE ON  
HEALTH AND HUMAN SERVICES

FEBRUARY 25, 2019

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to health insurance coverage. (BDR 57-734)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.  
Effect on the State: Yes.

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

AN ACT relating to insurance; requiring insurers to offer and issue a health benefit plan regardless of the health status of a person; and providing other matters properly relating thereto.

**Legislative Counsel’s Digest:**

1 Existing law prohibits an insurer from denying, limiting or excluding a benefit  
2 provided by a health care plan in certain limited circumstances, including, without  
3 limitation, when a person has contracted for a blanket policy of accident or health  
4 insurance or in certain cases relating to adoption. (NRS 689B.0265, 689B.500,  
5 689C.190, 695A.159, 695B.193, 695C.173, 695F.480) The federal Patient  
6 Protection and Affordable Care Act (Pub. L. No. 111-148, as amended) prohibits an  
7 insurer from establishing rules that limit eligibility for a health care plan based on  
8 certain health status factors, including, without limitation, preexisting conditions,  
9 claims history or genetic information of the insured and also prohibits an insurer  
10 from charging a higher premium, deductible or copay based on those health status  
11 factors. (42 U.S.C. § 300gg-4) **Sections 1, 6, 9, 13, 14, 18, 19, 23-25 and 26** of this  
12 bill: (1) align Nevada law with federal law and require all insurers to offer a health  
13 benefit plan regardless of the health status of a person or group, as applicable; and  
14 (2) prohibit an insurer from denying, limiting or excluding a covered benefit or  
15 requiring an insured to pay a higher premium, deductible, coinsurance or copay  
16 based on the health status of the insured or the covered spouse or dependent of the  
17 insured. **Sections 3, 4, 7, 10-12, 15, 17, 20, 21 and 29** of this bill remove partially  
18 duplicative provisions from existing law.

19 Federal regulations authorize a group health benefit plan to include a wellness  
20 program that offers discounts based on health status under certain conditions. (45  
21 C.F.R. § 146.121) **Sections 6, 9, 14, 18, 23 and 24** of this bill authorize group  
22 health benefit plans issued in this State to include such wellness programs under the  
23 same conditions as prescribed by federal regulations.



24 Existing law authorizes certain public officers and employees or the surviving  
25 spouse of such a retired officer or employee who is deceased to reinstate health  
26 insurance provided by the employer. If such an insurance plan is considered a  
27 grandfathered plan under the Patient Protection and Affordable Care Act, existing  
28 law authorizes such reinstatement to exclude claims for expenses for certain  
29 preexisting conditions. (NRS 287.0205) The Patient Protection and Affordable Care  
30 Act prohibits a grandfathered group plan from imposing such an exclusion. (42  
31 U.S.C. §§ 300gg-3, 18011(a)(4)(B)) **Section 27** of this bill removes authorization  
32 for certain government insurance plans to exclude claims for preexisting conditions  
33 for reinstated coverage in conformance with federal law and **sections 6 and 25** of  
34 this bill. **Section 25.5** of this bill authorizes such an insurance plan for only retired  
35 officers and employees to exclude claims for preexisting conditions under the same  
36 conditions as previously authorized for grandfathered plans. **Sections 5, 8, 16 and**  
37 **29** of this bill remove other provisions of existing law that reference exclusions  
38 based on a preexisting condition. **Sections 2 and 22** of this bill make other  
39 conforming changes.

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

1 **Section 1.** Chapter 689A of NRS is hereby amended by  
2 adding thereto a new section to read as follows:

3 *1. An insurer shall offer and issue a health benefit plan to*  
4 *any person regardless of the health status of the person or any*  
5 *dependent of the person. Such health status includes, without*  
6 *limitation:*

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

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

11 *(c) Genetic information relating to the person; and*

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

15 *2. An insurer that offers or issues a health benefit plan shall*  
16 *not:*

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

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

24 *3. An insurer that offers or issues a health benefit plan shall*  
25 *not adjust a premium, deductible, copay or coinsurance for any*  
26 *insured on the basis of genetic information relating to the insured*  
27 *or the covered dependent of the insured.*



1 **4. As used in this section, "health benefit plan" has the**  
2 **meaning ascribed to it in NRS 687B.470.**

3 **Sec. 2.** NRS 689A.330 is hereby amended to read as follows:

