# STUDY OF HEALTH INSURANCE BENEFITS REQUIRED BY LAW

*Bulletin No. 91-4*

**LEGISLATIVE COMMISSION**
**OF THE**
**LEGISLATIVE COUNSEL BUREAU**
**STATE OF NEVADA**

SEPTEMBER 1990

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Senate Concurrent Resolution No. 58—Committee on Commerce and Labor

FILE NUMBER 198

SENATE CONCURRENT RESOLUTION—Directing the Legislative Commission to conduct an interim study of health insurance benefits required by law and self-insured employers.

WHEREAS, Nevada law currently requires policies of health insurance to provide coverage for home health care, the treatment of alcohol and drug abuse, medical care rendered in hospices, surgical mastectomies, complications of pregnancy and medical care for newly born children; and

WHEREAS, Legislation has been introduced during this session that would require policies of health insurance to provide coverage for the treatment of infertility, care rendered by homeopathic physicians, chiropractors and physical therapists, measures for the prevention of breast cancer, routine child care and measures to prevent fetal defects; and

WHEREAS, Self-insured employers do not always provide such benefits, though their employees may wish to have such benefits; and

WHEREAS, It appears that such benefits will continue to be mandated because of the demand for high-quality health care and the rising cost of such care; and

WHEREAS, The unregulated billing practices of certain providers of health care may also be contributing to the increase in the cost of health care; and

WHEREAS, Mandated benefits increase the cost of health insurance and may also contribute to increases in the cost of health care; now, therefore, be it

RESOLVED BY THE SENATE OF THE STATE OF NEVADA, THE ASSEMBLY CONCURRING, That the Legislative Commission is hereby directed to conduct an interim study of:

1. Health insurance benefits required by law;
2. The effects of currently required and any proposed future health insurance benefits on the cost of health care and health insurance;
3. Laws governing employers who are self-insured;
4. Any problems concerning health insurance experienced by the employees of employers who are self-insured; and
5. The effects of current billing practices of providers of health care, other than hospitals, on the cost of health care;

and be it further

RESOLVED, That this study be conducted by a subcommittee appointed by the Legislative Commission, to be composed of:

1. The Chairman of the Senate Standing Committee on Commerce and Labor, who shall serve as chairman of the subcommittee;
2. Two Senators who are members of the Senate Standing Committee on Commerce and Labor; and
3. Three Assemblymen who are members of the Assembly Standing Committee on Commerce;

and be it further

RESOLVED, That the Legislative Commission report the results of the study and any recommended legislation to the 66th session of the Nevada Legislature.

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# REPORT OF THE LEGISLATIVE COMMISSION

TO THE MEMBERS OF THE 66TH SESSION OF THE NEVADA LEGISLATURE:

This report is submitted in compliance with Senate Concurrent Resolution 58 of the 65th session of the Nevada Legislature which directed the Legislative Commission to study health insurance benefits required by law.

The members of the subcommittee appointed by the Legislative Commission to conduct the study were:

Senator Randolph J. Townsend, Chairman
Assemblyman Gene T. Porter, Vice Chairman
Senator William R. O'Donnell
Senator John M. Vergiels
Assemblyman John B. Dubois
Assemblyman Leonard V. Nevin

Legislative Counsel Bureau staff services for the subcommittee were provided by Paul T. Mouritsen of the Research Division (principal staff), Jan Needham of the Legal Division (legal counsel) and Kay Graves of the Research Division (subcommittee secretary). The subcommittee wishes to acknowledge the valuable assistance it received from Nevada's Commissioner of Insurance in the Department of Commerce, and from members of his staff.

In this report, the subcommittee has attempted to present its recommendations in a concise form. All supporting documents and minutes are on file with the Research Library of the Legislative Counsel Bureau and are available for review.

This report is transmitted to the members of the 66th session of the Nevada Legislature for their consideration and appropriate action.

Respectfully submitted,

Legislative Commission
Legislative Counsel Bureau
State of Nevada

Carson City, Nevada
September 1990

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| Senator Randolph J. Townsend | Assemblyman Danny L. Thompson |
| Senator John M. Vergiels | |

## SUMMARY OF RECOMMENDATIONS

The Legislative Commission's Subcommittee to Study Health Insurance Benefits recommends that the 66th session of the Nevada Legislature:

1. Enact legislation requiring that insurers be prohibited from stopping the payment of health insurance benefits until an independent medical evaluation of a case is completed. Require that insurers inform claimants when an evaluation has been requested. Require that the evaluation include a personal medical examination by a physician of the claimant's choice, if the claimant desires, and that the insurer pay for the evaluation. (BDR 57-268)

2. Enact legislation allowing nonprofit organizations which receive 25 percent or more of their revenues from federal or state funds to participate in the state group insurance system. (BDR 23-269)

3. Exempt businesses with 25 or fewer employees from all mandated health insurance benefits if they offer coverage for at least the following medical services:

   a. Thirty days of hospitalization annually;

   b. Prenatal care;

   c. Obstetrical care;

   d. Well-baby and well-child checkups at the following age intervals--birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, and 6 years; and

   e. Two office visits per year.
   (BDR 57-270)

4. Pass a concurrent resolution requiring that the Senate Committee on Commerce and Labor and the Assembly Committee on Commerce analyze health insurance benefit mandates which may be proposed in the future in a fiscal and social context, using the following criteria as guidelines:

   a. The extent to which the service is generally utilized by a significant portion of the population;

   b. The extent to which insurance coverage is already generally available;

c. The extent to which the lack of coverage results in unreasonable financial hardship;

d. The level of public demand for the treatment or service;

e. The level of public demand for insurance coverage of the treatment or service;

f. The level of interest of collective bargaining agents in negotiating privately for insurance coverage of the treatment or service;

g. The extent to which insurance coverage will increase or decrease the cost of the treatment or service;

h. The extent to which insurance coverage will increase the appropriate use of the treatment or service;

i. The extent to which insurance coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders;

j. The effect which insurance coverage will have on the total expense of health care;

k. The likelihood of fulfilling the objective of meeting a consumer need as evidenced by the experience of other states;

l. Relevant findings of the state health agency relating to the social impact of the mandated benefit;

m. Alternative ways of meeting the identified need;

n. The impact of any social stigma attached to the benefit upon the market;

o. The impact of this benefit upon the availability of other benefits currently being offered;

p. The impact of the benefit on the decision of employers to shift to self-insured plans;

q. The methods which will be instituted to manage the utilization and costs of the proposed mandate;

r. The extent to which insurance coverage may affect the number and types of providers of the mandated service over the next 5 years;

s. The effects of the proposed mandate on the costs of health care borne by employers and employees, including the financial effect on small, medium-sized and large employers;

t. The medical efficacy of the treatment or service;

u. The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders;

v. The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders; and

w. The effect of the benefit or service on existing mandates. (BDR R-267)

5. Require that the Senate Committee on Commerce and Labor and the Assembly Committee on Commerce review at least five existing health insurance benefit mandates each legislative session for the next three sessions using, as guidelines, the criteria listed in BDR R-267. Require that all reviews be completed by July 1, 1997, and that the Senate Majority Leader and the Speaker of the Assembly submit a report to the Legislature regarding such reviews. (BDR R-271)

# REPORT TO THE 66TH SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMISSION'S SUBCOMMITTEE TO STUDY HEALTH INSURANCE BENEFITS

## I. INTRODUCTION

Health insurance has become a necessity for most Americans. Because of the rising costs of medical care, few families or individuals who are without health insurance are able to meet the expenses of a major medical emergency without severe financial hardship. At the same time, the cost of health insurance is rising rapidly, putting it out of the reach of many.

The increase in health insurance premiums has focused attention on the role of mandated benefits. Over the last decade and a half, the Nevada Legislature, like that of many other states, has enacted laws requiring that health insurance policies include coverage for certain types of treatments or for treatments by certain practitioners. Critics allege that these mandates add significantly to the cost of health insurance.

During the 1989 legislative session, more than a dozen bills relating to mandated benefits were introduced, including proposals to require coverage of treatment for infertility, care rendered by homeopathic physicians, chiropractors and physical therapists, measures for the prevention of breast cancer and fetal defects, and routine health care for children. In response to this flurry of proposals, the Legislature saw a need to carefully examine the issue and formulate a coherent policy relating to current and future mandates. The Legislature was also concerned about the growing tendency of large employers in the state to opt for self-insurance, in part to avoid the necessity of offering employees all the benefits required by state law. These considerations led to the passage of Senate Concurrent Resolution No. 58 of the 1989 legislative session (File No. 198, Statutes of Nevada 1989, pages 2375-2376).

The resolution directed the Legislative Commission to conduct a study of health insurance benefits required by law, laws governing self-insured employers, and billing practices of providers of health care other than hospitals. The subcommittee appointed to conduct this study held four hearings: two in Las Vegas, one in Reno, and one in Carson City, Nevada. At these hearings, extensive testimony was offered by representatives of the health insurance industry, health care practitioners, businesspersons and private citizens. This report includes a summary of the testimony

received by the subcommittee and the background for each of its recommendations.

## II. MANDATED BENEFITS IN NEVADA

The Nevada Legislature first became involved in mandating health care benefits in 1971 when it required that all policies sold in Nevada include coverage for home health care and hospice care. Since that time, almost every legislative session has seen the passage of new benefit mandates. Some of these mandates, such as those applying to newborns and adopted children, require coverage of certain classes of people. Others require payment for particular treatments or procedures, such as mammograms, or reconstructive surgery following a mastectomy. Reimbursement for services rendered by certain types of health care practitioners, such as chiropractors, marriage and family counselors, psychologists and social workers, are required by other provisions. Still other mandates deal with particular illnesses or conditions, such as problems affecting the temporomandibular joint (TMJ syndrome), complications of pregnancy, alcoholism or drug addiction. Appendix A contains a list of mandated benefits currently found in Nevada law.

Nevada is not the only state which has seen a proliferation of health insurance benefits mandated by law. In fact, the trend has been nationwide. According to data compiled by the Health Insurance Institute of America, the number of benefit mandates found in state laws across the country increased from 30, in 1970, to 686, in 1988. (See Jon R. Gabel and Gail A. Johnson, "The Price of State Mandated Benefits," Inquiry, Volume 26, Winter 1989, included as Exhibit F, minutes for the meeting of February 23, 1990). During the same period of time, the number of mandated benefits in Nevada increased from zero to 19, according to the same source.

As the number of mandates has increased, so has concern about their effect on insurance premiums. Reliable estimates of the total cost of mandated benefits in Nevada are not available. However, at the request of the subcommittee, several of Nevada's largest health insurers examined their claim records in an attempt to estimate the cost of the following six selected mandates:

A. Chiropractors;

B. Drug and alcohol abuse;

C. Home health agencies;

D. Hospice care;

E. Mastectomy and post mastectomy care; and

F. Psychologists.

The results of this limited survey indicated that these six mandates increased insurance premiums by between 5 and 11.4 percent over what they would have been in the absence of the mandates. This increase costs the average policyholder between $53 and $140 per year. These estimates are included in Appendix B.

The increase in cost attributable to mandated benefits may be at least partly responsible for the failure of some individuals to purchase health insurance and the failure of many businesses to provide coverage for their employees. In testimony before the subcommittee, spokespersons for the health insurance industry cited studies which indicated that one-sixth of all small employers in the United States who do not presently provide health insurance for their employees would do so if there were no mandated benefits (Gabel and Jensen, ibid.). Studies were also cited indicating that about 30 percent of the uninsured in Nevada lack coverage because of increased costs attributed to mandated benefits (John C. Goodman and Gerald L. Musgrave, "Freedom of Choice in Health Insurance," National Center for Policy Analysis, November 1988. Cited by Fred L. Hillerby and Marie H. Soldo in Exhibit D, minutes for the meeting of April 20, 1990).

## III. SELF-INSURANCE

In recent years a growing number of business firms in the U.S. have opted to drop traditional health insurance coverage and instead insure their employees themselves. This trend toward self-insurance has important implications for Nevada.

Unlike traditional health insurance companies, self-insured employers are not subject to state insurance laws. In 1974, the U.S. Congress enacted the Employee Retirement and Income Security Act (ERISA, 29 United States Code 1001 et seq.) which set standards for pension benefits and the compensation of employees. The federal courts have ruled that this enactment preempts state regulation. Consequently, state laws which mandate coverage of certain types of health insurance benefits do not apply to self-insured employers.

Businesses frequently find it advantageous to self-insure to avoid having to offer state mandated benefits and to gain

the flexibility to offer those benefits which their employees most desire. From the standpoint of public policy, self-insurance has a number of serious disadvantages. First, self-insured employers are not required to meet the same solvency requirements which apply to insurance companies. When a self-insured company fails, the medical claims of its employees may go unpaid. Second, self-insured employers are not subject to state laws which protect consumers of insurance. Spokespersons for the Insurance Division report that although the division receives many complaints regarding self-insured employers, there is generally little it can do to resolve them. Third, self-insured employers do not pay the insurance premium tax. This tax, which is levied at a rate of 3.5 percent of net premiums, is Nevada's third largest source of state revenue, producing over $55 million each year. With as many as 352,000 of Nevada's residents covered by self-insured plans, the loss of revenue to the state is significant. Fourth, self-insurance is generally not an option for small employers. Because small businesses have relatively few employees, self-insurance would expose them to unacceptable risks. If these businesses provide health insurance for their employees, they must comply with state mandated benefit laws.

Mandated benefits are apparently an important factor in the trend toward self-insurance. In testimony before the subcommittee, spokespersons for the insurance industry cited studies indicating that half the businesses which have switched to self-insurance would not have done so if there had been no mandated benefits. (See Gabel and Jensen, ibid.)

## IV. BACKGROUND ON RECOMMENDATIONS

During the subcommittee's hearings, a large number of suggestions were presented for dealing with mandated health insurance benefits and resolving other problems related to health insurance. After careful consideration, five proposals were recommended by the subcommittee to the 1991 Nevada Legislature. The background for each of these recommendations is summarized as follows.

### A. INDEPENDENT MEDICAL EVALUATIONS

At its final hearing, the subcommittee heard testimony from a citizen of Nevada who is afflicted with a number of severe and chronic medical problems which require continuing, costly treatments. This individual indicated that, in early 1989, her insurance company requested a copy of her medical records, reviewed the case, and stopped paying claims.

These actions were taken solely on the basis of her medical records and without conducting a physical examination. The subcommittee is concerned about the hardship which actions such as this one may cause for persons who are seriously ill. Therefore, it recommends that the Nevada Legislature:

**Enact legislation requiring that insurers be prohibited from stopping the payment of health insurance benefits until an independent medical evaluation of a case is completed. Require that insurers inform claimants when an evaluation has been requested. Require that the evaluation include a personal medical examination by a physician of the claimant's choice, if the claimant desires, and that the insurer pay for the evaluation. (BDR 57-268)**

## B. INSURANCE FOR NONPROFIT ORGANIZATIONS

Nevada is served by a large number of nonprofit agencies which provide a variety of valuable public services. Many of these organizations have relatively few employees. In many cases, they obtain a significant portion of their operating revenues from the federal or state government.

In the fall of 1989, a number of these nonprofit organizations met, under the auspices of the Truckee Meadows Human Services Association and United Way of Northern Nevada and the Sierra. They discussed the difficulties involved in obtaining health insurance coverage for their employees. A subsequent survey revealed that insurance coverage was unavailable for some types of organizations while others were experiencing high premium increases. Several of the organizations joined together to seek insurance coverage and requested proposals from 10 major insurers. None of these insurers responded with a bid.

