Senate Bill No. 482–Committee on
Health and Human Services

CHAPTER.....

AN ACT relating to health insurance; authorizing the Commissioner of Insurance to enter into certain types of interstate compacts; authorizing the Commissioner to allow reciprocal licensure with certain states; authorizing the Commissioner to apply to the Secretary of Health and Human Services for a certain waiver; removing certain waiting period requirements for health benefit plans for individuals not purchased on the Silver State Health Insurance Exchange; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

The McCarran-Ferguson Act reserves to the states the right to regulate the business of insurance, except in certain situations where the United States Congress explicitly regulates the business of insurance. (15 U.S.C. §§ 1011-1015) In 2010, the United States Congress enacted the Patient Protection and Affordable Care Act, through which the United States Congress authorized two or more states to enter into healthcare choice compacts under which the issuer of any qualified health plan to which the compact applies would be required to: (1) be licensed in each state; or (2) submit to the jurisdiction of each such state. (42 U.S.C. § 18053(a)(1)(B)(ii)) Existing law authorizes the Commissioner of Insurance to enter into such compacts with the regulatory officers in other states to further the uniform treatment of insurers throughout the United States. (NRS 679B.220) **Section 2** of this bill authorizes the Commissioner to enter into such compacts to also ensure: (1) market stability; or (2) essential insurance is available to Nevada residents. **Section 1** of this bill authorizes the Commissioner to allow reciprocal licenses to be issued to health carriers that are licensed to do business in Arizona, California, Idaho, Oregon or Utah without the health carrier first being required to obtain a certificate of authority to do business in Nevada. **Section 1** additionally authorizes the Commissioner to adopt regulations to carry out this reciprocal licensure program, including regulations authorizing the Commissioner to establish any fees the Commissioner deems appropriate to carry out this program. **Section 55** of this bill makes conforming changes by requiring certain certificates to be filed only at the request of the Commissioner.

Federal law authorizes a state to apply to the Secretary of Health and Human Services for a waiver of various requirements of the Patient Protection and Affordable Care Act with respect to health insurance coverage in the state for a plan year. (42 U.S.C. § 18502) **Section 45** of this bill incorporates this federal language into state law by authorizing the Commissioner to apply for such a waiver for a plan year beginning on January 1, 2020. **Sections 46-54, 58 and 59** of this bill make conforming changes.

Existing law requires any health benefit plan for individuals that is not purchased on the Silver State Health Insurance Exchange to be: (1) made available for purchase at any time during the calendar year; (2) subject to a waiting period of not more than 90 days after the date on which the application was received; (3) effective upon the first day of the month immediately after the month in which the waiting period ends; and (4) not retroactive to the date on which the application for

coverage was received. (NRS 687B.480) **Section 56** of this bill removes these requirements.

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 679B of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Commissioner may allow reciprocal licenses to be issued to health carriers licensed to do business in Arizona, California, Idaho, Oregon and Utah to enable said health carriers to do business in Nevada without completing a separate application for a certificate of authority in Nevada, other than a petition for recognition of their respective state's license with the grant of a reciprocal Nevada license.

2. The Commissioner may adopt regulations to carry out the provisions of subsection 1, including, without limitation, regulations to establish any fees the Commissioner deems appropriate to carry out the provisions of subsection 1.

Sec. 2. NRS 679B.220 is hereby amended to read as follows:

679B.220 1. The Commissioner shall communicate on request of the regulatory officer for insurance in any state, province or country any information which it is the duty of the Commissioner by law to ascertain respecting authorized insurers.

2. The Commissioner may:

(a) Be a member of the National Association of Insurance Commissioners or any successor organization;

(b) Exchange with the association or any successor organization any information, not otherwise confidential, relating to applicants and licensees under this title;

(c) Communicate with the association or any successor organization concerning the business of insurance generally;

(d) Enter into compacts with the regulatory officers in other states to ~~[further]~~ ***:***

(1) Further the uniform treatment of insurers throughout the United States;

(2) Ensure market stability; or

(3) Ensure essential insurance is made available to Nevada residents; and

(e) Participate in and support other cooperative activities of public officers having supervision of the business of insurance.