4 689A.330 If any policy is issued by a domestic insurer for  
5 delivery to a person residing in another state, and if the insurance  
6 commissioner or corresponding public officer of that other state has  
7 informed the Commissioner that the policy is not subject to approval  
8 or disapproval by that officer, the Commissioner may by ruling  
9 require that the policy meet the standards set forth in NRS 689A.030  
10 to 689A.320, inclusive ~~[ ]~~, **and section 1 of this act.**

11 **Sec. 3.** NRS 689A.417 is hereby amended to read as follows:

12 689A.417 1. Except as otherwise provided in subsection 2,  
13 an insurer who provides health insurance shall not:

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

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

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

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

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

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

29 3. As used in this section:

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

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

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

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

40 **Sec. 4.** NRS 689B.069 is hereby amended to read as follows:

41 689B.069 1. Except as otherwise provided in subsection 2, an  
42 insurer who provides group health insurance shall not:

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



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

5 (c) Determine the rates or any other aspect of the coverage or  
6 benefits for health care provided to an insured person based on ~~f~~  
7 ~~— (1) Whether~~ *whether* the insured person or any member of  
8 the family of the insured person has taken a genetic test. ~~f; or~~  
9 ~~— (2) Any genetic information of the insured person or any~~  
10 ~~member of the family of the insured person.]~~

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

14 3. As used in this section:

15 (a) “Genetic information” means any information that is  
16 obtained from a genetic test.

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

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

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

25 **Sec. 5.** NRS 689B.275 is hereby amended to read as follows:

26 689B.275 1. An insurer shall provide to each policyholder, or  
27 producer of insurance acting on behalf of a policyholder, on a form  
28 approved by the Commissioner, a summary of the coverage  
29 provided by each policy of group or blanket health insurance offered  
30 by the insurer. The summary must disclose any:

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

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

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

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

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

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

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



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

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

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

9 **Sec. 6.** NRS 689B.500 is hereby amended to read as follows:

10 689B.500 ~~[A carrier that issues a group health plan or coverage  
11 under blanket accident and health insurance or group health  
12 insurance shall not deny, exclude or limit a benefit for a preexisting  
13 condition.]~~

14 *1. A carrier shall offer and issue a health benefit plan to any  
15 group regardless of the health status of the group, any member of  
16 the group or any dependent of a member of the group. Such  
17 health status includes, without limitation:*

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

20 *(b) The claims history of an insured, including, without  
21 limitation, any prior health care services received by the insured;*

22 *(c) Genetic information relating to the insured; and*

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

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

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

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

35 *3. A carrier that offers or issues a health benefit plan shall  
36 not adjust a premium, deductible, copay or coinsurance for any  
37 insured on the basis of genetic information relating to the insured  
38 or the covered dependent of the insured.*

39 *4. A carrier that offers or issues a health benefit plan may  
40 include in the plan a wellness program that reduces a premium,  
41 deductible or copayment based on health status if:*

42 *(a) An insured who is eligible to participate in the wellness  
43 program is given the opportunity to qualify for the discount at  
44 least once each year;*



1 (b) *The amount of all discounts provided pursuant to such a*  
2 *wellness program does not exceed 30 percent, or if the program is*  
3 *designed to prevent or reduce tobacco use, 50 percent, of the cost*  
4 *of coverage for an insured or an insured and his or her*  
5 *dependents, as applicable, under the plan;*

6 (c) *The wellness program is reasonably designed to promote*  
7 *health or prevent disease;*

8 (d) *The carrier ensures that the full discount under the*  
9 *wellness program is available to all similarly situated insureds by*  
10 *providing a reasonable alternative standard by which an insured*  
11 *may qualify for the discount which, if based on health status, must*  
12 *accommodate the recommendations of the physician of the*  
13 *insured; and*

14 (e) *The plan discloses in all plan materials describing the*  
15 *terms of the wellness program, and in any disclosure that an*  
16 *insured did not satisfy the initial standard to be eligible for the*  
17 *discount, the availability of a reasonable alternative standard*  
18 *described in paragraph (d).*

19 5. *As used in this section, "health benefit plan" has the*  
20 *meaning ascribed to it in NRS 687B.470.*

21 **Sec. 7.** NRS 689B.550 is hereby amended to read as follows:

22 689B.550 1. A carrier shall not place any restriction on a  
23 person or a dependent of the person as a condition of being a  
24 participant in or a beneficiary of a policy of blanket accident and  
25 health insurance or group health insurance that is inconsistent with  
26 the provisions of this chapter.