Consequently, representatives of this group of nonprofit organizations approached the subcommittee for assistance. The subcommittee recommends that the Nevada Legislature:

**Enact legislation allowing nonprofit organizations which receive 25 percent or more of their revenues from federal or state funds to participate in the state group insurance system. (BDR 23-269)**

## C. EXEMPTIONS FOR SMALL BUSINESS

As was noted previously, many small businesses do not presently offer their employees group health insurance coverage. These employers are frequently unable to afford the cost of providing a health insurance policy which

includes all of the benefits presently mandated by law. Unlike larger companies, they are generally unable to avoid these mandates through self-insurance. The subcommittee determined that these employers should be allowed to offer their workers a health insurance policy which would provide for basic health care. Therefore, the panel recommends that the Nevada Legislature:

**Exempt businesses with 25 or fewer employees from all mandated health insurance benefits if they offer coverage for at least the following medical services:**

1. **Thirty days of hospitalization annually;**

2. **Prenatal care;**

3. **Obstetrical care;**

4. **Well-baby and well-child checkups at the following age intervals--birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, and 6 years; and**

5. **Two office visits per year.**
   **(BDR 57-270)**

NOTE: The basic services specified here are those included in a similar measure enacted by the Virginia Legislature in 1990 (Virginia House Bill 1108).

## D. REVIEW OF PROPOSED MANDATES

During recent sessions, the Nevada Legislature has faced an increasing number of calls to add new benefits to the list of those which are presently mandated. The subcommittee is of the opinion that to ensure these proposals are evaluated in a thorough and consistent manner, definite guidelines should be established. Therefore, it recommends that the Nevada Legislature:

**Pass a concurrent resolution requiring that the Senate Committee on Commerce and Labor and the Assembly Committee on Commerce analyze health insurance benefit mandates which may be proposed in the future in a fiscal and social context, using the following criteria as guidelines:**

1. **The extent to which the service is generally utilized by a significant portion of the population;**

2. The extent to which insurance coverage is already generally available;

3. The extent to which the lack of coverage results in unreasonable financial hardship;

4. The level of public demand for the treatment or service;

5. The level of public demand for insurance coverage of the treatment or service;

6. The level of interest of collective bargaining agents in negotiating privately for insurance coverage of the treatment or service;

7. The extent to which insurance coverage will increase or decrease the cost of the treatment or service;

8. The extent to which insurance coverage will increase the appropriate use of the treatment or service;

9. The extent to which insurance coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders;

10. The effect which insurance coverage will have on the total expense of health care;

11. The likelihood of fulfilling the objective of meeting a consumer need as evidenced by the experience of other states;

12. Relevant findings of the state health agency relating to the social impact of the mandated benefit;

13. Alternative ways of meeting the identified need;

14. The impact of any social stigma attached to the benefit upon the market;

15. The impact of this benefit upon the availability of other benefits currently being offered;

16. The impact of the benefit on the decision of employers to shift to self-insured plans;

17. The methods which will be instituted to manage the utilization and costs of the proposed mandate;

18. **The extent to which insurance coverage may affect the number and types of providers of the mandated service over the next 5 years;**

19. **The effects of the proposed mandate on the costs of health care borne by employers and employees, including the financial effect on small, medium-sized and large employers;**

20. **The medical efficacy of the treatment or service;**

21. **The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders;**

22. **The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders; and**

23. **The effect of the benefit or service on existing mandates.**
**(BDR R-267)**

NOTE: These criteria are based upon those contained in laws in effect in the states of Maine and Washington.

## E. EVALUATION OF EXISTING MANDATES

The mandated benefits which are currently found in Nevada law have been enacted over a period of more than a decade. As economic and social circumstances change and medical treatments advance, some of these mandates may become obsolete. The subcommittee is of the opinion that existing mandates should be subjected to the same scrutiny as those which may be proposed in the future. Therefore, it recommends that the Nevada Legislature:

**Require that the Senate Committee on Commerce and Labor and the Assembly Committee on Commerce review at least five existing health insurance benefit mandates each legislative session for the next three sessions using, as guidelines, the criteria listed in BDR R-267. Require that all reviews be completed by July 1, 1997, and that the Senate Majority Leader and the Speaker of the Assembly submit a report to the Legislature regarding such reviews. (BDR R-271)**

## V. APPENDICES

## APPENDIX A

Health Insurance Benefits Required
by Current Nevada Law

HEALTH INSURANCE BENEFITS REQUIRED
BY CURRENT NEVADA LAW

**Mandated Benefits Required Pursuant to NRS 689A.**

1. NRS 689A.0405 Cytologic Screening Test & Mammograms
   Added: 1989

2. NRS 689A.041 Mastectomy & Reconstructive Surgery
   Added: 1983, Amended 1989

3. NRS 689A.042 Complications of Pregnancy
   Added: 1977

4. NRS 689A.043 Coverage of Newlyborn & Adopted Children
   Added: 1975, Amended 1989

5. NRS 689A.045 Termination of Coverage on Dependent Child
   Added: 1973

6. NRS 689A.046 Alcohol & Drug Abuse
   Added: 1979, Amended 1983, 1985 (NRS 689A.030(9) makes this benefit optional at applicant's election)

7. NRS 689A.0465 Coverage of Temporomandibular Joint (TMJ)
   Added: 1989

8. NRS 689A.048 Reimbursement for Treatment by Licensed Psychologist
   Added: 1979, Amemded 1989

9. NRS 689A.0483 Reimbursement for Treatment by Licensed Marriage/Family Therapist
   Added: 1987

10. NRS 689A.0485 Reimbursement for Treatment by Licensed Associate in Social Work, Social Worker (SW), Independent SW, or Clinical SW
    Added: 1987

11. NRS 689A.049 Reimbursement for Treatment by Licensed Chiropractor
    Added: 1981, Amended 1983

12. NRS 689A.0495 Reimbursement for Services Performed by Certain Nurses
    Added: 1985

13. NRS 689A.0497 Reimbursement to Provider of Medical Transportation
    Added: 1989

14. NRS 689A.030(8) Home Health Care
    Added: 1971, amended 1973,1975, 1979, 1983, 1985

15. NRS 689A.030(10) Hospice Care
    (same as #14) + amended 1989

16. NRS 689A.0403 Binding Arbitration
    Effective 10-1-1989

**Mandated Benefits Required Pursuant to NRS 689B**

| | | |
|---|---|---|
| 1. | NRS 689B.0374 | Cytologic Screening Test & Mammograms<br>Added: 1989 |
| 2. | NRS 689B.0375 | Mastectomy & Reconstructive Surgery<br>Added: 1983, Amended 1989 |
| 3. | NRS 689B.260 | Complications of Pregnancy<br>Added: 1977 |
| 4. | NRS 689B.033 | Coverage of Newlyborn & Adopted Children<br>Added: 1975, Amended 1989 |
| 5. | NRS 689B.035 | Termination of Coverage on Dependent Child<br>Added: 1973 |
| 6. | NRS 689B.036 | Alcohol & Drug Abuse<br>Added: 1979, Amended 1983,1985 |
| 7. | NRS 689B.0379 | Coverage of Temporomandibular Joint (TMJ)<br>Added: 1989 |
| 8. | NRS 689B.038 | Reimbursement for Treatment by Licensed Psychologist<br>Added: 1981, Amemded 1989 |
| 9. | NRS 689B.0383 | Reimbursement for Treatment by Licensed Marriage/Family Therapist<br>Added: 1987 |
| 10. | NRS 689B.0385 | Reimbursement for Treatment by Licensed Associate in Social Work, Social Worker (SW), Independent SW, or Clinical SW<br>Added: 1987 |
| 11. | NRS 689B.039 | Reimbursement for Treatment by Licensed Chiropractor<br>Added: 1981, Amended 1983 |
| 12. | NRS 689B.045 | Reimbursement for Services Performed by Certain Nurses<br>Added: 1985 |
| 13. | NRS 689B.047 | Reimbursement to Provider of Medical Transportation<br>Added: 1989 |
| 14. | NRS 689B.0345 | Coverage for Employee on Leave W/O Pay - Total Disability<br>Added: 1989 |
| 15. | NRS 689B.030(4) | Home Health Care<br>Added: 1971, amended 1983, 1985 |
| 16. | NRS 689B.030(6) | Hospice Care<br>(same as #15) + amended 1989 |
| 17. | NRS 689B.270 | Binding Arbitration<br>Effective 10-1-1989 |

**Mandated Benefits Required Pursuant to NRS 695B.**

| | |
|---|---|
| 1. NRS 695B.1912 | Cytologic Screening Test & Mammograms<br>Added: 1989 |
| 2. NRS 695B.191 | Mastectomy & Reconstructive Surgery<br>Added: 1983, Amended 1989 |
| 3. NRS 695B.192 | Complications of Pregnancy<br>Added 1977 |
| 4. NRS 695B.193 | Coverage of Newlyborn & Adopted Children<br>Added: 1975, Amended 1989 |
| 5. NRS 695B.194 | Alcohol & Drug Abuse<br>Added: 1979, Amended 1983,1985,1989 |
| 6. NRS 695B.1931 | Coverage of Temporomandibular Joint (TMJ)<br>Added: 1989 |
| 7. NRS 695B.197 | Reimbursement for Treatment by Licensed Psychologist<br>Added: 1981, Amended 1989 |
| 8. NRS 695B.1973 | Reimbursement for Treatment by Licensed Marriage/Family Therapist<br>Added: 1987 |
| 9. NRS 695B.1975 | Reimbursement for Treatment by Licensed Associate in Social Work, Social Worker (SW), Independent SW, or Clinical SW<br>Added: 1987 |
| 10. NRS 695B.198 | Reimbursement for Treatment by Licensed Chiropractor<br>Added: 1981, Amended 1983 |
| 11. NRS 695B.199 | Reimbursement for Services Performed by Certain Nurses<br>Added: 1985 |
| 12. NRS 695B.1995 | Reimbursement to Provider of Medical Transportation<br>Added: 1989 |
| 13. NRS 695B.1944 | Coverage for Employee on Leave W/O Pay - Total Disability<br>Added: 1989 |
| 14. NRS 695B.180(9) | Hospice Care<br>Added: 1971, amended 1975, 1979, 1983, 1985, 1989 |
| 15. NRS 695B.182 | Binding Arbitration<br>Effective 10-1-1989 |

**Mandated Benefits Required Pursuant to NRS 695C.**

| | | |
|---|---|---|
| 1. | NRS 695C.1735 | Cytologic Screening Test & Mammograms<br>Added: 1989 |
| 2. | NRS 695C.171 | Mastectomy & Reconstructive Surgery<br>Added: 1983, Amended 1989 |
| 3. | NRS 695C.172 | Complications of Pregnancy<br>Added 1977 |
| 4. | NRS 695C.173 | Coverage of Newlyborn & Adopted Children<br>Added: 1975, Amended 1989 |
| 5. | NRS 695C.174 | Alcohol & Drug Abuse<br>Added: 1979, Amended 1983,1985, |
| 6. | NRS 695C.1755 | Coverage of Temporomandibular Joint (TMJ)<br>Added: 1989 |
| 7. | NRS 695C.177 | Reimbursement for Treatment by Licensed Psychologist<br>Added: 1981, Amemded 1989 |
| 8. | NRS 695C.1773 | Reimbursement for Treatment by Licensed Marriage/Family Therapist<br>Added: 1987 |
| 9. | NRS 695C.1775 | Reimbursement for Treatment by Licensed Associate in Social Work, Social Worker (SW), Independent SW, or Clinical SW<br>Added: 1987 |
| 10. | NRS 695C.178 | Reimbursement for Treatment by Licensed Chiropractor<br>Added: 1981, Amended 1983 |
| 11. | NRS 695C.179 | Reimbursement for Services Performed by Certain Nurses<br>Added: 1985 |
| 12. | NRS 695C.1795 | Direct Payment to Provider of Medical Transportation<br>Added: 1989 |
| 13. | NRS 695C.176 | Hospice Care<br>Added: 1983, Amended 1985, 1989 |
| 14. | NRS 695C.1709 | Coverage for Employee on Leave W/O Pay - Total Disability<br>Added: 1989 |