Secs. 3-44. (Deleted by amendment.)

Sec. 45. ***1. The Commissioner may apply to the Secretary of Health and Human Services pursuant to 42 U.S.C. § 18052 for a waiver for state innovation of applicable provisions of the Patient Protection and Affordable Care Act, Public Law 111-148, with respect to health insurance coverage in this State for a plan year beginning on or after January 1, 2020.***

2. The Commissioner may implement a state plan that meets the waiver requirements in a manner consistent with state and federal law and as approved by the Secretary of Health and Human Services.

Sec. 46. NRS 686B.010 is hereby amended to read as follows:

686B.010 1. The Legislature intends that NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** be liberally construed to achieve the purposes stated in subsection 2, which constitute an aid and guide to interpretation but not an independent source of power.

2. The purposes of NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** are to:

(a) Protect policyholders and the public against the adverse effects of excessive, inadequate or unfairly discriminatory rates;

(b) Encourage, as the most effective way to produce rates that conform to the standards of paragraph (a), independent action by and reasonable price competition among insurers;

(c) Provide formal regulatory controls for use if independent action and price competition fail;

(d) Authorize cooperative action among insurers in the rate-making process, and to regulate such cooperation in order to prevent practices that tend to bring about monopoly or to lessen or destroy competition;

(e) Encourage the most efficient and economic marketing practices; and

(f) Regulate the business of insurance in a manner that will preclude application of federal antitrust laws.

Sec. 47. NRS 686B.020 is hereby amended to read as follows:

686B.020 As used in NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act,*** unless the context otherwise requires:

1. "Advisory organization," except as limited by NRS 686B.1752, means any person or organization which is controlled by or composed of two or more insurers and which engages in activities related to rate making. For the purposes of this subsection, two or more insurers with common ownership or operating in this

State under common ownership constitute a single insurer. An advisory organization does not include:

(a) A joint underwriting association;

(b) An actuarial or legal consultant; or

(c) An employee or manager of an insurer.

2. "Market segment" means any line or kind of insurance or, if it is described in general terms, any subdivision thereof or any class of risks or combination of classes.

3. "Rate service organization" means any person, other than an employee of an insurer, who assists insurers in rate making or filing by:

(a) Collecting, compiling and furnishing loss or expense statistics;

(b) Recommending, making or filing rates or supplementary rate information; or

(c) Advising about rate questions, except as an attorney giving legal advice.

4. "Supplementary rate information" includes any manual or plan of rates, statistical plan, classification, rating schedule, minimum premium, policy fee, rating rule, rule of underwriting relating to rates and any other information prescribed by regulation of the Commissioner.

Sec. 48. NRS 686B.030 is hereby amended to read as follows:

686B.030 1. Except as otherwise provided in subsection 2 and NRS 686B.125, the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** apply to all kinds and lines of direct insurance written on risks or operations in this State by any insurer authorized to do business in this State, except:

(a) Ocean marine insurance;

(b) Contracts issued by fraternal benefit societies;

(c) Life insurance and credit life insurance;

(d) Variable and fixed annuities;

(e) Credit accident and health insurance;

(f) Property insurance for business and commercial risks;

(g) Casualty insurance for business and commercial risks other than insurance covering the liability of a practitioner licensed pursuant to chapters 630 to 640, inclusive, of NRS;

(h) Surety insurance;

(i) Health insurance offered through a group health plan maintained by a large employer; and

(j) Credit involuntary unemployment insurance.

2. The exclusions set forth in paragraphs (f) and (g) of subsection 1 extend only to issues related to the determination or approval of premium rates.