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

35 (a) Health status.

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

38 (c) Claims experience.

39 (d) Receipt of health care.

40 (e) Medical history.

41 (f) Genetic information.

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

44 (h) Disability.



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

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

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

10 ~~[4.—As a condition of enrollment or continued enrollment under  
11 a policy of blanket accident and health insurance or group health  
12 insurance, a carrier shall not require an employee to pay a premium  
13 or contribution that is greater than the premium or contribution for a  
14 similarly situated person covered by similar coverage on the basis of  
15 any factor described in subsection 2 in relation to the employee or a  
16 dependent of the employee.~~

17 —5.] 4. This section does not:

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

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

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

27 **Sec. 8.** NRS 689C.159 is hereby amended to read as follows:

28 689C.159 The provisions of NRS 689C.156 ~~[and 689C.190]~~ do  
29 not apply to health benefit plans offered by a carrier if the carrier  
30 makes the health benefit plan available in the small employer  
31 market only through a bona fide association.

32 **Sec. 9.** NRS 689C.190 is hereby amended to read as follows:

33 689C.190 *1.* A carrier ~~[serving small employers]~~ that issues a  
34 health benefit plan shall ~~[not deny, exclude or limit a benefit for a  
35 preexisting condition.]~~ *offer and issue a health benefit plan to any  
36 small employer regardless of the health status of the employees of  
37 the small employer. Such health status includes, without  
38 limitation:*

39 *(a) Any preexisting medical condition of an insured, including,  
40 without limitation, any physical or mental illness;*

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

43 *(c) Genetic information relating to the insured; and*



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

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

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

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

13 3. A carrier that offers or issues a health benefit plan shall  
14 not adjust a premium, deductible, copay or coinsurance for any  
15 insured on the basis of genetic information relating to the insured  
16 or the covered dependent of the insured.

17 4. A carrier that offers or issues a health benefit plan may  
18 include in the plan a wellness program that reduces a premium,  
19 deductible or copayment based on health status if:

20 (a) An insured who is eligible to participate in the wellness  
21 program is given the opportunity to qualify for the discount at  
22 least once each year;

23 (b) The amount of all discounts provided pursuant to such a  
24 wellness program does not exceed 30 percent, or if the program is  
25 designed to prevent or reduce tobacco use, 50 percent, of the cost  
26 of coverage for an insured or an insured and his or her  
27 dependents, as applicable, under the plan;

28 (c) The wellness program is reasonably designed to promote  
29 health or prevent disease;

30 (d) The carrier ensures that the full discount under the  
31 wellness program is available to all similarly situated insureds by  
32 providing a reasonable alternative standard by which an insured  
33 may qualify for the discount which, if based on health status, must  
34 accommodate the recommendations of the physician of the  
35 insured; and

36 (e) The plan discloses in all plan materials describing the  
37 terms of the wellness program, and in any disclosure that an  
38 insured did not satisfy the initial standard to be eligible for the  
39 discount, the availability of a reasonable alternative standard  
40 described in paragraph (d).

41 **Sec. 10.** NRS 689C.193 is hereby amended to read as follows:

42 689C.193 1. A carrier shall not place any restriction on a  
43 small employer or an eligible employee or a dependent of the  
44 eligible employee as a condition of being a participant in or a





1 beneficiary of a health benefit plan that is inconsistent with NRS  
2 689C.015 to 689C.355, inclusive.

3 2. A carrier that offers health insurance coverage to small  
4 employers pursuant to this chapter shall not establish rules of  
5 eligibility ~~§~~ *which conflict with the provisions of NRS 689B.550,*  
6 including, but not limited to, rules which define applicable waiting  
7 periods, for the initial or continued enrollment under a health benefit  
8 plan offered by the carrier that are based on the following factors  
9 relating to the eligible employee or a dependent of the eligible  
10 employee:

11 (a) Health status.

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

14 (c) Claims experience.

15 (d) Receipt of health care.

16 (e) Medical history.

17 (f) Genetic information.

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

20 (h) Disability.