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## APPENDIX B

Estimated Costs of Selected Mandated Benefits

TESTIMONY OF

AD HOC COMMITTEE OF

NEVADA DOMESTIC HEALTH INSURANCE ORGANIZATIONS

REGARDING

COSTS OF MANDATED HEALTH INSURANCE BENEFITS

TO

THE LEGISLATIVE COMMISSIONS'S SUBCOMMITTEE

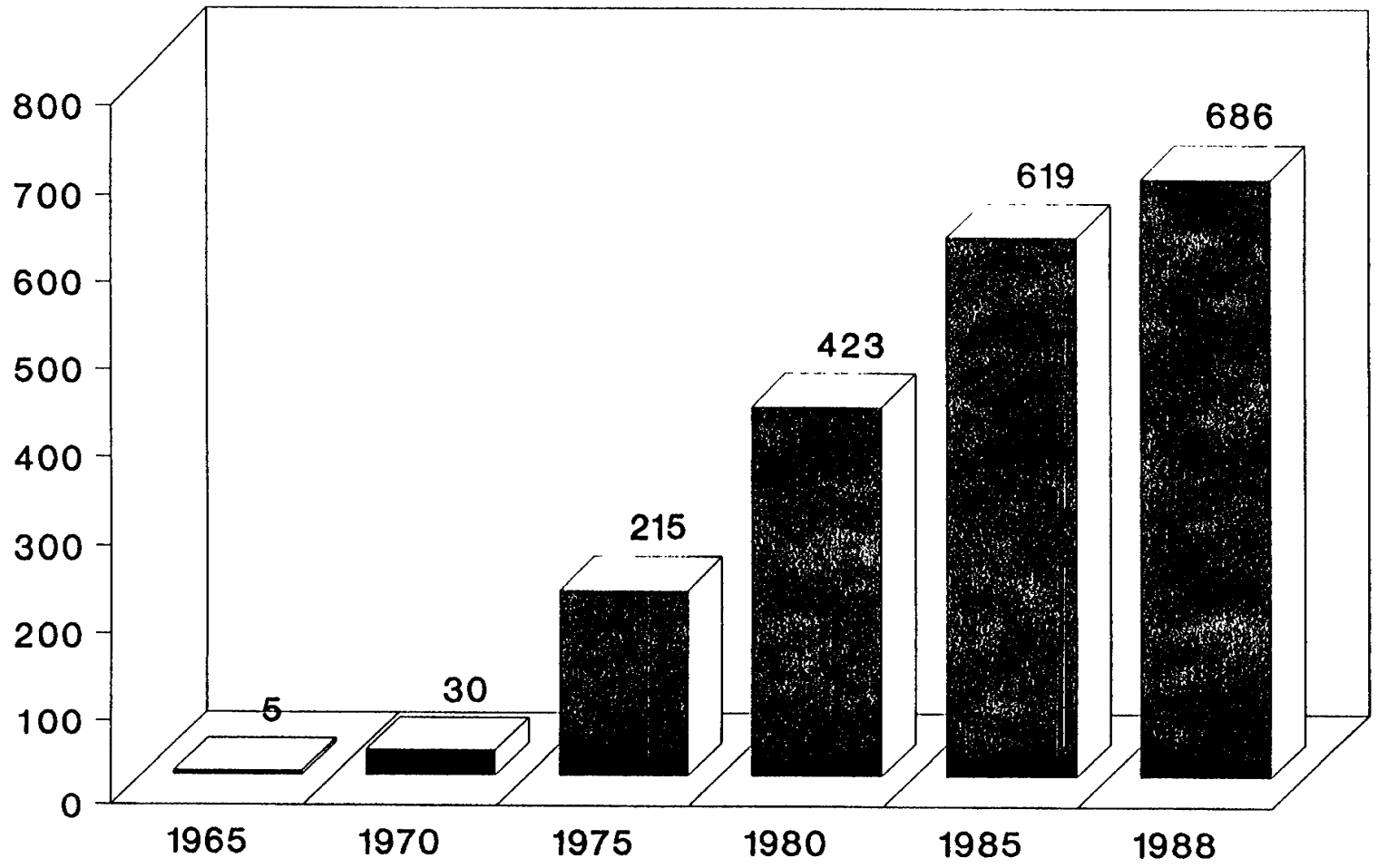
TO STUDY HEALTH INSURANCE BENEFITS

**-- EXHIBITS --**

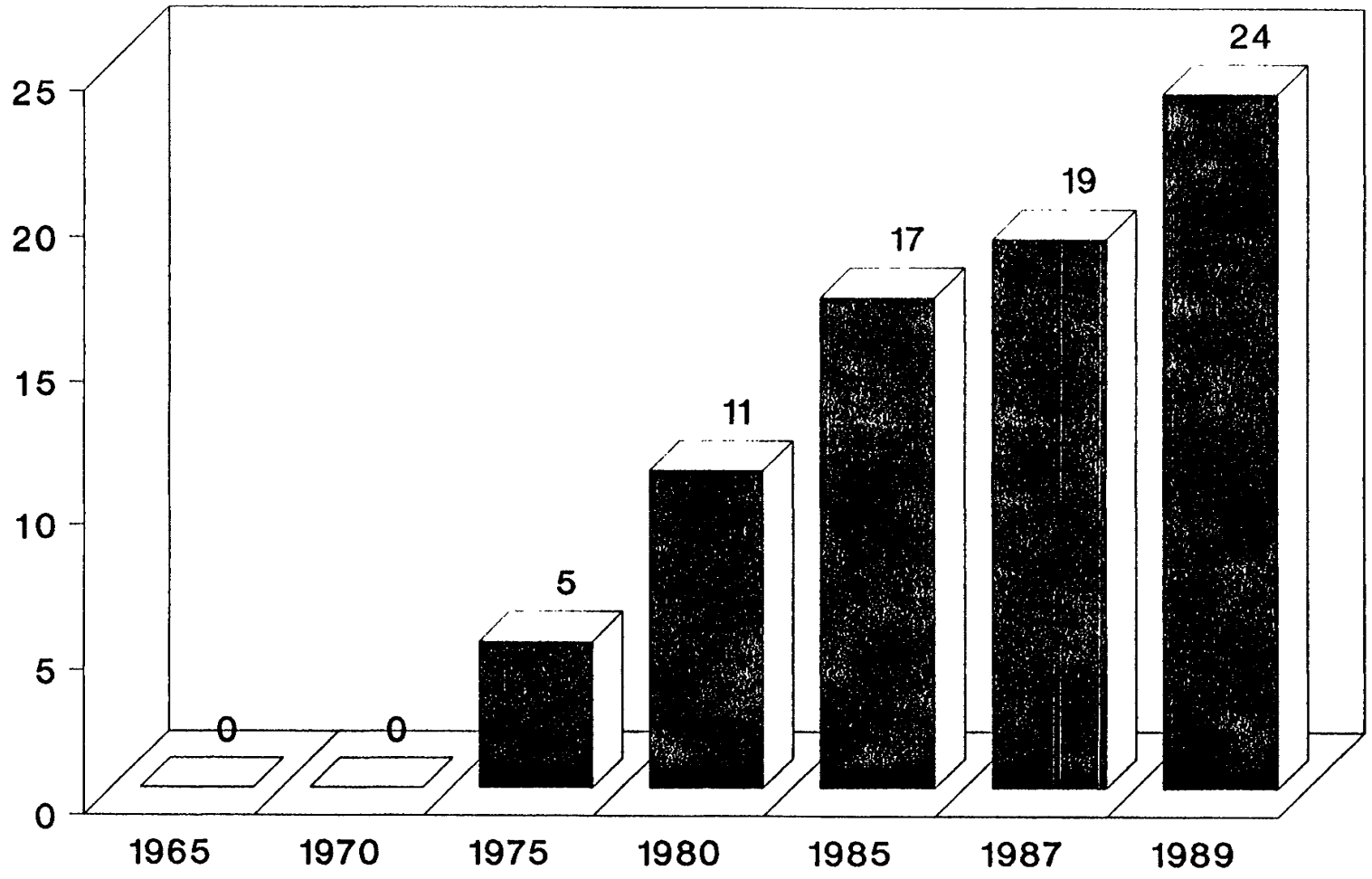
FEBRUARY 23, 1990

LAS VEGAS, NEVADA

# NUMBER OF MANDATED HEALTH INSURANCE BENEFITS ENACTED BY STATE GOVERNMENTS



# NUMBER OF MANDATED HEALTH INSURANCE BENEFITS ENACTED BY NEVADA LEGISLATURE



# RESULTS OF STUDY OF COST OF MANDATED HEALTH INSURANCE BENEFITS

**BENEFIT: DRUG AND ALCOHOL ABUSE**

**COST RANGE: $9.60 TO $62.28 PER MEMBER PER YEAR**

**PERCENT AVERAGE PREMIUM RANGE: .9% TO 5.1%**

**BENEFIT DESCRIPTION: Provides inpatient and outpatient coverage for treatment of alcohol or drug abuse, including treatment for withdrawal and counseling.**

# RESULTS OF STUDY OF COST OF MANDATED HEALTH INSURANCE BENEFITS

**BENEFIT: MASTECTOMY/POST MASTECTOMY**

**COST RANGE: $1.20 TO $10.92 PER MEMBER PER YEAR**

**PERCENT AVERAGE PREMIUM RANGE: .1% TO 1.1%**

**BENEFIT DESCRIPTION: Provides coverage for reconstructive surgery and prosthetic devices if policy covers mastectomy.**

# RESULTS OF STUDY OF COST OF MANDATED HEALTH INSURANCE BENEFITS

**BENEFIT: HOME HEALTH AGENCY**

**COST RANGE: $8.40 TO $26.52 PER MEMBER PER YEAR**

**PERCENT AVERAGE PREMIUM RANGE: .7% TO 2.4%**

**BENEFIT DESCRIPTION: Provides coverage for home health care services if prescribed by a physician and if such services would be covered if performed in a medical facility.**

# RESULTS OF STUDY OF COST OF MANDATED HEALTH INSURANCE BENEFITS

**BENEFIT: HOSPICE**

**COST RANGE: $.96 TO $5.40 PER MEMBER PER YEAR**

**PERCENT AVERAGE PREMIUM RANGE: .1% TO .4%**

**BENEFIT DESCRIPTION: Provides coverage for services rendered by a hospice if those services are covered when rendered by a hospital or other medical facility.**

# RESULTS OF STUDY OF COST OF MANDATED HEALTH INSURANCE BENEFITS

**BENEFIT: CHIROPRACTOR**

**COST RANGE: $.12 TO $52.68 PER MEMBER PER YEAR**

**PERCENT AVERAGE PREMIUM RANGE: <.1% TO 4.3%**

**BENEFIT DESCRIPTION: Provides coverage for licensed chiropractor's treatments if policy covers treatment of an illness which is within authorized scope of chiropractor's practice.**

# RESULTS OF STUDY OF COST OF MANDATED HEALTH INSURANCE BENEFITS

**BENEFIT: CERTIFIED PSYCHOLOGIST**

**COST RANGE: $9.00 TO $12.00 PER MEMBER PER YEAR**

**PERCENT AVERAGE PREMIUM RANGE: .8% TO 1.2%**

**BENEFIT DESCRIPTION: Provides coverage for psychological treatments if policy covers treatment of an illness which is within authorized scope of licensed psychologist's practice.**

# RESULTS OF STUDY OF COST OF MANDATED HEALTH INSURANCE BENEFITS

## SUMMARY

| BENEFIT | PER MEMBER PER YEAR COST RANGE FROM | TO | % AVERAGE PREMIUM FROM | TO |
|---|---|---|---|---|
| DRUG AND ALCOHOL ABUSE | $9.60 | $62.28 | .9 | 5.1 |
| MASTECTOMY/POST MASTECTOMY | 1.20 | 10.92 | .1 | 1.1 |
| HOME HEALTH AGENCY | 8.40 | 26.52 | .7 | 2.4 |
| HOSPICE | .96 | 5.40 | .1 | .4 |
| CHIROPRACTOR | .12 | 52.68 | <.1 | 4.3 |
| CERTIFIED PSYCHOLOGIST | 9.00 | 12.00 | .8 | 1.2 |
| TOTAL | 53.04 | 139.92 | 5.0 | 11.4 |

June 16, 1989

| | | |
|---|---|---|
| **Blue Cross/Blue Shield** | | |
| Employee rate | 140.03 x 43 = | $ 6,021.29 |
| Dependent rate | 226.85 x 14 = | 3,175.90 |
| Total/Month | | $ 9,197.19 |
| Total/Annual | | $110,366.28 |
| **Hospital Health Plan** | | |
| Employee rate | 116.10 x 43 = | $ 4,992.30 |
| Dependent rate | 255.49 x 14 = | 3,576.86 |
| Total/Month | | $ 8,569.16 |
| Total/Annual | | $102,829.92 |
| **Alternative Group Plan** | | |
| Employee rate | 48.46 x 43 = | $ 2,096.68 |
| Dependent rate | 75.57 x 14 = | 1,057.98 |
| (1) Total (Fixed) | | $ 3,154.66 |
| Total/Annual | | $ 37,855.92 |
| Employee rate | 90.87 x 43 = | $ 3,907.41 |
| Dependent rate | 136.30 x 14 = | 1,908.20 |
| (2) Total Mo.(Aggregate/Fund) | | $ 5,815.61 |
| Total/Annual | | $ 69,787.32 |
| Total Exposure (#1 & #2) | | $107,643.24 |
| Expected claims = 60% of aggregate/fund | | $ 41,872.39 |
| Potential Savings | | $ 27,914.93 |

## APPENDIX C

Suggested Legislation

SUMMARY--Revises provisions governing independent medical evaluation required by insurer for final determination of benefits. (BDR 57-268)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to insurance; requiring an insurer to pay for an independent medical evaluation which is required for a final determination of benefits; limiting the evaluation to a review of existing medical records unless the patient requests a physical examination; prohibiting the insurer from limiting or denying coverage for care while the evaluation is being conducted; and providing other matters properly relating thereto.

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

**Section 1.** NRS 689A.0403 is hereby amended to read as follows:

689A.0403 1. Each policy of health insurance must include a procedure for binding arbitration to resolve disputes concerning independent medical evaluations pursuant to the rules of the American Arbitration Association.

2. If an insurer, for any final determination of benefits or care, requires an independent evaluation of the medical or chiropractic care of any person for whom such care is covered under the terms of the contract of insurance, [only a physician or chiropractor who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field may conduct the independent evaluation.] *the insurer shall, within 3 working days after requiring the independent evaluation, send written notice to the insured person that the evaluation is required. The insurer shall pay for the independent evaluation.*

3. The independent evaluation must include [a physical examination of the patient, unless he is deceased, and a] *:*

*(a) A* personal review of all X-rays and reports prepared by the primary treating physician or chiropractor [.] *; and*

*(b) A physical examination of the patient if he so requests. If a physical examination is requested, the examination must be performed by a physician or chiropractor chosen by the patient who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field.*

*4.* A certified copy of all reports of findings must be sent to the primary treating physician or chiropractor and the insured person within 10 working days after the evaluation. If the insured person disagrees with the finding of the evaluation, he must submit an appeal to the insurer pursuant to the procedure for binding arbitration set forth in the policy of insurance within 30 days after

he receives the finding of the evaluation. Upon its receipt of an appeal, the insurer shall so notify in writing the primary treating physician or chiropractor.

[4.] *5.* The insurer shall not limit or deny coverage for care related to a disputed claim while [the] *:*

*(a) An independent examination is being conducted, unless the insured person agrees in writing to the limitation or denial of coverage.*

*(b) The* dispute is in arbitration, except that, if the insurer prevails in the arbitration, the primary treating physician or chiropractor may not recover any payment from either the insurer, insured person or the patient for services that he provided to the patient after receiving written notice from the insurer pursuant to subsection [3] *4* concerning the appeal of the insured person.

**Sec. 2.** NRS 689B.270 is hereby amended to read as follows:

689B.270 1. Each policy of group or blanket health insurance must include a procedure for binding arbitration to resolve disputes concerning independent medical evaluations pursuant to the rules of the American Arbitration Association.

2. If an insurer, for any final determination of benefits or care, requires an independent evaluation of the medical or chiropractic care of any person for whom such care is covered under the terms of a policy of group or blanket health insurance, [only a physician or chiropractor who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field may conduct the independent evaluation.] *the insurer shall, within 3 working days after requiring the*

*independent evaluation, send written notice to the insured person that the evaluation is required. The insurer shall pay for the independent evaluation.*

3. The independent evaluation must include [a physical examination of the patient, unless he is deceased, and a] *:*

*(a) A* personal review of all X-rays and reports prepared by the primary treating physician or chiropractor [.] *; and*

*(b) A physical examination of the patient if he so requests. If a physical examination is requested, the examination must be performed by a physician or chiropractor chosen by the patient who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field.*

*4.* A certified copy of all reports of findings must be sent to the primary treating physician or chiropractor and the insured person within 10 working days after the evaluation. If the insured person disagrees with the finding of the evaluation, he must submit an appeal to the insurer pursuant to the procedure for binding arbitration set forth in the policy of insurance within 30 days after he receives the finding of the evaluation. Upon its receipt of an appeal, the insurer shall so notify in writing the primary treating physician or chiropractor.

[4.] *5.* The insurer shall not limit or deny coverage for care related to a disputed claim while [the] *:*

*(a) An independent examination is being conducted, unless the insured person agrees in writing to the limitation or denial of coverage.*

*(b) The* dispute is in arbitration, except that, if the insurer prevails in the arbitration, the primary treating physician or chiropractor may not recover any payment from either the insurer, insured person or the patient for services that he provided to the patient after receiving written notice from the insurer pursuant to subsection [3] *4* concerning the appeal of the insured person.

**Sec. 3.** NRS 695A.183 is hereby amended to read as follows:

695A.183 1. Each certificate of health insurance must include a procedure for binding arbitration to resolve disputes concerning independent medical evaluations pursuant to the rules of the American Arbitration Association.

2. If a society, for any final determination of benefits or care, requires an independent evaluation of the medical or chiropractic care of any person for whom such care is covered under a certificate of health insurance, [only a physician or chiropractor who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field may conduct the independent evaluation.] *the society shall, within 3 working days after requiring the independent evaluation, send written notice to the insured person that the evaluation is required. The society shall pay for the independent evaluation.*

3. The independent evaluation must include [a physical examination of the patient, unless he is deceased, and a] *:*

*(a) A* personal review of all X-rays and reports prepared by the primary treating physician or chiropractor [.] *; and*

*(b) A physical examination of the patient if he so requests. If a physical examination is requested, the examination must be performed by a physician or chiropractor chosen by the patient who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field.*

*4.* A certified copy of all reports of findings must be sent to the primary treating physician or chiropractor and the insured person within 10 working days after the evaluation. If the insured person disagrees with the finding of the evaluation, he must submit an appeal to the insurer pursuant to the procedure for binding arbitration set forth in the certificate of insurance within 30 days after he receives the finding of the evaluation. Upon its receipt of an appeal, the insurer shall so notify in writing the primary treating physician or chiropractor.

**[**4.**]** *5.* The insurer shall not limit or deny coverage for care related to a disputed claim while **[**the**]** *:*

*(a) An independent examination is being conducted, unless the insured person agrees in writing to the limitation or denial of coverage.*

*(b) The* dispute is in arbitration, except that, if the insurer prevails in the arbitration, the primary treating physician or chiropractor may not recover any payment from either the insurer, insured person or the patient for services that he provided to the patient after receiving written notice from the insurer pursuant to subsection **[**3**]** *4* concerning the appeal of the insured person.

**Sec. 4.** NRS 695B.182 is hereby amended to read as follows:

695B.182 1. Each contract for hospital or medical services must include a procedure for binding arbitration to resolve disputes concerning independent medical evaluations pursuant to the rules of the American Arbitration Association.