Sec. 49. NRS 686B.040 is hereby amended to read as follows:

686B.040 1. Except as otherwise provided in subsection 2, the Commissioner may by rule exempt any person or class of persons or any market segment from any or all of the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** if and to the extent that the Commissioner finds their application unnecessary to achieve the purposes of those sections.

2. The Commissioner may not, by rule or otherwise, exempt an insurer from the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** with regard to insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of the practitioner's professional duty toward a patient.

Sec. 50. NRS 686B.080 is hereby amended to read as follows:

686B.080 1. Except as otherwise provided in subsections 2 to 5, inclusive, each filing and any supporting information filed under NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** must, as soon as filed, be open to public inspection at any reasonable time. Copies may be obtained by any person on request and upon payment of a reasonable charge therefor.

2. All rates for health benefit plans available for purchase by individuals and small employers are considered proprietary and constitute trade secrets, and are not subject to disclosure by the Commissioner to persons outside the Division except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

3. The provisions of subsection 2 expire annually on the date 30 days before open enrollment.

4. Except in cases of violations of NRS 689A.010 to 689A.740, inclusive, or 689C.015 to 689C.355, inclusive, the unified rate review template and rate filing documentation used by carriers servicing the individual and small employer markets are considered proprietary and constitute a trade secret, and are not subject to disclosure by the Commissioner to persons outside the Division except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

5. An insurer providing blanket health insurance in accordance with the provisions of chapter 689B of NRS shall make all information concerning rates available to the Commissioner upon request. Such information is considered proprietary and constitutes a trade secret and is not subject to disclosure by the Commissioner to

persons outside the Division except as agreed by the insurer or as ordered by a court of competent jurisdiction.

6. For the purposes of this section:

(a) "Open enrollment" has the meaning ascribed to it in 45 C.F.R. § 147.104(b)(1)(ii).

(b) "Rate filing documentation" and "unified rate review template" have the meanings ascribed to them in 45 C.F.R. § 154.215.

Sec. 51. NRS 686B.110 is hereby amended to read as follows:

686B.110 1. Except as otherwise provided in NRS 686B.112, the Commissioner shall consider each proposed increase or decrease in the rate of any kind or line of insurance or subdivision thereof filed with the Commissioner pursuant to subsection 1 of NRS 686B.070. If the Commissioner finds that a proposed increase will result in a rate which is not in compliance with NRS 686B.050 or subsection 3 of NRS 686B.070, the Commissioner shall disapprove the proposal. The Commissioner shall approve or disapprove each proposal no later than 30 days after it is determined by the Commissioner to be complete pursuant to subsection 6. If the Commissioner fails to approve or disapprove the proposal within that period, the proposal shall be deemed approved.

2. If the Commissioner disapproves a proposed increase or decrease in any rate pursuant to subsection 1, the Commissioner shall send a written notice of disapproval to the insurer or the rate service organization that filed the proposal. The notice must set forth the reasons the proposal is not in compliance with NRS 686B.050 or subsection 3 of NRS 686B.070 and must be sent to the insurer or the rate service organization not more than 30 days after the Commissioner determines that the proposal is complete pursuant to subsection 6.

3. Upon receipt of a written notice of disapproval from the Commissioner pursuant to subsection 2 or 6, the insurer or rate service organization may request that the Commissioner reconsider the proposed increase or decrease. The request for reconsideration must be received by the Commissioner not more than 30 days after the insurer or rate service organization receives the written notice of disapproval from the Commissioner, except that if the insurer or rate service organization requests, in writing, an extension of 30 additional days in which to request a reconsideration, the Commissioner shall grant the extension. A request for reconsideration submitted pursuant to this subsection may include, without limitation, any documents or other information for review by the Commissioner in reconsidering the proposal. The

Commissioner shall approve or disapprove the proposal upon reconsideration not later than 30 days after receipt of the request for reconsideration and shall notify the insurer or rate service organization of his or her approval or disapproval.