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

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

31 ~~5.~~ Nothing in this section:

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

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

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

41 ~~6.~~ 5. As used in this section:

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



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

5 **Sec. 11.** NRS 689C.198 is hereby amended to read as follows:

6 689C.198 1. Except as otherwise provided in subsection 2, a  
7 carrier serving small employers shall not:

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

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

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

16 ~~— (1) Whether~~ *whether* the insured person or any member of  
17 the family of the insured person has taken a genetic test. ~~f; or~~

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

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

23 3. As used in this section:

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

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

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

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

34 **Sec. 12.** NRS 689C.220 is hereby amended to read as follows:

35 689C.220 A carrier serving small employers shall not charge  
36 adjustments in rates for ~~[claim experience, health status and]~~  
37 duration of coverage *or any reason prohibited by NRS 689C.190* to  
38 individual employees or dependents. Any such adjustment must be  
39 applied uniformly to the rates charged for all employees and  
40 dependents of a small employer.

41 **Sec. 13.** Chapter 695A of NRS is hereby amended by adding  
42 thereto a new section to read as follows:

43 *1. A society shall offer and issue a health benefit plan to any*  
44 *person regardless of the health status of the person or any*



1 *dependent of the person. Such health status includes, without*  
2 *limitation:*

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

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

7 *(c) Genetic information relating to the person; and*

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

11 *2. A society that offers or issues a health benefit plan shall*  
12 *not:*

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

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

20 *3. A society that offers or issues a health benefit plan shall*  
21 *not adjust a premium, deductible, copay or coinsurance for any*  
22 *insured on the basis of genetic information relating to the insured*  
23 *or the covered dependent of the insured.*

24 *4. As used in this section, "health benefit plan" has the*  
25 *meaning ascribed to it in NRS 687B.470.*

26 **Sec. 14.** Chapter 695B of NRS is hereby amended by adding  
27 thereto a new section to read as follows:

28 *1. An insurer shall offer and issue a health benefit plan to*  
29 *any person regardless of the health status of the person or any*  
30 *dependent of the person. Such health status includes, without*  
31 *limitation:*

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

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

36 *(c) Genetic information relating to the person; and*

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

40 *2. An insurer that offers or issues a health benefit plan shall*  
41 *not:*

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

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



1 *based on his or her health status which is greater than the*  
2 *premium, deductible, copay or coinsurance charged to a similarly*  
3 *situated insured who does not have such a health status.*

4 3. *An insurer that offers or issues a health benefit plan shall*  
5 *not adjust a premium, deductible, copay or coinsurance for any*  
6 *insured on the basis of genetic information relating to the insured*  
7 *or the covered dependent of the insured.*

8 4. *An insurer that offers or issues a health benefit plan may*  
9 *include in the plan a wellness program that reduces a premium,*  
10 *deductible or copayment based on health status if:*

11 (a) *An insured who is eligible to participate in the wellness*  
12 *program is given the opportunity to qualify for the discount at*  
13 *least once each year;*

14 (b) *The amount of all discounts provided pursuant to such a*  
15 *wellness program does not exceed 30 percent, or if the program is*  
16 *designed to prevent or reduce tobacco use, 50 percent, of the cost*  
17 *of coverage for an insured or an insured and his or her*  
18 *dependents, as applicable, under the plan;*

19 (c) *The wellness program is reasonably designed to promote*  
20 *health or prevent disease;*

21 (d) *The insurer ensures that the full discount under the*  
22 *wellness program is available to all similarly situated insureds by*  
23 *providing a reasonable alternative standard by which an insured*  
24 *may qualify for the discount which, if based on health status, must*  
25 *accommodate the recommendations of the physician of the*  
26 *insured; and*

27 (e) *The plan discloses in all plan materials describing the*  
28 *terms of the wellness program, and in any disclosure that an*  
29 *insured did not satisfy the initial standard to be eligible for the*  
30 *discount, the availability of a reasonable alternative standard*  
31 *described in paragraph (d).*

32 5. *As used in this section, "health benefit plan" has the*  
33 *meaning ascribed to it in NRS 687B.470.*

34 **Sec. 15.** NRS 695B.193 is hereby amended to read as follows:

35 695B.193 1. All individual and group service or indemnity-  
36 type contracts issued by a nonprofit corporation which provide  
37 coverage for a family member of the subscriber must as to such  
38 coverage provide that the health benefits applicable for children are  
39 payable with respect to:

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

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



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

6 ↪ The contracts must provide the coverage specified in subsection  
7 3, and must not exclude premature births.