2. If a corporation subject to the provisions of this chapter, for any final determination of benefits or care, requires an independent evaluation of the medical or chiropractic care of any person for whom such care is covered under a contract for hospital or medical services, [only a physician or chiropractor who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field may conduct the independent evaluation.] *the corporation shall, within 3 working days after requiring the independent evaluation, send written notice to the insured person that the evaluation is required. The corporation shall pay for the independent evaluation.*

3. The independent evaluation must include [a physical examination of the patient, unless he is deceased, and a] *:*

*(a) A* personal review of all X-rays and reports prepared by the primary treating physician or chiropractor [.] *; and*

*(b) A physical examination of the patient if he so requests. If a physical examination is requested, the examination must be performed by a physician or chiropractor chosen by the patient who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field.*

*4.* A certified copy of all reports of findings must be sent to the primary treating physician or chiropractor and the insured person within 10 working days after the evaluation. If the insured person disagrees with the finding of the evaluation, he must submit an appeal to the insurer pursuant to the procedure for binding arbitration set forth in the contract for services within 30 days after he receives the finding of the evaluation. Upon its receipt of an appeal, the insurer shall so notify in writing the primary treating physician or chiropractor.

**[**4.**]** *5.* The insurer shall not limit or deny coverage for care related to a disputed claim while **[**the**]** *:*

*(a) An independent evaluation is being conducted, unless the insured person agrees in writing to the limitation or denial of coverage.*

*(b) The* dispute is in arbitration, except that, if the insurer prevails in the arbitration, the primary treating physician or chiropractor may not recover any payment from either the insurer, insured person or the patient for services that he provided to the patient after receiving written notice from the insurer pursuant to subsection **[**3**]** *4* concerning the appeal of the insured person.

**Sec. 5.** NRS 695C.265 is hereby amended to read as follows:

695C.265 1. If a health maintenance organization, for any final determination of benefits or care, requires an independent evaluation of the medical or chiropractic care of any person for whom such care is provided under the evidence of coverage:

(a) The evidence of coverage must include a procedure for binding arbitration to resolve disputes concerning independent medical evaluations pursuant to the rules of the American Arbitration Association . [; and

(b) Only a physician or chiropractor who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field may conduct the independent evaluation.]

*(b) The health maintenance organization shall, within 3 working days after requiring the independent evaluation, send written notice to the insured person that the evaluation is required.*

*(c) The health maintenance organization shall pay for the independent evaluation.*

2. The independent evaluation must include [a physical examination of the patient, unless he is deceased, and a] *:*

*(a) A* personal review of all X-rays and reports prepared by the primary treating physician or chiropractor [.] *; and*

*(b) A physical examination of the patient if he so requests. If a physical examination is requested, the examination must be performed by a physician or chiropractor chosen by the patient who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field.*

*3.* A certified copy of all reports of findings must be sent to the primary treating physician or chiropractor and the insured person within 10 working days after the evaluation. If the insured person disagrees with the finding of the

evaluation, he must submit an appeal to the insurer pursuant to the procedure for binding arbitration set forth in the evidence of coverage within 30 days after he receives the finding of the evaluation. Upon its receipt of an appeal, the insurer shall so notify in writing the primary treating physician or chiropractor.

[3.] *4.* The insurer shall not limit or deny coverage for care related to a disputed claim while [the] *:*

*(a) An independent examination is being conducted, unless the insured person agrees in writing to the limitation or denial of coverage.*

*(b) The* dispute is in arbitration, except that, if the insurer prevails in the arbitration, the primary treating physician or chiropractor may not recover any payment from either the insurer, insured person or the patient for services that he provided to the patient after receiving written notice from the insurer pursuant to subsection [2] *3* concerning the appeal of the insured person.

SUMMARY--Allows certain nonprofit organizations to participate in state's program of group insurance. (BDR 23-269)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to insurance for state officers and employees; allowing certain nonprofit organizations to participate in the state's program of group insurance; and providing other matters properly relating thereto.

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

**Section 1.** NRS 287.043 is hereby amended to read as follows:

287.043 The committee on group insurance shall:

1. Act as an advisory body on matters relating to group life, accident or health insurance, or any combination thereof, for the benefit of all state officers and employees [.] *and the officers and employees of nonprofit organizations participating in the state's program of group insurance.*

2. Except as otherwise provided in this subsection, negotiate and contract with the governing body of any public agency enumerated in NRS 287.010 which is desirous of obtaining group insurance for its officers and employees

by participation in the state's program of group insurance. If such an agency has 200 officers and employees or fewer, the rates and coverage must be the same as those established for state employees. If such an agency has more than 200 officers and employees, the committee may establish by regulation separate rates and coverage for those officers and employees based on actuarial reports.

3. *Negotiate and contract with any nonprofit organization which is desirous of obtaining group insurance for its officers and employees by participation in the state's program of group insurance. A nonprofit organization may participate in the state's program of group insurance if it receives at least 25 percent of its funding from this state or the Federal Government, or both.*

*4.* Give public notice in writing of proposed changes in rates or coverage to each participating [public] employer who may be affected by the changes. Notice must be provided at least 30 days before the effective date of the changes.

[4.] *5.* Purchase policies of life, accident or health insurance, or any combination thereof, from any insurance company qualified to do business in this state or provide similar coverage through a plan of self-insurance for the benefit of all eligible [public] officers and employees who participate in the state's program of group insurance.

[5.] *6.* Consult the state risk manager and obtain his advice in the performance of the duties set forth in this section.

[6.] *7.* Adopt such regulations and perform such other duties as may be necessary to carry out the provisions of NRS 287.041 to 287.049, inclusive, including the establishment of:

(a) Fees for applications for participation in the state's program and for the late payment of premiums; and

(b) Conditions for entry and reentry into the state's program by public agencies enumerated in NRS 287.010 [.] *and eligible nonprofit organizations.*

[7.] *8.* Appoint an independent certified public accountant. The accountant shall provide an annual audit of the plan and report to the committee and the legislative commission.

**Sec. 2.** NRS 287.0434 is hereby amended to read as follows:

287.0434 The committee on group insurance may:

1. Use its assets to pay the expenses of health care for its members and covered dependents, to pay its employees' salaries and to pay administrative and other expenses.

2. Enter into contracts relating to the administration of a plan of insurance, including contracts with licensed administrators and qualified actuaries.

3. Enter into contracts with physicians, surgeons, hospitals, health maintenance organizations and rehabilitative facilities for medical, surgical and rehabilitative care and the evaluation, treatment and nursing care of members and covered dependents.

4. Enter into contracts for the services of other experts and specialists as required by a plan of insurance.

5. Charge and collect from an insurer, health maintenance organization, organization for dental care or nonprofit medical service corporation, a fee for the actual expenses incurred by the committee, the state or a participating [public] employer in administering a plan of insurance offered by that insurer, organization or corporation.

**Sec. 3.** NRS 287.0439 is hereby amended to read as follows:

287.0439 1. A participating [public] employer shall, on request, furnish to the committee on group insurance any information necessary to carry out the provisions of this chapter. Members of the committee and its employees or agents may examine under oath any officer, agent or employee of a participating [public] employer concerning the information.

2. The books, records and payrolls of a participating [public] employer must be available for inspection by members of the committee and its employees and agents to obtain any information necessary for the administration of the plan, including the accuracy of the payroll and identity of employees.

**Sec. 4.** NRS 287.044 is hereby amended to read as follows:

287.044 1. A part of the cost of the premiums or contributions for that group insurance, not to exceed the amount specified by law, applied to both group life and group accident or health coverage, for each public officer, except a senator or assemblyman, or employee electing to participate in the *state's program of* group insurance , [program,] may be paid by the department, agency, commission or public agency which employs the officer or

employee in whose behalf that part is paid from money appropriated to or authorized for that department, agency, commission or public agency for that purpose.

*2. A part of the cost of the premiums or contributions for that group insurance, applied to both group life and group accident or health coverage, for each officer or employee of a nonprofit organization electing to participate in the state's program of group insurance may be paid by the nonprofit organization.*

*3.* Participation by the state in the cost of premiums or contributions must not exceed the amounts specified by law.

*4.* If an officer or employee chooses to cover his dependents, whenever this option is made available by the committee on group insurance, he must pay the difference between the amount of the premium or contribution for the coverage for himself and his dependents and the amount paid by [the state.

2.] *his employer.*

*5.* A department, agency, commission , [or] public agency *or nonprofit organization* shall not pay any part of those premiums if the group life insurance or group accident or health insurance is not approved by the committee on group insurance.

**Sec. 5.** NRS 287.0445 is hereby amended to read as follows:

287.0445 The department, agency, commission , [or] public agency *or nonprofit organization* which employed an officer or employee who:

1. Was injured in the course of that employment;

2. Receives compensation for a temporary total disability pursuant to NRS 616.585; and

3. Was a member of the state's *program of* group insurance [program] at the time of the injury,

shall pay the [state's] *employer's* share of the cost of the premiums of the group insurance for that officer or employee for a period of not more than 9 months or until the officer or employee is able to return to work, whichever is less.

**Sec. 6.** NRS 287.045 is hereby amended to read as follows:

287.045 1. Except as otherwise provided in subsections 2 and 4, every officer or employee of the state *or of a participating nonprofit organization* is eligible to participate in the program on the first day of the month following the completion of 90 days of full-time employment.

2. Professional employees of the University of Nevada System who have annual employment contracts are eligible to participate in the program on:

(a) The effective dates of their respective employment contracts, if those dates are on the first day of a month; or

(b) The first day of the month following the effective dates of their respective employment contracts, if those dates are not on the first day of a month.

3. Every officer or employee who is employed by a participating public agency *or nonprofit organization* on a permanent and full-time basis on the date the agency *or organization* enters into an agreement to participate in the

state's *program of* group insurance , [program,] and every officer or employee who commences his employment after that date is eligible to participate in the program on the first day of the month following the completion of 90 days of full-time employment.

4. Every senator and assemblyman is eligible to participate in the program on the first day of the month following the 90th day after his initial term of office begins.

**Sec. 7.** NRS 287.046 is hereby amended to read as follows:

287.046 1. Except as otherwise provided in subsection 3, any state or other participating officer or employee who elects to participate in the state's *program of* group insurance [program] may participate, and the department, agency, commission , [or] public agency *or nonprofit organization* which employs the officer or employee shall pay the [state's] *employer's* share of the cost of the premiums or contributions for the group insurance [from money appropriated or authorized] as provided in NRS 287.044. Employees who elect to participate in the state's *program of* group insurance [program] must authorize deductions from their compensation for the payment of premiums or contributions on the insurance.

2. The department of personnel shall pay the amount provided by law for that fiscal year toward the cost of the premiums or contributions for group insurance for persons retired from the service of the state who have continued to participate. The department shall agree through the committee on group insurance with the insurer for billing of remaining premiums or contributions

for the retired participant and his dependents to the retired participant and to his dependents who elect to continue coverage under the group insurance after his death.

3. A senator or assemblyman who elects to participate in the state's *program of* group insurance [program] shall pay the entire premium or contribution for his insurance.

**Sec. 8.** NRS 287.0465 is hereby amended to read as follows:

287.0465 1. If an officer or employee [of the state] *participating in the state's program of group insurance* or dependent thereof incurs an illness or injury for which medical services are payable under the plan for self-insurance adopted by the committee on group insurance and the illness or injury is incurred under circumstances creating a legal liability in some person, other than the officer, employee or dependent, to pay all or part of the cost of those services, the committee on group insurance is subrogated to the right of the officer, employee or dependent to the extent of all such costs, and may join or intervene in any action by the officer, employee or dependent or his successors in interest, to enforce that legal liability.

2. If an officer, employee or dependent or his successors in interest fail or refuse to commence an action to enforce that legal liability, the committee on group insurance may commence an independent action, after notice to the officer, employee or dependent or his successors in interest, to recover all costs to which it is entitled. In any such action by the committee on group

insurance, the officer, employee or dependent may be joined as third party defendants.

3. If the committee on group insurance is subrogated to the rights of the officer, employee or dependent or his successors in interest as provided in subsection 1, the committee on group insurance has a lien upon the total proceeds of any recovery from the persons liable, whether the proceeds of the recovery are by way of a judgment or settlement or otherwise. Within 15 days after recovery by receipt of the proceeds of the judgment, settlement or other recovery, the officer, employee or dependent or his successors in interest shall notify the committee on group insurance of the recovery and pay the committee on group insurance the amount due to it pursuant to this section. The officer, employee or dependent or his successors in interest are not entitled to double recovery for the same injury.

4. The officer, employee or dependent or his successors in interest shall notify the committee on group insurance in writing before entering any settlement or agreement or commencing any action to enforce the legal liability referred to in subsection 1.

**Sec. 9.** NRS 287.047 is hereby amended to read as follows:

287.047 If the retention is consistent with the terms of any agreement between the state and the insurance company which issued the policies pursuant to the program or with the plan of self-insurance:

1. Upon the termination of his employment other than by retirement, any state or other participating officer or employee, except a senator or

assemblyman, may retain his membership in the state's *program of* group insurance , [program,] but no part of the cost of the premiums or contributions for the group insurance may thereafter be paid by the department, agency, commission , [or] public agency *or nonprofit organization* which employed the officer or employee.

2. A participating state employee who retires on or after July 1, 1985, *or an employee of a participating nonprofit organization who retires on or after July 1, 1991,* may retain his membership in and his dependents' coverage by the state's *program of* group insurance . [program.]

3. A participating legislator who retires from the service of the state or who completes 8 years of service as such may retain his membership in and his dependents' coverage by the state's *program of* group insurance . [program.]

**Sec. 10.** NRS 287.0475 is hereby amended to read as follows:

287.0475 1. A public employee who has retired pursuant to NRS 286.510 or 286.620 or a contract issued pursuant to NRS 286.802, or the surviving spouse of such a retired public employee who is deceased may, in any even-numbered year, reinstate any insurance, except life insurance, which was provided to him and his dependents at the time of his retirement under NRS 287.010, 287.020 or 287.0433 as a public employee by:

(a) Giving written notice of his intent to reinstate the insurance to the employees' last public employer not later than January 31, of an even-numbered year;

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

(c) Paying any portion of the policy's premiums, in the manner set forth in NRS 286.615, which are due from the date of reinstatement and not paid by the public employer.

*2. An employee of a participating nonprofit organization who has retired, or the surviving spouse of such a retired employee who is deceased may, in any even-numbered year, reinstate any insurance, except life insurance, which was provided to him and his dependents at the time of his retirement from the organization by:*

*(a) Giving written notice of his intent to reinstate the insurance to the nonprofit organization not later than January 31, of an even-numbered year;*

*(b) Accepting the organization's current program or plan of insurance and any subsequent changes thereto; and*

*(c) Paying any portion of the policy's premiums which are due from the date of reinstatement and not paid by the organization.*

*3.* The last public employer *or the nonprofit organization* shall give the insurer notice of the reinstatement no later than March 31, of the year in which the [public] employee or surviving spouse gives notice of his intent to reinstate the insurance. The insurer shall approve or disapprove the request for reinstatement within 90 days after the date of the request.

[2.] *3.* Reinstatement of insurance excludes claims for expenses for any condition for which medical advice, treatment or consultation was rendered within 12 months before reinstatement unless:

(a) The person has not received any medical advice, treatment or consultation for a period of 6 consecutive months after the reinstatement; or

(b) The reinstated insurance has been in effect more than 12 consecutive months.

[3.] *4.* The retired [public] employee, his dependents and the surviving spouse of such a retired [public] employee who is deceased must show evidence of their good health as a condition of the reinstatement.

**Sec. 11.** NRS 287.048 is hereby amended to read as follows:

287.048 NRS 287.041 to 287.047, inclusive, do not require any officer or employee of the State of Nevada , [or of] a participating public agency *or a participating nonprofit organization* to accept or join the state's *program of* group insurance , [program,] or to assign his wages or salary to or authorize deductions from his wages or salary in payment of premiums or contributions for group insurance.