4. Whenever an insurer has no legally effective rates as a result of the Commissioner's disapproval of rates or other act, the Commissioner shall on request specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by the Commissioner. When new rates become legally effective, the Commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis must not be required.

5. If the Commissioner disapproves a proposed rate pursuant to subsection 1 or subsection 6 or upon reconsideration pursuant to subsection 3 and an insurer requests a hearing to determine the validity of the action of the Commissioner, the insurer has the burden of showing compliance with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive ~~[.]~~ ***, and section 45 of this act.*** Any such hearing must be held:

(a) Within 30 days after the request for a hearing has been submitted to the Commissioner; or

(b) Within a period agreed upon by the insurer and the Commissioner.

➥ If the hearing is not held within the period specified in paragraph (a) or (b), or if the Commissioner fails to issue an order concerning the proposed rate for which the hearing is held within 45 days after the hearing, the proposed rate shall be deemed approved.

6. The Commissioner shall by regulation specify the documents or any other information which must be included in a proposal to increase or decrease a rate submitted to the Commissioner pursuant to subsection 1. Each such proposal shall be deemed complete upon its filing with the Commissioner, unless the Commissioner, within 15 business days after the proposal is filed with the Commissioner, determines that the proposal is incomplete because the proposal does not comply with the regulations adopted by the Commissioner pursuant to this subsection. The Commissioner shall notify the insurer or rate service organization if the Commissioner determines that the proposal is incomplete. The notice must be sent within 15 business days after the proposal is filed with the Commissioner and must set forth the documents or other information that is required to complete the proposal. The

Commissioner may disapprove the proposal if the insurer or rate service organization fails to provide the documents or other information to the Commissioner within 30 days after the insurer or rate service organization receives the notice that the proposal is incomplete. If the Commissioner disapproves the proposal pursuant to this subsection, the Commissioner shall notify the insurer or rate service organization of that fact in writing.

Sec. 52. NRS 686B.112 is hereby amended to read as follows:

686B.112 1. The Commissioner shall consider each proposed increase or decrease in the rate of a health plan issued pursuant to the provisions of chapter 689A, 689B, 689C, 695B, 695C, 695D or 695F of NRS, including, without limitation, long-term care and Medicare supplement plans, filed with the Commissioner pursuant to subsection 1 of NRS 686B.070. If the Commissioner finds that a proposed increase will result in a rate which is not in compliance with NRS 686B.050 or subsection 3 of NRS 686B.070, the Commissioner shall disapprove the proposal. The Commissioner shall approve or disapprove each proposal not later than 60 days after the proposal is determined by the Commissioner to be complete pursuant to subsection 4. If the Commissioner fails to approve or disapprove the proposal within that period, the proposal shall be deemed approved.

2. Whenever an insurer has no legally effective rates as a result of the Commissioner's disapproval of rates or other act, the Commissioner shall on request specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by the Commissioner. When new rates become legally effective, the Commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis must not be required.

3. If the Commissioner disapproves a proposed rate pursuant to subsection 1, and an insurer requests a hearing to determine the validity of the action of the Commissioner, the insurer has the burden of showing compliance with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive ~~[.]~~ ***, and section 45 of this act.*** Any such hearing must be held:

(a) Within 30 days after the request for a hearing has been submitted to the Commissioner; or

(b) Within a period agreed upon by the insurer and the Commissioner.

➥ If the hearing is not held within the period specified in paragraph (a) or (b), or if the Commissioner fails to issue an order concerning the proposed rate for which the hearing is held within 45 days after the hearing, the proposed rate shall be deemed approved.

4. The Commissioner shall by regulation specify the documents or any other information which must be included in a proposal to increase or decrease a rate submitted to the Commissioner pursuant to subsection 1. Each such proposal shall be deemed complete upon its filing with the Commissioner, unless the Commissioner, within 15 business days after the proposal is filed with the Commissioner, determines that the proposal is incomplete because the proposal does not comply with the regulations adopted by the Commissioner pursuant to this subsection.