8 2. The contract may require that notification of:

9 (a) The birth of a newly born child;

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

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

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

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

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

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

35 **Sec. 16.** NRS 695B.2555 is hereby amended to read as  
36 follows:

37 695B.2555 A converted contract ~~[must not exclude a~~  
38 ~~preexisting condition not excluded by the group contract, but a~~  
39 ~~converted contract]~~ may provide that any hospital, surgical or  
40 medical benefits payable under it may be reduced by the amount of  
41 any benefits payable under the group contract after his or her  
42 termination. A converted contract may provide that during the first  
43 contract year the benefits payable under it, together with the benefits  
44 payable under the group contract, must not exceed those that would



1 have been payable if the subscriber's coverage under the group  
2 contract had remained in effect.

3 **Sec. 17.** NRS 695B.317 is hereby amended to read as follows:

4 695B.317 1. Except as otherwise provided in subsection 2, a  
5 corporation that provides health insurance shall not:

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

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

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

14 ~~—(1) Whether] whether~~ the insured person or any member of  
15 the family of the insured person has taken a genetic test. ~~f; or~~

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

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

21 3. As used in this section:

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

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

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

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

32 **Sec. 18.** Chapter 695C of NRS is hereby amended by adding  
33 thereto a new section to read as follows:

34 *1. A health maintenance organization shall offer and issue a*  
35 *health benefit plan to any person regardless of the health status of*  
36 *the person or any dependent of the person. Such health status*  
37 *includes, without limitation:*

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

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

42 *(c) Genetic information relating to the person; and*

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



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

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

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

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

15       4. A health maintenance organization that offers or issues a  
16 health benefit plan may include in the plan a wellness program  
17 that reduces a premium, deductible or copayment based on health  
18 status if:

19       (a) An enrollee who is eligible to participate in the wellness  
20 program is given the opportunity to qualify for the discount at  
21 least once each year;

22       (b) The amount of all discounts provided pursuant to such a  
23 wellness program does not exceed 30 percent, or if the program is  
24 designed to prevent or reduce tobacco use, 50 percent, of the cost  
25 of coverage for an enrollee or an enrollee and his or her  
26 dependents, as applicable, under the plan;

27       (c) The wellness program is reasonably designed to promote  
28 health or prevent disease;

29       (d) The health maintenance organization ensures that the full  
30 discount under the wellness program is available to all similarly  
31 situated enrollees by providing a reasonable alternative standard  
32 by which an enrollee may qualify for the discount which, if based  
33 on health status, must accommodate the recommendations of the  
34 physician of the enrollee; and

35       (e) The plan discloses in all plan materials describing the  
36 terms of the wellness program, and in any disclosure that an  
37 enrollee did not satisfy the initial standard to be eligible for the  
38 discount, the availability of a reasonable alternative standard  
39 described in paragraph (d).

40       5. As used in this section, "health benefit plan" has the  
41 meaning ascribed to it in NRS 687B.470.

42       **Sec. 19.** NRS 695C.050 is hereby amended to read as follows:

43       695C.050 1. Except as otherwise provided in this chapter or  
44 in specific provisions of this title, the provisions of this title are not  
45 applicable to any health maintenance organization granted a



1 certificate of authority under this chapter. This provision does not  
2 apply to an insurer licensed and regulated pursuant to this title  
3 except with respect to its activities as a health maintenance  
4 organization authorized and regulated pursuant to this chapter.

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

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

12 4. The provisions of NRS 695C.110, 695C.125, 695C.1691,  
13 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to  
14 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734,  
15 695C.1751, 695C.1755, 695C.176 to 695C.200, inclusive, and  
16 695C.265 do not apply to a health maintenance organization that  
17 provides health care services through managed care to recipients of  
18 Medicaid under the State Plan for Medicaid or insurance pursuant to  
19 the Children's Health Insurance Program pursuant to a contract with  
20 the Division of Health Care Financing and Policy of the Department  
21 of Health and Human Services. This subsection does not exempt a  
22 health maintenance organization from any provision of this chapter  
23 for services provided pursuant to any other contract.

24 5. The provisions of NRS 695C.1694 to 695C.1698, inclusive,  
25 695C.1708, 695C.1731, 695C.17345, 695C.1735, 695C.1745 and  
26 695C.1757 *and section 18 of this act* apply to a health maintenance  
27 organization that provides health care services through managed  
28 care to recipients of Medicaid under the State Plan for Medicaid.