**Sec. 12.** This act becomes effective on July 1, 1991.

SUMMARY--Authorizes issuance of policies of health insurance to certain employers who provide coverage for their employees for basic levels of medical care. (BDR 57-270)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to insurance; authorizing the issuance of policies of health insurance to certain employers who provide coverage for their employees for basic levels of medical care; establishing the basic levels of coverage that must be provided; and providing other matters properly relating thereto.

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

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

*1. A policy of health insurance which provides coverage for basic levels of medical care may be delivered or issued for delivery to an employer in this state in order to provide coverage for an employee and his dependents, if the employer does not have more than 25 employees.*

*2. A policy of health insurance issued pursuant to this section must provide coverage for:*

*(a) At least 30 days of hospitalization per year.*

*(b) Prenatal care that includes:*

*(1) At least one examination by a physician per month during the first two trimesters of pregnancy, two examinations per month during the 7th and 8th months of pregnancy and one examination per week during the remaining months of the pregnancy. The coverage for each examination must include coverage for compiling a medical history, a physical examination and any laboratory and diagnostic procedures which are deemed necessary by the patient's physician.*

*(2) Such prenatal counseling as the patient's physician deems necessary.*

*(c) Obstetrical care that includes coverage for all physicians' services, treatment received in the delivery room and any other hospital services received which are medically necessary.*

*(d) A physical examination of any children of the insured conducted by a physician at birth and at the ages of 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years and 6 years. The coverage for each examination must include coverage for:*

*(1) Compiling a medical history;*

*(2) A complete physical examination;*

*(3) A developmental assessment;*

*(4) Any guidance counseling which is necessary;*

*(5) Appropriate immunizations; and*

*(6) Any laboratory tests which are medically necessary.*

*(e) At least two examinations by a physician per year for other persons covered under the policy.*

*3. Each insurer who issues policies of health insurance pursuant to the provisions of this section shall maintain separate records for those policies that contain:*

*(a) Information relating to the costs of premiums, deductibles and claims; and*

*(b) Such other information as may be required by the commissioner.*

*4. This section does not prohibit an insurer from issuing a policy of health insurance to an employer with not more than 25 employees that provides any additional coverage not required by this section if such a policy is requested.*

*5. The commissioner shall adopt such regulations as are necessary to carry out the purposes of this section.*

**Sec. 2.** NRS 689A.030 is hereby amended to read as follows:

689A.030 A policy of health insurance must not be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:

1. The entire money and other considerations for the policy must be expressed therein.

2. The time when the insurance takes effect and terminates must be expressed therein.

3. It must purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two or more eligible members of that family, including the husband, wife, dependent children, from the time of birth, adoption or placement for the purpose of adoption as provided in NRS 689A.043, or any children under a specified age which must not exceed 19 years except as provided in NRS 689A.045, and any other person dependent upon the policyholder.

4. The style, arrangement and overall appearance of the policy must not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers must be plainly printed in light-faced type of a style in general use, the size of which must be uniform and not less than 10 points with a lower case unspaced alphabet length not less than 120 points. "Text" includes all printed matter except the name and address of the insurer, the name or the title of the policy, the brief description, if any, and captions and subcaptions.

5. The exceptions and reductions of indemnity must be set forth in the policy and, other than those contained in NRS 689A.050 to 689A.290, inclusive, must be printed, at the insurer's option, with the benefit provision to which they apply or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of that

exception or reduction must be included with the benefit provision to which it applies.

6. Each such form, including riders and endorsements, must be identified by a number in the lower left-hand corner of the first page thereof.

7. The policy must not contain any provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless that portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short-rate table filed with the commissioner.

8. *Except for a policy issued pursuant to section 1 of this act:*

*(a)* The policy must provide benefits for expense arising from care at home or health supportive services if that care or service was prescribed by a physician and would have been covered by the policy if performed in a medical facility or facility for the dependent as defined in chapter 449 of NRS.

[9.] *(b)* The policy must provide, at the option of the applicant, benefits for expenses incurred for the treatment of abuse of alcohol or drugs, unless the policy provides coverage only for a specified disease or provides for the payment of a specific amount of money if the insured is hospitalized or receiving health care in his home.

[10.] *(c)* The policy must provide benefits for expense arising from hospice care.

**Sec. 3.** NRS 689A.0403 is hereby amended to read as follows:

689A.0403 1. [Each] *Except for a policy of health insurance issued pursuant to section 1 of this act, each* policy of health insurance must include a procedure for binding arbitration to resolve disputes concerning independent medical evaluations pursuant to the rules of the American Arbitration Association.

2. If an insurer, for any final determination of benefits or care, requires an independent evaluation of the medical or chiropractic care of any person for whom such care is covered under the terms of the contract of insurance, only a physician or chiropractor who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field may conduct the independent evaluation.

3. The independent evaluation must include a physical examination of the patient, unless he is deceased, and a personal review of all X-rays and reports prepared by the primary treating physician or chiropractor. A certified copy of all reports of findings must be sent to the primary treating physician or chiropractor and the insured person within 10 working days after the evaluation. If the insured person disagrees with the finding of the evaluation, he must submit an appeal to the insurer pursuant to the procedure for binding arbitration set forth in the policy of insurance within 30 days after he receives the finding of the evaluation. Upon its receipt of an appeal, the insurer shall so notify in writing the primary treating physician or chiropractor.

4. The insurer shall not limit or deny coverage for care related to a disputed claim while the dispute is in arbitration, except that, if the insurer

prevails in the arbitration, the primary treating physician or chiropractor may not recover any payment from either the insurer, insured person or the patient for services that he provided to the patient after receiving written notice from the insurer pursuant to subsection 3 concerning the appeal of the insured person.

**Sec. 4.** NRS 689A.0405 is hereby amended to read as follows:

689A.0405 1. A policy of health insurance *, except for a policy issued pursuant to section 1 of this act,* must provide coverage for benefits payable for expenses incurred for:

(a) An annual cytologic screening test for women 18 years of age or older;

(b) A baseline mammogram for women between the ages of 35 and 40; and

(c) An annual mammogram for women 40 years of age or older.

2. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 1989, *except a policy issued pursuant to section 1 of this act,* has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

**Sec. 5.** NRS 689A.041 is hereby amended to read as follows:

689A.041 1. **[**Any**]** *Except for a policy of health insurance issued pursuant to section 1 of this act, any* policy of health insurance which provides coverage for the surgical procedure known as a mastectomy must also provide commensurate coverage for at least two prosthetic devices and for reconstructive surgery incident to the mastectomy. Except as otherwise

provided in subsection 2, this coverage must be subject to the same terms and conditions that apply to the coverage for the mastectomy.

2. If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal the amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the terms, conditions and exclusions contained in the policy at the time of the reconstructive surgery.

3. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 1989, *except a policy issued pursuant to section 1 of this act,* has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. For the purposes of this section, "reconstructive surgery" means a surgical procedure performed following a mastectomy on one breast or both breasts to reestablish symmetry between the two breasts. The term includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

**Sec. 6.** NRS 689A.042 is hereby amended to read as follows:

689A.042 1. **[**No**]** *Except as otherwise provided in section 1 of this act, no policy of* health insurance **[**policy**]** may be delivered or issued for delivery in this state if it contains any exclusion, reduction or other limitation of coverage

relating to complications of pregnancy, unless the provision applies generally to all benefits payable under the policy.

2. As used in this section, the term "complications of pregnancy" includes any condition which requires [hospital] confinement *in a hospital* for medical treatment and:

(a) If the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or

(b) If the pregnancy is terminated, results in nonelective cesarean section, ectopic pregnancy or spontaneous termination.

3. A policy subject to the provisions of this chapter which is delivered or issued for delivery on or after July 1, 1977, *except a policy issued pursuant to section 1 of this act,* has the legal effect of including the coverage required by this section, and any provision of the policy which is in conflict with this section is void.

**Sec. 7.** NRS 689A.043 is hereby amended to read as follows:

689A.043 1. All individual *policies of* health insurance [policies] providing family coverage on an expense-incurred basis must as to family members' coverage provide that the health benefits applicable for children are payable with respect to:

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

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

(c) A child placed with the insured for the purpose of adoption from the moment of placement as certified by the public or private agency making the placement. The coverage of such a child ceases if the adoption proceedings are terminated as certified by the public or private agency making the placement. [The] *Except as otherwise provided in section 1 of this act, the* policies must provide the coverage specified in subsection 3 and must not exclude premature births.

2. The policy or contract may require that notification of:

(a) The birth of a newly born child;

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

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

and payments of the required premium or fees, if any, must be furnished to the insurer within 31 days after the date of birth, adoption or placement for adoption in order to have the coverage continue beyond the 31-day period.

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

**Sec. 8.** NRS 689A.045 is hereby amended to read as follows:

689A.045 1. [Any] *Except for a policy of health insurance issued pursuant to section 1 of this act, any policy of* health insurance [policy] delivered or issued for delivery after November 1, 1973, which provides for the termination of coverage on a dependent child of a policyholder when [such] *the* child attains a contractually specified limiting age [shall] *must* also provide that [such coverage shall not terminate] *the coverage may not be terminated* when the dependent child reaches [such] *that* age if [such] *the* child is and continues to be:

(a) Incapable of self-sustaining employment due to a physical handicap or mental retardation; and

(b) Dependent on the policyholder for support and maintenance.

2. Proof of [such] *the* child's incapacity and dependency [shall] *must* be furnished to the insurer by the policyholder within 31 days after [such] *the* child attains the specified limiting age and as often as the insurer may thereafter require, but no more than once a year beginning 2 years after [such] *the* child attains the specified limiting age.

**Sec. 9.** NRS 689A.046 is hereby amended to read as follows:

689A.046 1. [The] *Except as otherwise provided in this section, the* benefits provided by a policy for health insurance for treatment of the abuse of alcohol or drugs must consist of:

(a) Treatment for withdrawal from the physiological effect of alcohol or drugs, with a maximum benefit of $1,500 per calendar year.

(b) Treatment for a patient admitted to a facility, with a maximum benefit of $9,000 per calendar year.

(c) Counseling for a person, group or family who is not admitted to a facility, with a maximum benefit of $2,500 per calendar year.

2. The maximum amount which may be paid in the lifetime of the insured for any combination of the treatments listed in subsection 1 is $39,000.

3. These benefits must be paid in the same manner as benefits for any other illness covered by a similar policy are paid.

4. The insured person is entitled to these benefits if treatment is received in any:

(a) Facility for the treatment of abuse of alcohol or drugs which is certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources.

(b) Hospital or other medical facility or facility for the dependent which is licensed by the health division of the department of human resources, accredited by the Joint Commission on Accreditation of Hospitals and provides a program for the treatment of abuse of alcohol or drugs as part of its accredited activities.

*5. The provisions of this section do not apply to a policy of health insurance issued pursuant to section 1 of this act.*

**Sec. 10.** NRS 689A.0465 is hereby amended to read as follows:

689A.0465 1. Except as otherwise provided in this section **[**,**]** *and section 1 of this act,* no policy of health insurance may be delivered or issued for

delivery in this state if it contains an exclusion of coverage of treatment of the temporomandibular joint whether by specific language in the policy or by a claims settlement practice. A policy may exclude coverage of those methods of treatment which are recognized as dental procedures, including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints.

2. The insurer may limit its liability on the treatment of the temporomandibular joint to:

(a) No more than 50 percent of the usual and customary charges for such treatment actually received by an insured, but in no case more than 50 percent of the maximum benefits provided by the policy for such treatment; and

(b) Treatment which is medically necessary.

3. Any provision of a policy subject to the provisions of this chapter and issued or delivered on or after January 1, 1990, *except for a provision in a policy issued pursuant to section 1 of this act,* which is in conflict with this section is void.

**Sec. 11.** NRS 689A.048 is hereby amended to read as follows:

689A.048 [If] *1. Except as otherwise provided in this section, if* any policy of health insurance provides coverage for treatment of an illness which is within the authorized scope of the practice of a qualified psychologist, the insured is entitled to reimbursement for treatments by a psychologist who is licensed pursuant to chapter 641 of NRS.

*2. The provisions of this section do not apply to a policy of health insurance issued pursuant to section 1 of this act.*

**Sec. 12.** NRS 689A.0483 is hereby amended to read as follows:

689A.0483 **[If]** *1. Except as otherwise provided in this section, if* any policy of health insurance provides coverage for treatment of an illness which is within the authorized scope of the practice of a licensed marriage and family therapist, the insured is entitled to reimbursement for treatment by a marriage and family therapist who is licensed pursuant to chapter 641A of NRS.

*2. The provisions of this section do not apply to a policy of health insurance issued pursuant to section 1 of this act.*

**Sec. 13.** NRS 689A.0485 is hereby amended to read as follows:

689A.0485 **[If]** *1. Except as otherwise provided in this section, if* any policy of health insurance provides coverage for treatment of an illness which is within the authorized scope of the practice of a licensed associate in social work, social worker, independent social worker or clinical social worker, the insured is entitled to reimbursement for treatment by an associate in social work, social worker, independent social worker or clinical social worker who is licensed pursuant to chapter 641B of NRS.

*2. The provisions of this section do not apply to a policy of health insurance issued pursuant to section 1 of this act.*

**Sec. 14.** NRS 689A.049 is hereby amended to read as follows:

689A.049 1. **[If]** *Except as otherwise provided in this section, if* any policy of health insurance provides coverage for treatment of an illness which is

within the authorized scope of practice of a qualified chiropractor, the insured is entitled to reimbursement for treatments by a chiropractor who is licensed pursuant to chapter 634 of NRS.

2. The terms of the policy must not limit:

(a) Coverage for treatments by a chiropractor to a number less than for treatments by other physicians.

(b) Reimbursement for treatments by a chiropractor to an amount less than that reimbursed for similar treatments by other physicians.

*3. The provisions of this section do not apply to a policy of health insurance issued pursuant to section 1 of this act.*

**Sec. 15.** NRS 689A.0495 is hereby amended to read as follows:

689A.0495 1. **[**If**]** *Except as otherwise provided in this section, if* any policy of health insurance provides coverage for services which are within the authorized scope of practice of a registered nurse who is authorized pursuant to chapter 632 of NRS to perform additional acts in an emergency or under other special conditions as prescribed by the state board of nursing, and which are reimbursed when provided by another provider of health care, the insured is entitled to reimbursement for services provided by such a registered nurse.

2. The terms of the policy must not limit:

(a) Coverage for services provided by such a registered nurse to a number of occasions less than for services provided by another provider of health care.

(b) Reimbursement for services provided by such a registered nurse to an amount less than that reimbursed for similar services provided by another provider of health care.

3. An insurer is not required to pay for services provided by such a registered nurse which duplicate services provided by another provider of health care.

*4. The provisions of this section do not apply to a policy of health insurance issued pursuant to section 1 of this act.*

**Sec. 16.** NRS 689A.0497 is hereby amended to read a follows:

689A.0497 1. Except as otherwise provided in subsection 3, every policy of health insurance amended, delivered or issued for delivery in this state after October 1, 1989, that provides coverage for medical transportation, must contain a provision for the direct reimbursement of a provider of medical transportation for covered services if that provider does not receive reimbursement from any other source.

2. The insured or the provider may submit the claim for reimbursement. The provider shall not demand payment from the insured until after that reimbursement has been granted or denied.

3. Subsection 1 does not apply to [any] *:*

*(a) Any* agreement between an insurer and a provider of medical transportation for the direct payment by the insurer for the provider's services.

*(b) A policy of health insurance issued pursuant to section 1 of this act.*

**Sec. 17.** NRS 689A.280 is hereby amended to read as follows:

689A.280 1. There may be a provision as follows:

> Intoxicants and Narcotics: The insurer is not liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

2. If the insurer includes the provision set forth in subsection 1, he shall also provide that [such] *the* provision in no way affects benefits payable for the treatment of alcohol or drug abuse, as required by [subsection 9] *paragraph (b) of subsection 8* of NRS 689A.030.