Sec. 53. NRS 686B.115 is hereby amended to read as follows:

686B.115 1. Any hearing held by the Commissioner to determine whether rates comply with the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** must be open to members of the public.

2. All costs for transcripts prepared pursuant to such a hearing must be paid by the insurer requesting the hearing.

3. At any hearing which is held by the Commissioner to determine whether rates comply with the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** and which involves rates for insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of the practitioner's professional duty toward a patient, if a person is not otherwise authorized pursuant to this title to become a party to the hearing by intervention, the person is entitled to provide testimony at the hearing if, not later than 2 days before the date set for the hearing, the person files with the Commissioner a written statement which states:

(a) The name and title of the person;

(b) The interest of the person in the hearing; and

(c) A brief summary describing the purpose of the testimony the person will offer at the hearing.

4. If a person provides testimony at a hearing in accordance with subsection 3:

(a) The Commissioner may, if the Commissioner finds it necessary to preserve order, prevent inordinate delay or protect the rights of the parties at the hearing, place reasonable limitations on the duration of the testimony and prohibit the person from providing testimony that is not relevant to the issues raised at the hearing.

(b) The Commissioner shall consider all relevant testimony provided by the person at the hearing in determining whether the rates comply with the provisions of NRS 686B.010 to 686B.1799, inclusive ~~[.]~~ ***, and section 45 of this act.***

Sec. 54. NRS 686B.130 is hereby amended to read as follows:

686B.130 1. A rate service organization and an advisory organization shall not provide any service relating to the rates of any insurance subject to NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** and an insurer shall not utilize the services of an organization for such purposes unless the organization has obtained a license pursuant to NRS 686B.140.

2. A rate service organization and an advisory organization shall not refuse to supply any services for which it is licensed in this state to any insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services.

Sec. 55. NRS 687B.120 is hereby amended to read as follows:

687B.120 1. Except as otherwise provided in subsection 2:

(a) No life or health insurance policy or contract, annuity contract form, policy form, health care plan or plan for dental care, whether individual, group or blanket, including those to be issued by a health maintenance organization, organization for dental care or prepaid limited health service organization, or application form where a written application is required and is to be made a part of the policy or contract, or printed rider or endorsement form or form of renewal certificate, or form of individual certificate or statement of coverage to be issued under group or blanket contracts, or by a health maintenance organization, organization for dental care or prepaid limited health service organization, may be delivered or issued for delivery in this state, unless the form has been filed with and approved by the Commissioner.

(b) As to ***individual policies pursuant to paragraph (d) of subsection 2 of NRS 679B.220 or*** group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the ~~[group]~~ certificates to be delivered or issued for delivery in this state must be filed, for informational purposes only, with the Commissioner at the request of the Commissioner.

2. As to group insurance policies to be issued to a group approved pursuant to NRS 688B.030 or 689B.026, no policies of group insurance may be marketed to a resident or employer of this State unless the policy and any form or certificate to be issued pursuant to the policy has been filed with and approved by the Commissioner.

3. Every filing made pursuant to the provisions of subsection 1 or 2 must be made not less than 45 days in advance of any delivery pursuant to subsection 1 or marketing pursuant to subsection 2. At the expiration of 45 days the form so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the Commissioner. Approval of any such form by the Commissioner constitutes a waiver of any unexpired portion of such waiting period. The Commissioner may extend by not more than an additional 30 days the period within which the Commissioner may so affirmatively approve or disapprove any such form, by giving notice to the insurer of the extension before expiration of the initial 45-day period. At the expiration of any such period as so extended, and in the absence of prior affirmative approval or disapproval, any such form shall be deemed approved. The Commissioner may at any time, after notice and for cause shown, withdraw any such approval.