29 **Sec. 20.** NRS 695C.173 is hereby amended to read as follows:

30 695C.173 1. All individual and group health care plans which  
31 provide coverage for a family member of the enrollee must as to  
32 such coverage provide that the health care services applicable for  
33 children are payable with respect to:

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

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

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

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

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





- 1 (a) The birth of a newly born child;
- 2 (b) The effective date of adoption of a child; or
- 3 (c) The date of placement of a child for adoption,
- 4 ↪ and payments of the required charge, if any, must be furnished to
- 5 the health maintenance organization within 31 days after the date of
- 6 birth, adoption or placement for adoption in order to have the
- 7 coverage continue beyond the 31-day period.

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

17 4. ~~[A health maintenance organization shall not restrict the~~  
18 ~~coverage of a dependent child adopted or placed for adoption solely~~  
19 ~~because of a preexisting condition the child has at the time the child~~  
20 ~~would otherwise become eligible for coverage pursuant to that plan.~~  
21 ~~Any provision relating to an exclusion for a preexisting condition~~  
22 ~~must comply with NRS 689B.500 or 689C.190, as appropriate.~~  
23 ~~—5.]~~ For covered services provided to the child, the health  
24 maintenance organization shall reimburse noncontracted providers  
25 of health care to an amount equal to the average amount of payment  
26 for which the organization has agreements, contracts or  
27 arrangements for those covered services.

28 **Sec. 21.** NRS 695C.207 is hereby amended to read as follows:  
29 695C.207 1. A health maintenance organization shall not:

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

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

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

38 ~~—(1) Whether] whether~~ the enrollee or any member of the  
39 family of the enrollee has taken a genetic test. ~~§; or~~

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

42 2. As used in this section:

43 (a) “Genetic information” means any information that is  
44 obtained from a genetic test.



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

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

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

9 **Sec. 22.** NRS 695C.330 is hereby amended to read as follows:

10 695C.330 1. The Commissioner may suspend or revoke any  
11 certificate of authority issued to a health maintenance organization  
12 pursuant to the provisions of this chapter if the Commissioner finds  
13 that any of the following conditions exist:

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

21 (b) The health maintenance organization issues evidence of  
22 coverage or uses a schedule of charges for health care services  
23 which do not comply with the requirements of NRS 695C.1691 to  
24 695C.200, inclusive, *and section 18 of this act*, or 695C.207;

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

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

29 (1) Does not meet the requirements of subsection 1 of NRS  
30 695C.080; or

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

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

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

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

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



1 (2) Conducting external reviews of adverse determinations  
2 that comply with the provisions of NRS 695G.241 to 695G.310,  
3 inclusive;

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

7 (i) The continued operation of the health maintenance  
8 organization would be hazardous to its enrollees or creditors or to  
9 the general public;

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

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

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

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

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

32 **Sec. 23.** Chapter 695F of NRS is hereby amended by adding  
33 thereto a new section to read as follows:

34 *1. A prepaid limited health service organization shall offer*  
35 *and issue a health benefit plan to any person regardless of the*  
36 *health status of the person or any dependent of the person. Such*  
37 *health status includes, without limitation:*

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

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

42 *(c) Genetic information relating to the person; and*

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



1       2. A prepaid limited health service organization that offers or  
2 issues a health benefit plan shall not:

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

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

10      3. A prepaid limited health service organization that offers or  
11 issues a health benefit plan shall not adjust a premium, deductible,  
12 copay or coinsurance for any enrollee on the basis of genetic  
13 information relating to the enrollee or the covered dependent of  
14 the enrollee.

15      4. A prepaid limited health service organization that offers or  
16 issues a health benefit plan may include in the plan a wellness  
17 program that reduces a premium, deductible or copayment based  
18 on health status if:

19      (a) An enrollee who is eligible to participate in the wellness  
20 program is given the opportunity to qualify for the discount at  
21 least once each year;

22      (b) The amount of all discounts provided pursuant to such a  
23 wellness program does not exceed 30 percent, or if the program is  
24 designed to prevent or reduce tobacco use, 50 percent, of the cost  
25 of coverage for an enrollee or an enrollee and his or her  
26 dependents, as applicable, under the plan;

27      (c) The wellness program is reasonably designed to promote  
28 health or prevent disease;

29      (d) The prepaid limited health service organization ensures  
30 that the full discount under the wellness program is available to  
31 all similarly situated enrollees by providing a reasonable  
32 alternative standard by which an enrollee may qualify for the  
33 discount which, if based on health status, must accommodate the  
34 recommendations of the physician of the enrollee; and

35      (e) The plan discloses in all plan materials describing the  
36 terms of the wellness program, and in any disclosure that an  
37 enrollee did not satisfy the initial standard to be eligible for the  
38 discount, the availability of a reasonable alternative standard  
39 described in paragraph (d).