**Sec. 18.** NRS 689A.330 is hereby amended to read as follows:

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

**Sec. 19.** Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

*1. A policy of group health insurance which provides coverage for basic levels of medical care may be delivered or issued for delivery to an employer in*

*this state in order to provide coverage for his employees and their dependents, if the employer does not have more than 25 employees.*

*2. A policy of group health insurance issued pursuant to this section must provide coverage for:*

*(a) At least 30 days of hospitalization per year.*

*(b) Prenatal care that includes:*

*(1) At least one examination by a physician per month during the first two trimesters of pregnancy, two examinations per month during the 7th and 8th months of pregnancy and one examination per week during the remaining months of the pregnancy. The coverage for each examination must include coverage for compiling a medical history, a physical examination and any laboratory and diagnostic procedures which are deemed necessary by the patient's physician.*

*(2) Such prenatal counseling as the patient's physician deems necessary.*

*(c) Obstetrical care that includes coverage for all physicians' services, treatment received in the delivery room and any other hospital services received which are medically necessary.*

*(d) A physical examination of any children of the insured conducted by a physician at birth and at the ages of 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years and 6 years. The coverage for each examination must include coverage for:*

*(1) Compiling a medical history;*

*(2) A complete physical examination;*

*(3) A developmental assessment;*

*(4) Any guidance counseling which is necessary;*

*(5) Appropriate immunizations; and*

*(6) Any laboratory tests which are medically necessary.*

*(e) At least two examinations by a physician per year for other persons covered under the policy.*

*3. Each insurer who issues policies of group health insurance pursuant to the provisions of this section shall maintain separate records for those policies that contain:*

*(a) Information relating to the costs of premiums, deductibles and claims; and*

*(b) Such other information as may be required by the commissioner.*

*4. This section does not prohibit an insurer from issuing a policy of group health insurance to an employer with not more than 25 employees that provides any additional coverage not required by this section if such a policy is requested.*

*5. The commissioner shall adopt such regulations as are necessary to carry out the purposes of this section.*

**Sec. 20.** NRS 689B.030 is hereby amended to read as follows:

689B.030 Each *policy of* group health insurance **[**policy**]** must contain in substance the following provisions:

1. A provision that, in the absence of fraud, all statements made by applicants or the policyholders or by an insured person are representations and

not warranties, and that no statement made for the purpose of effecting insurance voids the insurance or reduces its benefits unless the statement is contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to him or his beneficiary.

2. A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of that employee or member and to whom benefits thereunder are payable. If dependents are included in the coverage, only one statement need be issued for each family.

3. A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

4. *Except as otherwise provided in section 19 of this act:*

*(a)* A provision for benefits for expense arising from care at home or health supportive services if the care or service was prescribed by a physician and would have been covered by the policy if performed in a medical facility or facility for the dependent as defined in chapter 449 of NRS.

**[**5.**]** *(b)* A provision for benefits payable for expenses incurred for the treatment of the abuse of alcohol or drugs, as provided in NRS 689B.036.

**[**6.**]** *(c)* A provision for benefits for expenses arising from hospice care.

**Sec. 21.** NRS 689B.033 is hereby amended to read a follows:

689B.033 1. All *policies of* group health insurance **[**policies**]** providing coverage on an expense-incurred basis and all employee welfare plans

providing medical, surgical or hospital care or benefits established or maintained for employees or their families or dependents, or for both, must as to the family members' coverage provide that the health benefits applicable for children are payable with respect to:

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

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

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

[The] *Except as otherwise provided in section 19 of this act, the* policies must provide the coverage specified in subsection 3 and must not exclude premature births.

2. The policy or contract may require that notification of:

(a) The birth of a newly born child;

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

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

and payments of the required premium or fees, if any, must be furnished to the insurer or welfare plan within 31 days after the date of birth, adoption or placement for adoption in order to have the coverage continue beyond the 31-day period.

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

**Sec. 22.** NRS 689B.0345 is hereby amended to read as follows:

689B.0345 1. As used in this section, "total disability" and "totally disabled" mean the continuing inability of the employee or member, because of an injury or illness, to perform substantially the duties related to his employment for which he is otherwise qualified.

2. [No] *Except as otherwise provided in section 19 of this act, no* group policy of health insurance may be delivered or issued for delivery in this state unless it provides continuing coverage for an employee or member of the insured group, and his dependents who are otherwise covered by the policy, while the employee or member is on leave without pay as a result of a total disability. The coverage must be for any injury or illness suffered by the employee or member which is not related to the total disability or for any injury or illness suffered by his dependent. The coverage for such injury or illness must be equal to or greater than the coverage otherwise provided by the policy.

3. The coverage required pursuant to subsection 2 must continue until:

(a) The date on which the employment of the employee or member is terminated;

(b) The date on which the employee or member obtains another policy of health insurance;

(c) The date on which the group policy of health insurance is terminated; or

(d) After a period of 12 months in which benefits under such coverage are provided to the employee or member,

whichever occurs first.

**Sec. 23.** NRS 689B.035 is hereby amended to read as follows:

689B.035 1. [A] *Except for a policy of group health insurance issued pursuant to section 19 of this act, a policy of* group health insurance [policy] delivered or issued for delivery after November 1, 1973, which provides for the termination of coverage on a dependent child of a member of the insured group, when [such] *the* child attains a contractually specified limiting age, [shall] *must* also provide that [such coverage shall not terminate] *the coverage may not be terminated* when the dependent child reaches [such] *that* age if [such] *the* child is and continues to be:

(a) Incapable of self-sustaining employment due to a physical handicap or mental retardation; and

(b) Dependent on the member of the insured group for support and maintenance.

2. Proof of [such] *the* child's incapacity and dependency [shall] *must* be furnished to the insurer by the member of the insured group within 31 days

after [such] *the* child attains the specified limiting age and as often as the insurer may thereafter require, but no more than once a year beginning 2 years after [such] *the* child attains the specified limiting age.

**Sec. 24.** NRS 689B.036 is hereby amended to read as follows:

689B.036 1. [The] *Except as otherwise provided in this section, the* benefits provided by a group policy for health insurance, as required in [subsection 5] *paragraph (b) of subsection 4* of NRS 689B.030, for treatment of the abuse of alcohol or drugs must consist of:

(a) Treatment for withdrawal from the physiological effects of alcohol or drugs, with a maximum benefit of $1,500 per calendar year.

(b) Treatment for a patient admitted to a facility, with a maximum benefit of $9,000 per calendar year.

(c) Counseling for a person, group or family who is not admitted to a facility, with a maximum benefit of $2,500 per calendar year.

2. The maximum amount which may be paid in the lifetime of the insured for any combination of the treatments listed in subsection 1 is $39,000.

3. These benefits must be paid in the same manner as benefits for any other illness covered by a similar policy are paid.

4. The insured person is entitled to these benefits if treatment is received in any:

(a) Facility for the treatment of abuse of alcohol or drugs which is certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources.

(b) Hospital or other medical facility or facility for the dependent which is licensed by the health division of the department of human resources, accredited by the Joint Commission on Accreditation of Hospitals and provides a program for the treatment of abuse of alcohol or drugs as part of its accredited activities.

*5. The provisions of this section do not apply to a policy of group health insurance issued pursuant to section 19 of this act.*

**Sec. 25.** NRS 689B.0374 is hereby amended to read as follows:

689B.0374 1. [A] *Except as otherwise provided in section 19 of this act, a* policy of group health insurance must provide coverage for benefits payable for expenses incurred for:

(a) An annual cytologic screening test for women 18 years of age or older;

(b) A baseline mammogram for women between the ages of 35 and 40; and

(c) An annual mammogram for women 40 years of age or older.

2. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 1989, *except a policy issued pursuant to section 19 of this act,* has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

**Sec. 26.** NRS 689B.0375 is hereby amended to read as follows:

689B.0375 1. [Any] *Except for a policy of group health insurance issued pursuant to section 19 of this act, any* policy of group health insurance which provides coverage for the surgical procedure known as a mastectomy must also

provide commensurate coverage for at least two prosthetic devices and for reconstructive surgery incident to the mastectomy. Except as otherwise provided in subsection 2, this coverage must be subject to the same terms and conditions that apply to the coverage for the mastectomy.

2. If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal those amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the terms, conditions and exclusions contained in the policy at the time of the reconstructive surgery.

3. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 1989, *except a policy issued pursuant to section 19 of this act,* has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. For the purposes of this section, "reconstructive surgery" means a surgical procedure performed following a mastectomy on one breast or both breasts to reestablish symmetry between the two breasts. The term includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

**Sec. 27.** NRS 689B.0379 is hereby amended to read as follows:

689B.0379 1. Except as otherwise provided in this section **[**,**]** *and section 19 of this act,* no policy of group health insurance may be delivered or issued

for delivery in this state if it contains an exclusion of coverage of the treatment of the temporomandibular joint whether by specific language in the policy or by a claims settlement practice. A policy may exclude coverage of those methods of treatment which are recognized as dental procedures, including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints.

2. The insurer may limit its liability on the treatment of the temporomandibular joint to:

(a) No more than 50 percent of the usual and customary charges for such treatment actually received by an insured, but in no case more than 50 percent of the maximum benefits provided by the policy for such treatment; and

(b) Treatment which is medically necessary.

3. Any provision of a policy subject to the provisions of this chapter and issued or delivered on or after January 1, 1990, *except a provision in a policy issued pursuant to section 19 of this act,* which is in conflict with this section is void.

**Sec. 28.** NRS 689B.038 is hereby amended to read as follows:

689B.038 **[**If**]** *1. Except as otherwise provided in this section, if* any policy of group health insurance provides coverage for treatment of an illness which is within the authorized scope of the practice of a qualified psychologist, the insured is entitled to reimbursement for treatment by a psychologist who is licensed pursuant to chapter 641 of NRS.

*2. The provisions of this section do not apply to a policy of group health insurance issued pursuant to section 19 of this act.*

**Sec. 29.** NRS 689B.0383 is hereby amended to read as follows:

689B.0383 **[**If**]** *1. Except as otherwise provided in this section, if* any policy of group health insurance provides coverage for treatment of an illness which is within the authorized scope of the practice of a licensed marriage and family therapist, the insured is entitled to reimbursement for treatment by a marriage and family therapist who is licensed pursuant to chapter 641A of NRS.

*2. The provisions of this section do not apply to a policy of group health insurance issued pursuant to section 19 of this act.*

**Sec. 30.** NRS 689B.0385 is hereby amended to read as follows:

689B.0385 **[**If**]** *1. Except as otherwise provided in this section, if* any policy of group health insurance provides coverage for treatment of an illness which is within the authorized scope of the practice of a licensed associate in social work, social worker, independent social worker or clinical social worker, the insured is entitled to reimbursement for treatment by an associate in social work, social worker, independent social worker or clinical social worker who is licensed pursuant to chapter 641B of NRS.

*2. The provisions of this section do not apply to a policy of group health insurance issued pursuant to section 19 of this regulation.*

**Sec. 31.** NRS 689B.039 is hereby amended to read as follows:

689B.039 1. **[**If**]** *Except as otherwise provided in this section, if* any group policy of health insurance provides coverage for treatment of an illness which

is within the authorized scope of practice of a qualified chiropractor, the insured is entitled to reimbursement for treatments by a chiropractor who is licensed pursuant to chapter 634 of NRS.

2. The terms of the policy must not limit:

(a) Coverage for treatments by a chiropractor to a number less than for treatments by other physicians.

(b) Reimbursement for treatments by a chiropractor to an amount less than that charged for similar treatments by other physicians.

*3. The provisions of this section do not apply to a policy of group health insurance issued pursuant to section 19 of this act.*

**Sec. 32.** NRS 689B.045 is hereby amended to read as follows:

689B.045 1. **[**If any group**]** *Except as otherwise provided in this section, if any* policy of *group* health insurance provides coverage for services which are within the authorized scope of practice of a registered nurse who is authorized pursuant to chapter 632 of NRS to perform additional acts in an emergency or under other special conditions as prescribed by the state board of nursing, and which are reimbursed when provided by another provider of health care, the insured is entitled to reimbursement for services provided by such a registered nurse.

2. The terms of the policy must not limit:

(a) Coverage for services provided by such a registered nurse to a number of occasions less than for services provided by another provider of health care.

(b) Reimbursement for services provided by such a registered nurse to an amount less than that reimbursed for similar services provided by another provider of health care.

3. An insurer is not required to pay for services provided by such a registered nurse which duplicate services provided by another provider of health care.

*4. The provisions of this section do not apply to a policy of group health insurance issued pursuant to section 19 of this act.*

**Sec. 33.** NRS 689B.047 is hereby amended to read as follows:

689B.047 1. Except as otherwise provided in subsection 3, every policy of group health insurance amended, delivered or issued for delivery in this state after October 1, 1989, that provides coverage for medical transportation, must contain a provision for the direct reimbursement of a provider of medical transportation for covered services if that provider does not receive reimbursement from any other source.

2. The insured or the provider may submit the claim for reimbursement. The provider shall not demand payment from the insured until after that reimbursement has been granted or denied.

3. Subsection 1 does not apply to [any] *:*

*(a) Any* agreement between an insurer and a provider of medical transportation for the direct payment by the insurer for the provider's services.

*(b) A policy of group health insurance issued pursuant to section 19 of this act.*

**Sec. 34.** NRS 689B.065 is hereby amended to read as follows:

689B.065 1. A policy of group health insurance issued to replace any discontinued policy or coverage for group health insurance must:

(a) Provide coverage for all persons who were covered under the previous policy or coverage on the date it was discontinued; and

(b) Except as otherwise provided in subsection 2, provide benefits which are at least as extensive as the benefits provided by the previous policy or coverage, except that benefits may be reduced or excluded to the extent that such a reduction or exclusion was permissible under the terms of the previous policy or coverage,

if that replacement policy is issued within 60 days after the date on which the previous policy or coverage was discontinued.

2. If an employer obtains a replacement policy pursuant to subsection 1 to cover his employees, any benefits provided by the previous policy or coverage may be reduced if [notice] *:*

*(a) Notice* of the reduction is given to his employees pursuant to NRS 608.1577 [.] *; and*

*(b) The previous policy was not issued pursuant to section 19 of this act.*

3. Any insurer which issues a replacement policy pursuant to subsection 1 may submit a written request to the insurer who provided the previous policy or coverage for a statement of benefits which were provided under that policy or coverage. Upon receiving such a request, the insurer who provided the previous policy or coverage shall give a written statement to the insurer

providing the replacement policy which indicates what benefits were provided and what exclusions or reductions were in effect under the previous policy or coverage.

4. The provisions of this section apply to a self-insured employer who provides health benefits to his employees and replaces those benefits with a policy of group health insurance.

**Sec. 35.** NRS 689B.245 is hereby amended to read as follows:

689B.245 1. If an employer who employs [less than 20] *not more than 25* employees maintains a policy of group health insurance which covers those employees, the policy must contain a provision which permits:

(a) An employee to elect to continue identical coverage under the policy, excluding coverage provided for eye or dental care, if:

(1) His employment is terminated for any reason other than gross misconduct; or

(2) The number of his working hours is reduced so that he ceases to be eligible for coverage.

(b) The spouse or dependent child of an employee to elect to continue coverage, excluding coverage provided for eye or dental care, if:

(1) The employee's employment is terminated for any reason other than gross misconduct or the number of his working hours is reduced so that he ceases to be eligible for coverage;

(2) The employee dies;

(3) The employee and his spouse are divorced or legally separated;

(4) The dependent child ceases to be eligible for coverage under the terms of the policy; or

(5) The spouse ceases to be eligible for coverage after becoming eligible for Medicare.

2. The period of continued coverage is limited to:

(a) Eighteen months for an employee.

(b) Thirty-six months for an employee's spouse or dependent child.