4. Any order of the Commissioner disapproving any such form or withdrawing a previous approval must state the grounds therefor and the particulars thereof in such detail as reasonably to inform the insurer thereof. Any such withdrawal of a previously approved form is effective at the expiration of such a period, not less than 30 days after the giving of notice of withdrawal, as the Commissioner in such notice prescribes.

5. The Commissioner may, by order, exempt from the requirements of this section for so long as the Commissioner deems proper any insurance document or form or type thereof specified in the order, to which, in the opinion of the Commissioner, this section may not practicably be applied, or the filing and approval of which are, in the opinion of the Commissioner, not desirable or necessary for the protection of the public.

6. Appeals from orders of the Commissioner disapproving any such form or withdrawing a previous approval may be taken as provided in NRS 679B.310 to 679B.370, inclusive.

Sec. 56. NRS 687B.480 is hereby amended to read as follows:

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

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

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

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

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

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

Sec. 57. (Deleted by amendment.)

Sec. 58. NRS 690B.330 is hereby amended to read as follows:

690B.330 1. In each rating plan of an insurer that issues a policy of professional liability insurance to a practitioner licensed pursuant to chapter 630 or 633 of NRS, the insurer shall provide for a reduction in the premium for the policy if the practitioner implements a qualified risk management system. The amount of the reduction in the premium must be determined by the Commissioner in accordance with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive ~~[.]~~ ***, and section 45 of this act.***

2. A qualified risk management system must comply with all requirements established by the Commissioner.

3. The Commissioner shall adopt regulations to:

(a) Establish the requirements for a qualified risk management system; and

(b) Carry out the provisions of this section.

4. The provisions of this section apply to all rating plans which an insurer that issues a policy of professional liability insurance to a practitioner licensed pursuant to chapter 630 or 633 of NRS files with the Commissioner on and after the effective date of the regulations adopted by the Commissioner pursuant to this section.

Sec. 59. NRS 690B.360 is hereby amended to read as follows:

690B.360 1. The Commissioner may collect all information which is pertinent to monitoring whether an insurer that issues professional liability insurance for a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS is complying with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive ~~[.]~~ ***, and section 45 of this act.*** Such information may include, without limitation:

(a) The amount of gross premiums collected with regard to each medical specialty;

(b) Information relating to loss ratios;

(c) Information reported pursuant to NRS 690B.260; and

(d) Information reported pursuant to NRS 679B.430 and 679B.440.

2. In addition to the information collected pursuant to subsection 1, the Commissioner may request any additional information from an insurer:

(a) Whose rates and credit utilization are materially different from other insurers in the market for professional liability insurance for a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS in this State;

(b) Whose credit utilization shows a substantial change from the previous year; or

(c) Whose information collected pursuant to subsection 1 indicates a potentially adverse trend.

3. If the Commissioner requests additional information from an insurer pursuant to subsection 2, the Commissioner may:

(a) Determine whether the additional information offers a reasonable explanation for the results described in paragraph (a), (b) or (c) of subsection 2; and

(b) Take any steps permitted by law that are necessary and appropriate to assure the ongoing stability of the market for professional liability insurance for a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS in this State.

4. On an ongoing basis, the Commissioner may analyze and evaluate the information collected pursuant to this section to determine trends in and measure the health of the market for professional liability insurance for a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS in this State.

5. If the Commissioner convenes a hearing pursuant to subsection 1 of NRS 690B.350 and determines that the market for professional liability insurance issued to any class, type or specialty of practitioner licensed pursuant to chapter 630, 631 or 633 of NRS is not competitive and that such insurance is unavailable or unaffordable for a substantial number of such practitioners, the Commissioner shall prepare and submit a report of the Commissioner's findings and recommendations to the Director of the Legislative Counsel Bureau for transmittal to members of the Legislature.

Sec. 60. (Deleted by amendment.)

Sec. 61. 1. This section and sections 1 to 55, inclusive, 58, 59 and 60 of this act become effective upon passage and approval.

2. Sections 56 and 57 of this act become effective on October 1, 2019.