40      5. As used in this section, "health benefit plan" has the  
41 meaning ascribed to it in NRS 687B.470.

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

44      1. A managed care organization shall offer and issue a health  
45 benefit plan to any person regardless of the health status of the



1 *person or any dependent of the person. Such health status*  
2 *includes, without limitation:*

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

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

7 *(c) Genetic information relating to the person; and*

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

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

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

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

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

24 *4. A managed care organization that offers or issues a health*  
25 *benefit plan may include in the plan a wellness program that*  
26 *reduces a premium, deductible or copayment based on health*  
27 *status if:*

28 *(a) An insured who is eligible to participate in the wellness*  
29 *program is given the opportunity to qualify for the discount at*  
30 *least once each year;*

31 *(b) The amount of all discounts provided pursuant to such a*  
32 *wellness program described in this subsection does not exceed 30*  
33 *percent, or if the program is designed to prevent or reduce tobacco*  
34 *use, 50 percent, of the cost of coverage for an insured or an*  
35 *insured and his or her dependents, as applicable, under the plan;*

36 *(c) The wellness program is reasonably designed to promote*  
37 *health or prevent disease;*

38 *(d) The managed care organization ensures that the full*  
39 *discount under the wellness program is available to all similarly*  
40 *situated insureds by providing a reasonable alternative standard*  
41 *by which an insured may qualify for the discount which, if based*  
42 *on health status, must accommodate the recommendations of the*  
43 *physician of the insured; and*

44 *(e) The plan discloses in all plan materials describing the*  
45 *terms of the wellness program, and in any disclosure that an*



1 *insured did not satisfy the initial standard to be eligible for the*  
2 *discount, the availability of a reasonable alternative standard*  
3 *described in paragraph (d).*

4 *5. As used in this section, "health benefit plan" has the*  
5 *meaning ascribed to it in NRS 687B.470.*

6 **Sec. 25.** NRS 287.010 is hereby amended to read as follows:

7 287.010 1. The governing body of any county, school  
8 district, municipal corporation, political subdivision, public  
9 corporation or other local governmental agency of the State of  
10 Nevada may:

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

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

26 (c) Provide group life, accident or health coverage through a  
27 self-insurance reserve fund and, where necessary, deduct  
28 contributions to the maintenance of the fund from the compensation  
29 of officers and employees and pay the deductions into the fund. The  
30 money accumulated for this purpose through deductions from the  
31 compensation of officers and employees and contributions of the  
32 governing body must be maintained as an internal service fund as  
33 defined by NRS 354.543. The money must be deposited in a state or  
34 national bank or credit union authorized to transact business in the  
35 State of Nevada. Any independent administrator of a fund created  
36 under this section is subject to the licensing requirements of chapter  
37 683A of NRS, and must be a resident of this State. Any contract  
38 with an independent administrator must be approved by the  
39 Commissioner of Insurance as to the reasonableness of  
40 administrative charges in relation to contributions collected and  
41 benefits provided. The provisions of NRS 687B.408, 689B.030 to  
42 689B.050, inclusive, ~~and~~ 689B.287 *and 689B.500* apply to  
43 coverage provided pursuant to this paragraph, except that the  
44 provisions of NRS 689B.0378 , ~~and~~ 689B.03785 *and 689B.500*



1 only apply to coverage for active officers and employees of the  
2 governing body, or the dependents of such officers and employees.

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

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

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

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

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

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

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

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

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

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



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

4 **Sec. 25.5.** NRS 287.0205 is hereby amended to read as  
5 follows:

6 287.0205 1. A public officer or employee of any county,  
7 school district, municipal corporation, political subdivision, public  
8 corporation or other local governmental agency of the State of  
9 Nevada who has retired pursuant to NRS 1A.350 or 1A.480, or  
10 286.510 or 286.620, or is enrolled in a retirement program provided  
11 pursuant to NRS 286.802, or the surviving spouse of such a retired  
12 public officer or employee who is deceased, may, except as  
13 otherwise provided in NRS 287.0475, in any even-numbered year,  
14 reinstate any insurance, except life insurance, that, at the time of  
15 reinstatement, is provided by the last public employer of the retired  
16 public officer or employee to the active officers and employees and  
17 their dependents of that public employer:

18 (a) Pursuant to NRS 287.010, 287.015, 287.020 or paragraph  
19 (b), (c) or (d) of subsection 1 of NRS 287.025; or

20 (b) Under the Public Employees' Benefits Program, if the last  
21 public employer of the retired officer or employee participates in the  
22 Public Employees' Benefits Program pursuant to paragraph (a) of  
23 subsection 1 of NRS 287.025.