3. An employee who voluntarily leaves his employment, or the spouse or dependent child of that employee, is not eligible to continue coverage pursuant to this section.

4. An employee, spouse or dependent child who has not been covered under any group policy of the employer for at least 12 consecutive months before the termination of his coverage is not eligible to continue coverage pursuant to this section.

**Sec. 36.** NRS 689B.260 is hereby amended to read as follows:

689B.260 1. **[**No**]** *Except as otherwise provided in section 19 of this act, no* group health or blanket health policy may be delivered or issued for delivery in this state if it contains any exclusion, reduction or other limitation of coverage relating to complications of pregnancy, unless the provision applies generally to all benefits payable under the policy.

2. As used in this section, the term "complications of pregnancy" includes any condition which requires **[**hospital**]** confinement *in a hospital* for medical treatment and:

(a) If the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or

(b) If the pregnancy is terminated, results in nonelective cesarean section, ectopic pregnancy or spontaneous termination.

3. A policy subject to the provisions of this chapter which is delivered or issued for delivery on or after July 1, 1977, *except a policy issued pursuant to section 19 of this act,* has the legal effect of including the coverage required by this section, and any provision of the policy which is in conflict with this section is void.

**Sec. 37.** NRS 689B.270 is hereby amended to read as follows:

689B.270 1. [Each] *Except for a policy of group health insurance issued pursuant to section 19 of this act, each* policy of group or blanket health insurance must include a procedure for binding arbitration to resolve disputes concerning independent medical evaluations pursuant to the rules of the American Arbitration Association.

2. If an insurer, for any final determination of benefits or care, requires an independent evaluation of the medical or chiropractic care of any person for whom such care is covered under the terms of a policy of group or blanket health insurance, only a physician or chiropractor who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field may conduct the independent evaluation.

3. The independent evaluation must include a physical examination of the patient, unless he is deceased, and a personal review of all X-rays and reports prepared by the primary treating physician or chiropractor. A certified copy of all reports of findings must be sent to the primary treating physician or chiropractor and the insured person within 10 working days after the evaluation. If the insured person disagrees with the finding of the evaluation, he must submit an appeal to the insurer pursuant to the procedure for binding arbitration set forth in the policy of insurance within 30 days after he receives the finding of the evaluation. Upon its receipt of an appeal, the insurer shall so notify in writing the primary treating physician or chiropractor.

4. The insurer shall not limit or deny coverage for care related to a disputed claim while the dispute is in arbitration, except that, if the insurer prevails in the arbitration, the primary treating physician or chiropractor may not recover any payment from either the insurer, insured person or the patient for services that he provided to the patient after receiving written notice from the insurer pursuant to subsection 3 concerning the appeal of the insured person.

**Sec. 38.** Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

*1. An individual or group contract for hospital or medical services which provides coverage for basic levels of medical care may be delivered or issued for delivery to an employer in this state in order to provide coverage for his*

*employees and their dependents if the employer does not have more than 25 employees.*

*2. A contract for hospital or medical services issued pursuant to this section must provide coverage for:*

*(a) At least 30 days of hospitalization per year.*

*(b) Prenatal care that includes:*

*(1) At least one examination by a physician per month during the first two trimesters of pregnancy, two examinations per month during the 7th and 8th months of pregnancy and one examination per week during the remaining months of the pregnancy. The coverage for each examination must include coverage for compiling a medical history, a physical examination and any laboratory and diagnostic procedures which are deemed necessary by the patient's physician.*

*(2) Such prenatal counseling as the patient's physician deems necessary.*

*(c) Obstetrical care that includes coverage for all physicians' services, treatment received in the delivery room and any other hospital services received which are medically necessary.*

*(d) A physical examination of any children of the insured conducted by a physician at birth and at the ages of 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years and 6 years. The coverage for each examination must include coverage for:*

*(1) Compiling a medical history;*

*(2) A complete physical examination;*

*(3) A developmental assessment;*

*(4) Any guidance counseling which is necessary;*

*(5) Appropriate immunizations; and*

*(6) Any laboratory tests which are medically necessary.*

*(e) At least two examinations by a physician per year for other persons covered under the contract.*

*3. Each corporation that issues contracts for hospital or medical services pursuant to the provisions of this section shall maintain separate records for those contracts that contain:*

*(a) Information relating to the costs of premiums, deductibles and claims; and*

*(b) Such other information as may be required by the commissioner.*

*4. This section does not prohibit a corporation from issuing a contract for hospital or medical services to an employer with not more than 25 employees that provides any additional coverage not required by this section if such a contract is requested.*

*5. The commissioner shall adopt such regulations as are necessary to carry out the purposes of this section.*

**Sec. 39.** NRS 695B.180 is hereby amended to read as follows:

695B.180 A contract for hospital, medical or dental services must not be entered into between a corporation proposing to furnish or provide any one or more of the services authorized under this chapter and a subscriber:

1. Unless the entire consideration therefor is expressed in the contract.

2. Unless the times at which the benefits or services to the subscriber take effect and terminate are stated in a portion of the contract above the evidence of its execution.

3. If the contract purports to entitle more than one person to benefits or services, except for family contracts issued under NRS 695B.190, group contracts issued under NRS 695B.200, and blanket contracts issued under NRS 695B.220.

4. Unless every printed portion and any endorsement or attached papers are plainly printed in type of which the face is not smaller than 10 points.

5. Except for group contracts and blanket contracts issued under NRS 695B.220, unless the exceptions of the contract are printed with greater prominence than the benefits to which they apply.

6. Except for group contracts and blanket contracts issued under NRS 695B.230, unless, if any portion of the contract purports, by reason of the circumstances under which an illness, injury or disablement is incurred to reduce any service to less than that provided for the same illness, injury or disablement incurred under ordinary circumstances, that portion is printed in boldface type and with greater prominence than any other text of the contract.

7. If the contract contains any provisions purporting to make any portion of the charter, constitution or bylaws of a nonprofit corporation a part of the contract unless that portion is set forth in full in the contract.

8. *Except for an individual or group contract for hospital or medical services issued pursuant to section 38 of this act:*

*(a)* Unless the contract, if it is a group contract, contains a provision for benefits payable for expenses incurred for the treatment of the abuse of alcohol or drugs, as provided in NRS 695B.194.

[9.] *(b)* Unless the contract provides benefits for expenses incurred for hospice care.

[10.] *9.* Unless the contract for service in a hospital contains in blackface type, not less than 10 points, the following provisions:

> This contract does not restrict or interfere with the right of any person entitled to service and care in a hospital to select the contracting hospital or to make a free choice of his attending physician, who must be the holder of a valid and unrevoked physician's license and a member of, or acceptable to, the attending staff and board of directors of the hospital in which the services are to be provided.

**Sec. 40.** NRS 695B.182 is hereby amended to read as follows:

695B.182 1. [Each] *Except for a contract issued pursuant to section 38 of this act, each* contract for hospital or medical services must include a procedure for binding arbitration to resolve disputes concerning independent medical evaluations pursuant to the rules of the American Arbitration Association.

2. If a corporation subject to the provisions of this chapter, for any final determination of benefits or care, requires an independent evaluation of the medical or chiropractic care of any person for whom such care is covered under a contract for hospital or medical services, only a physician or chiropractor who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field may conduct the independent evaluation.

3. The independent evaluation must include a physical examination of the patient, unless he is deceased, and a personal review of all X-rays and reports prepared by the primary treating physician or chiropractor. A certified copy of all reports of findings must be sent to the primary treating physician or chiropractor and the insured person within 10 working days after the evaluation. If the insured person disagrees with the finding of the evaluation, he must submit an appeal to the insurer pursuant to the procedure for binding arbitration set forth in the contract for services within 30 days after he receives the finding of the evaluation. Upon its receipt of an appeal, the insurer shall so notify in writing the primary treating physician or chiropractor.

4. The insurer shall not limit or deny coverage for care related to a disputed claim while the dispute is in arbitration, except that, if the insurer prevails in the arbitration, the primary treating physician or chiropractor may not recover any payment from either the insurer, insured person or the patient for services that he provided to the patient after receiving written notice from

the insurer pursuant to subsection 3 concerning the appeal of the insured person.

**Sec. 41.** NRS 695B.187 is hereby amended to read as follows:

695B.187 1. A group contract for hospital, medical or dental services issued by a nonprofit hospital, medical or dental service corporation to replace any discontinued policy or coverage for group health insurance must:

(a) Provide coverage for all persons who were covered under the previous policy or coverage on the date it was discontinued; and

(b) Except as otherwise provided in subsection 2, provide benefits which are at least as extensive as the benefits provided by the previous policy or coverage, except that the benefits may be reduced or excluded to the extent that such a reduction or exclusion was permissible under the terms of the previous policy or coverage,

if that contract is issued within 60 days after the date on which the previous policy or coverage was discontinued.

2. If an employer obtains a replacement contract pursuant to subsection 1 to cover his employees, any benefits provided by the previous policy or coverage may be reduced if **[**notice**]** *:*

*(a) Notice* of the reduction is given to his employees pursuant to NRS 608.1577 **[**.**]** *; and*

*(b) The previous contract was not issued pursuant to section 38 of this act.*

3. Any corporation which issues a replacement contract pursuant to subsection 1 may submit a written request to the insurer which provided the

previous policy or coverage for a statement of benefits which were provided under that policy or coverage. Upon receiving such a request, the insurer shall give a written statement to the corporation which indicates what benefits were provided and what exclusions or reductions were in effect under the previous policy or coverage.

4. The provisions of this section apply to a self-insured employer who provides health benefits to his employees and replaces those benefits with a group contract for hospital, medical or dental services issued by a nonprofit hospital, medical or dental service corporation.

**Sec. 42.** NRS 695B.191 is hereby amended to read as follows:

695B.191 1. [Any] *Except for a contract issued pursuant to section 38 of this act, any* policy of health insurance, issued by a medical service corporation, which provides coverage for the surgical procedure known as a mastectomy must also provide commensurate coverage for at least two prosthetic devices and for reconstructive surgery incident to the mastectomy. Except as otherwise provided in subsection 2, this coverage must be subject to the same terms and conditions that apply to the coverage for the mastectomy.

2. If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal those amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the terms, conditions and exclusions contained in the policy at the time of the reconstructive surgery.

3. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 1989, *except a contract issued pursuant to section 38 of this act,* has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. For the purposes of this section, "reconstructive surgery" means a surgical procedure performed following a mastectomy on one breast or both breasts to reestablish symmetry between the two breasts. The term includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

**Sec. 43.** NRS 695B.1912 is hereby amended to read as follows:

695B.1912 1. **[**A**]** *Except as otherwise provided in section 38 of this act, a* policy of health insurance issued by a hospital or medical service corporation must provide coverage for benefits payable for expenses incurred for:

(a) An annual cytologic screening test for women 18 years of age or older;

(b) A baseline mammogram for women between the ages of 35 and 40; and

(c) An annual mammogram for women 40 years of age or older.

2. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 1989, *except a contract issued pursuant to section 38 of this act,* has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

**Sec. 44.** NRS 695B.192 is hereby amended to read as follows:

695B.192 1. [No] *Except as otherwise provided in section 38 of this act, no* hospital, medical or dental service contract issued by a corporation under the provisions of this chapter may contain any exclusion, reduction or other limitation of coverage relating to complications of pregnancy, unless the provision applies generally to all benefits payable under the contract.

2. As used in this section, the term "complications of pregnancy" includes any condition which requires hospital confinement for medical treatment and:

(a) If the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or

(b) If the pregnancy is terminated, results in nonelective cesarean section, ectopic pregnancy or spontaneous termination.

3. A contract subject to the provisions of this chapter which is issued or delivered on or after July 1, 1977, *except a contract issued pursuant to section 38 of this act,* has the legal effect of including the coverage required by this section, and any provision of the contract which is in conflict with this section is void.

**Sec. 45.** NRS 695B.193 is hereby amended to read as follows:

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

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

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

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

[The] *Except as otherwise provided in section 38 of this act, the* contracts must provide the coverage specified in subsection 3, and must not exclude premature births.

2. The contract may require that notification of:

(a) The birth of a newly born child;

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

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

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

3. The coverage for newly born and adopted children and children placed for adoption consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center under major

medical policies, and with respect to basic policies to the extent such costs are charged by the treatment center.

4. For covered services provided to the child, the corporation shall reimburse noncontracted providers of health care to an amount equal to the average amount of payment for which the organization has agreements, contracts or arrangements for those covered services.

**Sec. 46.** NRS 695B.1931 is hereby amended to read as follows:

695B.1931 1. Except as otherwise provided in this section **[**,**]** *and section 38 of this act,* no contract for hospital or medical service may be delivered or issued for delivery in this state if it contains an exclusion of coverage of the treatment of the temporomandibular joint whether by specific language in the contract or by a claims settlement practice. A contract for hospital or medical service may exclude coverage of those methods of treatment which are recognized as dental procedures, including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints.

2. Pursuant to a contract for hospital or medical service, a corporation may limit its liability on the treatment of the temporomandibular joint to:

(a) No more than 50 percent of the usual and customary charges for such treatment actually received by a subscriber, but in no case more than 50 percent of the maximum benefits provided by the contract for such treatment; and

(b) Treatment which is medically necessary.

3. Any provision of a contract subject to the provisions of this chapter and issued or delivered on or after January 1, 1990, *except for a provision in a contract issued pursuant to section 38 of this act,* which is in conflict with this section is void.

**Sec. 47.** NRS 695B.194 is hereby amended to read as follows:

695B.194 1. [The] *Except as otherwise provided in this section, the* annual benefits provided by a policy for group health insurance issued by a medical service corporation, as required by *paragraph (a) of* subsection 8 of NRS 695B.180, for treatment of the abuse of alcohol or drugs must consist of:

(a) Treatment for withdrawal from the physiological effects of alcohol or drugs, with a maximum benefit of $1,500 per calendar year.

(b) Treatment for a patient admitted to a facility, with a maximum benefit of $9,000 per calendar year.

(c) Counseling for a person, group or family who is not admitted to a facility, with a maximum benefit of $2,500 per calendar year.

2. The maximum amount which may be paid in the lifetime of the insured for any combination of the treatments listed in subsection 1 is $39,000.

3. These benefits must be paid in the same manner as benefits for any other illness covered by a similar policy are paid.

4. The insured person is entitled to these benefits if treatment is received in any:

(a) Facility for the treatment of abuse of alcohol or drugs which is certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources.

(b) Hospital or other medical facility or facility for the dependent which is licensed by the health division of the department of human resources, accredited by the Joint Commission on Accreditation of Hospitals and provides a program for the treatment of abuse of alcohol or drugs as part of its accredited activities.

*5. The provisions of this section do not apply to a contract issued pursuant to section 38 of this act.*

**Sec. 48.** NRS 695B.1944 is hereby amended to read as follows:

695B.1944 1. As used in this section, "total disability" and "totally disabled" mean the continuing inability of the employee or member, because of an injury or illness, to perform substantially the duties related to his employment for which he is otherwise qualified.

2. **[**No**]** *Except as otherwise provided in section 38 of this act, no* group subscriber contract for hospital, medical or dental service may be delivered or issued for delivery in this state unless it provides continuing coverage for an employee or member and his dependents who are otherwise covered by the policy while the employee or member is on leave without pay as a result of a total disability. The coverage must be for any injury or illness suffered by the employee or member which is not related to the total disability or for any injury or illness suffered by his dependent. The coverage for such injury or

illness must be equal to or greater than the coverage otherwise provided by the policy.

3. The coverage required pursuant to subsection 2 must continue until:

(a) The date on which the employment of the employee or member is terminated;

(b) The date on which the employee or member obtains another policy of health insurance;

(c) The date on which the group subscriber contract is terminated; or

(d) After a period of 12 months in which benefits under such coverage are provided to the employee or member,

whichever occurs first.