24 2. Reinstatement pursuant to paragraph (a) of subsection 1  
25 must be requested by:

26 (a) Giving written notice of the intent of the public officer or  
27 employee or surviving spouse to reinstate the insurance to the last  
28 public employer of the public officer or employee not later than  
29 January 31 of an even-numbered year;

30 (b) Accepting the public employer's current program or plan of  
31 insurance and any subsequent changes thereto; and

32 (c) Except as otherwise provided in paragraph (b) of subsection  
33 4 of NRS 287.023, paying any portion of the premiums or  
34 contributions of the public employer's program or plan of insurance,  
35 in the manner set forth in NRS 1A.470 or 286.615, which is due  
36 from the date of reinstatement and not paid by the public employer.

37 ➤ The last public employer shall give the insurer notice of the  
38 reinstatement not later than March 31 of the year in which the public  
39 officer or employee or surviving spouse gives notice of the intent to  
40 reinstate the insurance.

41 3. Reinstatement pursuant to paragraph (b) of subsection 1  
42 must be requested pursuant to NRS 287.0475.

43 4. *If a plan provides coverage only to retired public officers*  
44 *and employees and dependents thereof, reinstatement of insurance*  
45 *pursuant to subsection 1 may exclude claims for expenses related*





1 *to any condition for which medical advice, treatment or*  
2 *consultation was rendered within 12 months before the*  
3 *reinstatement.*

4 5. The last public employer of a retired officer or employee  
5 who reinstates insurance, except life insurance, which was provided  
6 to the retired officer or employee and the retired officer's or  
7 employee's dependents at the time of retirement pursuant to NRS  
8 287.010, 287.015, 287.020 or paragraph (b), (c) or (d) of subsection  
9 1 of NRS 287.025 shall, for the purpose of establishing actuarial  
10 data to determine rates and coverage for such persons, commingle  
11 the claims experience of such persons with the claims experience of  
12 active and retired officers and employees and their dependents who  
13 participate in that group insurance, plan of benefits or medical and  
14 hospital service.

15 **Sec. 26.** NRS 287.04335 is hereby amended to read as  
16 follows:

17 287.04335 If the Board provides health insurance through a  
18 plan of self-insurance, it shall comply with the provisions of NRS  
19 687B.409, 689B.255, 695G.150, 695G.160, 695G.162, 695G.164,  
20 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.173,  
21 inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to  
22 695G.310, inclusive, and 695G.405, *and section 24 of this act* in the  
23 same manner as an insurer that is licensed pursuant to title 57 of  
24 NRS is required to comply with those provisions.

25 **Sec. 27.** Section 15 of chapter 453, Statutes of Nevada 2011,  
26 at page 2746, is hereby amended to read as follows:

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

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

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

36 **Sec. 28.** The provisions of sections 1, 6, 9, 13, 14, 18, 23 and  
37 24 of this act apply to any contract, agreements, network plan,  
38 policy of health insurance, policy of group health insurance, health  
39 benefit plan, benefit contract, contract for hospital or medical  
40 service and health care plan that is delivered, issued for delivery or  
41 renewed on or after January 1, 2020.

42 **Sec. 29.** NRS 689A.523, 689A.585, 689B.450, 689C.082,  
43 695A.159 and 695F.480 are hereby repealed.

44 **Sec. 30.** This act becomes effective:



- 1 1. Upon passage and approval for the purpose of performing
- 2 any preparatory administrative tasks that are necessary to carry out
- 3 the provisions of this act; and
- 4 2. On January 1, 2020, for all other purposes.

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**LEADLINES OF REPEALED SECTIONS**

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**689A.523 “Exclusion for a preexisting condition” defined.**

**689A.585 “Preexisting condition” defined.**

**689B.450 “Preexisting condition” defined.**

**689C.082 “Preexisting condition” defined.**

**695A.159 Society prohibited from restricting coverage of child based on preexisting condition when person who is eligible for group coverage adopts or assumes legal obligation for child.**

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