**Sec. 49.** NRS 695B.197 is hereby amended to read as follows:

695B.197 **[**If**]** *1. Except as otherwise provided in this section, if* any contract for hospital or medical service provides coverage for treatment of an illness which is within the authorized scope of the practice of a qualified psychologist, the insured is entitled to reimbursement for treatments by a psychologist who is licensed pursuant to chapter 641 of NRS.

*2. The provisions of this section do not apply to an individual or group contract for hospital or medical services issued pursuant to section 38 of this act.*

**Sec. 50.** NRS 695B.1973 is hereby amended to read as follows:

695B.1973 **[**If**]** *1. Except as otherwise provided in this section, if* any contract for hospital or medical service provides coverage for treatment of an

illness which is within the authorized scope of the practice of a licensed marriage and family therapist, the insured is entitled to reimbursement for treatment by a marriage and family therapist who is licensed pursuant to chapter 641A of NRS.

*2. The provisions of this section do not apply to an individual or group contract for hospital or medical services issued pursuant to section 38 of this act.*

**Sec. 51.** NRS 695B.1975 is hereby amended to read as follows:

695B.1975 [If] *1. Except as otherwise provided in this section, if* any contract for hospital or medical service provides coverage for treatment of an illness which is within the authorized scope of the practice of a licensed associate in social work, social worker, independent social worker or clinical social worker, the insured is entitled to reimbursement for treatment by an associate in social work, social worker, independent social worker or clinical social worker who is licensed pursuant to chapter 641B of NRS.

*2. The provisions of this section do not apply to an individual or group contract for hospital or medical services issued pursuant to section 38 of this act.*

**Sec. 52.** NRS 695B.198 is hereby amended to read as follows:

695B.198 1. [If] *Except as otherwise provided in this section, if* any contract for hospital or medical service provides coverage for treatment of an illness which is within the authorized scope of practice of a qualified chiropractor, the

insured is entitled to reimbursement for treatments by a chiropractor who is licensed pursuant to chapter 634 of NRS.

2. The terms of the policy must not limit:

(a) Coverage for treatments by a chiropractor to a number less than for treatments by other physicians.

(b) Reimbursement for treatments by a chiropractor to an amount less than that charged for similar treatments by other physicians.

*3. The provisions of this section do not apply to an individual or group contract for hospital or medical services issued pursuant to section 38 of this act.*

**Sec. 53.** NRS 695B.199 is hereby amended to read as follows:

695B.199 1. **[**If**]** *Except as otherwise provided in this section, if* any contract for medical service provides coverage for services which are within the authorized scope of practice of a registered nurse who is authorized pursuant to chapter 632 of NRS to perform additional acts in an emergency or under other special conditions as prescribed by the state board of nursing, and which are reimbursed when provided by another provider of health care, the insured is entitled to reimbursement for services provided by such a registered nurse.

2. The terms of the contract must not limit:

(a) Coverage for services provided by such a registered nurse to a number of occasions less than for services provided by another provider of health care.

(b) Reimbursement for services provided by such a registered nurse to an amount less than that reimbursed for similar services provided by another provider of health care.

3. An insurer is not required to pay for services provided by such a registered nurse which duplicate services provided by another provider of health care.

*4. The provisions of this section do not apply to an individual or group contract for hospital or medical services issued pursuant to section 38 of this act.*

**Sec. 54.** NRS 695B.1995 is hereby amended to read as follows:

695B.1995 1. Except as otherwise provided in subsection 3, every contract for medical service amended, delivered or issued for delivery in this state after October 1, 1989, that provides coverage for medical transportation, must contain a provision for the direct reimbursement of a provider of medical transportation for covered services if that provider does not receive reimbursement from any other source.

2. The subscriber or the provider may submit the claim for reimbursement. The provider shall not demand payment from the subscriber until after that reimbursement has been granted or denied.

3. Subsection 1 does not apply to **[**any**]** *:*

*(a) Any* agreement between a corporation for medical service and a provider of medical transportation for the direct payment by the corporation for the provider's services.

*(b) An individual or group contract for hospital or medical services issued pursuant to section 38 of this act.*

**Sec. 55.** Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

*1. A health care plan which provides coverage for basic levels of medical care may be delivered or issued for delivery to an employer in this state in order to provide coverage for his employees and their dependents if the employer does not have more than 25 employees.*

*2. A health care plan issued pursuant to this section must provide coverage for:*

*(a) At least 30 days of hospitalization per year.*

*(b) Prenatal care that includes:*

*(1) At least one examination by a physician per month during the first two trimesters of pregnancy, two examinations per month during the 7th and 8th months of pregnancy and one examination per week during the remaining months of the pregnancy. The coverage for each examination must include coverage for compiling a medical history, a physical examination and any laboratory and diagnostic procedures which are deemed necessary by the patient's physician.*

*(2) Such prenatal counseling as the patient's physician deems necessary.*

*(c) Obstetrical care that includes coverage for all physicians' services, treatment received in the delivery room and any other hospital services received which are medically necessary.*

*(d) A physical examination of any children of the insured conducted by a physician at birth and at the ages of 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years and 6 years. The coverage for each examination must include coverage for:*

*(1) Compiling a medical history;*

*(2) A complete physical examination;*

*(3) A developmental assessment;*

*(4) Any guidance counseling which is necessary;*

*(5) Appropriate immunizations; and*

*(6) Any laboratory tests which are medically necessary.*

*(e) At least two examinations by a physician per year for other persons covered under the plan.*

*3. Each health maintenance organization that issues health care plans pursuant to the provisions of this section shall maintain separate records for those plans that contain:*

*(a) Information relating to the costs of premiums, deductibles and claims; and*

*(b) Such other information as may be required by the commissioner.*

*4. This section does not prohibit a health maintenance organization from issuing a health care plan to an employer with not more than 25 employees that provides any additional coverage not required by this section if such a plan is requested.*

*5. The commissioner shall adopt such regulations as are necessary to carry out the purposes of this section.*

**Sec. 56.** NRS 695C.170 is hereby amended to read as follows:

695C.170 1. Every enrollee residing in this state is entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy, whether by option or otherwise, the insurer shall issue the evidence of coverage. Otherwise, the health maintenance organization shall issue the evidence of coverage.

2. Evidence of coverage or *an* amendment thereto must not be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment thereto has been filed with and approved by the commissioner.

3. An evidence of coverage:

(a) Must not contain any provisions or statements which are unjust, unfair, inequitable, misleading **[**,**]** *or* deceptive, which encourage misrepresentation or which are untrue, misleading or deceptive as defined in subsection 1 of NRS 695C.300; and

(b) Must contain a clear and complete statement, if a contract, or a reasonably complete summary if a certificate, of:

(1) The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan;

(2) Any limitations on the services, kind of services, benefits, or kind of benefits, to be provided, including any deductible or copayment feature;

(3) Where and in what manner the services may be obtained;

(4) The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay; and

(5) [A] *Except for an evidence of coverage for a health care plan issued pursuant to section 55 of this act, a* provision for benefits payable for expenses incurred for the treatment of the abuse of alcohol or drugs, as provided in NRS 695C.174.

Any subsequent change may be evidenced in a separate document issued to the enrollee.

4. A copy of the form of the evidence of coverage to be used in this state and any amendment thereto is subject to the requirements for filing and approval of subsection 2 unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance, in which event the provisions for filing and approval of those laws apply. To the extent that such provisions do not apply to the requirements in subsection 3, such provisions are amended to incorporate the requirements of subsection 3 in approving or disapproving an evidence of coverage required by subsection 2.

**Sec. 57.** NRS 695C.1705 is hereby amended to read as follows:

695C.1705 1. A group health care plan issued by a health maintenance organization to replace any discontinued policy or coverage for group health insurance must:

(a) Provide coverage for all persons who were covered under the previous policy or coverage on the date it was discontinued; and

(b) Except as otherwise provided in subsection 2, provide benefits which are at least as extensive as the benefits provided by the previous policy or coverage, except that benefits may be reduced or excluded to the extent that such a reduction or exclusion was permissible under the terms of the previous policy or coverage,

if that plan is issued within 60 days after the date on which the previous policy or coverage was discontinued.

2. If an employer obtains a replacement plan pursuant to subsection 1 to cover his employees, any benefits provided by the previous policy or coverage may be reduced if **[**notice**]** *:*

*(a) Notice* of the reduction is given to his employees pursuant to NRS 608.1577 **[**.**]** *; and*

*(b) The previous policy or coverage was not issued pursuant to section 55 of this act.*

3. Any health maintenance organization which issues a replacement plan pursuant to subsection 1 may submit a written request to the insurer which provided the previous policy or coverage for a statement of benefits which were provided under that policy or coverage. Upon receiving such a request, the insurer shall give a written statement to the organization indicating what benefits were provided and what exclusions or reductions were in effect under the previous policy or coverage.

4. If an employee or enrollee was a recipient of benefits under the coverage provided pursuant to NRS 695C.1709, he is not entitled to have issued to him by a health maintenance organization a replacement plan unless he has reported for his normal employment for a period of 90 consecutive days after last being eligible to receive any benefits under the coverage provided pursuant to NRS 695C.1709.

5. The provisions of this section apply to a self-insured employer who provides health benefits to his employees and replaces those benefits with a group health care plan issued by a health maintenance organization.

**Sec. 58.** NRS 695C.1709 is hereby amended to read as follows:

695C.1709 1. As used in this section, "total disability" and "totally disabled" mean the continuing inability of the enrollee, because of an injury or illness, to perform substantially the duties related to his employment for which he is otherwise qualified.

2. [No] *Except as otherwise provided in section 55 of this act, no* policy of group insurance to which an enrollee is entitled under a health care plan provided by a health maintenance organization may be delivered or issued for delivery in this state unless it provides continuing coverage for an enrollee and his dependents who are otherwise covered by the policy while the enrollee is on leave without pay as a result of a total disability. The coverage must be for any injury or illness suffered by the enrollee which is not related to the total disability or for any injury or illness suffered by his dependent. The coverage

must be equal to or greater than the coverage otherwise provided by the policy.

3. The coverage required pursuant to subsection 2 must continue until:

(a) The date on which the employment of the enrollee is terminated;

(b) The date on which the enrollee obtains another policy of health insurance;

(c) The date on which the policy of group insurance is terminated; or

(d) After a period of 12 months in which benefits under such coverage are provided to the enrollee,

whichever occurs first.

**Sec. 59.** NRS 695C.171 is hereby amended to read as follows:

695C.171 1. **[**Any health maintenance**]** *Except for a health care plan issued pursuant to section 55 of this act, any health care* plan which provides coverage for the surgical procedure known as a mastectomy must also provide commensurate coverage for at least two prosthetic devices and for reconstructive surgery incident to the mastectomy. Except as otherwise provided in subsection 2, this coverage must be subject to the same terms and conditions that apply to the coverage for the mastectomy.

2. If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal those amounts provided for in the policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the

terms, conditions and exclusions contained in the policy at the time of the reconstructive surgery.

3. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 1989, *except a policy issued pursuant to section 55 of this act,* has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

4. For the purposes of this section, "reconstructive surgery" means a surgical procedure performed following a mastectomy on one breast or both breasts to reestablish symmetry between the two breasts. The term includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

**Sec. 60.** NRS 695C.172 is hereby amended to read as follows:

695C.172 1. **[**No**]** *Except as otherwise provided in section 55 of this act, no* health maintenance organization may issue evidence of coverage under a health care plan to any enrollee in this state if it contains any exclusion, reduction or other limitation of coverage relating to complications of pregnancy unless the provision applies generally to all benefits payable under the policy.

2. As used in this section, the term "complications of pregnancy" includes any condition which requires hospital confinement for medical treatment and:

(a) If the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or

(b) If the pregnancy is terminated, results in nonelective cesarean section, ectopic pregnancy or spontaneous termination.

3. Evidence of coverage under a health care plan subject to the provisions of this chapter which is issued on or after July 1, 1977, *except an evidence of coverage for a health care plan issued pursuant to section 55 of this act,* has the legal effect of including the coverage required by this section, and any provision which is in conflict with this section is void.

**Sec. 61.** NRS 695C.173 is hereby amended to read as follows:

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

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

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

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

[The] *Except as otherwise provided in section 55 of this act, the* plans must provide the coverage specified in subsection 3, and must not exclude premature births.

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

(a) The birth of a newly born child;

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

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

and payments of the required charge, if any, must be furnished to the health maintenance organization within 31 days after the date of birth, adoption or placement for adoption in order to have the coverage continue beyond the 31-day period.

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

4. For covered services provided to the child, the health maintenance organization shall reimburse noncontracted providers of health care to an amount equal to the average amount of payment for which the organization has agreements, contracts or arrangements for those covered services.

**Sec. 62.** NRS 695C.1735 is hereby amended to read as follows:

695C.1735 1. [A health maintenance] *Except as otherwise provided in section 55 of this act, a health care* plan must provide coverage for benefits payable for expenses incurred for:

(a) An annual cytologic screening test for women 18 years of age or older;

(b) A baseline mammogram for women between the ages of 35 and 40; and

(c) An annual mammogram for women 40 years of age or older.

2. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after October 1, 1989, *except a policy issued pursuant to section 55 of this act,* has the legal effect of including the coverage required by this section, and any provision of the policy or the renewal which is in conflict with this section is void.

**Sec. 63.** NRS 695C.174 is hereby amended to read as follows:

695C.174 1. [The] *Except as otherwise provided in this section, the* benefits provided by health [maintenance] *care* plans for treatment of the abuse of alcohol or drugs as required by subparagraph (5) of paragraph (b) of subsection 3 of NRS 695C.170, must consist of:

(a) Treatment for withdrawal from the physiological effects of alcohol or drugs, with a maximum benefit of $1,500 per calendar year.

(b) Treatment for a patient admitted to a facility, with a maximum benefit of $9,000 per calendar year.

(c) Counseling for a person, group or family who is not admitted to a facility, with a maximum benefit of $2,500 per calendar year.

2. The maximum amount which may be paid in the lifetime of the insured for any combination of the treatments listed in subsection 1 is $39,000.

3. These benefits must be paid in the same manner as benefits for any other illness covered by a similar policy are paid.

4. The insured person is entitled to these benefits if treatment is received in any:

(a) Facility for the treatment of abuse of alcohol or drugs which is certified by the bureau of alcohol and drug abuse in the rehabilitation division of the department of human resources.

(b) Hospital or other medical facility or facility for the dependent which is licensed by the health division of the department of human resources, accredited by the Joint Commission on Accreditation of Hospitals and provides a program for the treatment of abuse of alcohol or drugs as part of its accredited activities.

*5. The provisions of this section do not apply to a health care plan issued pursuant to section 55 of this act.*

**Sec. 64.** NRS 695C.1755 is hereby amended to read as follows:

695C.1755 1. Except as otherwise provided in this section **[**,**]** *and section 55 of this act,* no evidence of coverage may be delivered or issued for delivery in this state if it contains an exclusion of coverage of the treatment of the temporomandibular joint whether by specific language in the evidence of coverage or by a claims settlement practice. An evidence of coverage may exclude coverage of those methods of treatment which are recognized as dental

procedures, including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints.

2. The health maintenance organization may limit its liability on the treatment of the temporomandibular joint to:

(a) No more than 50 percent of the usual and customary charges for such treatment actually received by an enrollee, but in no case more than 50 percent of the maximum benefits provided by the evidence of coverage for such treatment; and

(b) Treatment which is medically necessary.

3. Any provision of an evidence of coverage subject to the provisions of this chapter and issued or delivered on or after January 1, 1990, *except an evidence of coverage for a health care plan issued pursuant to section 55 of this act,* which is in conflict with this section is void.

**Sec. 65.** NRS 695C.176 is hereby amended to read as follows:

695C.176 [Each] *Except as otherwise provided in section 55 of this act, each* health care plan must provide benefits for hospice care.

**Sec. 66.** NRS 695C.177 is hereby amended to read as follows:

695C.177 [If] *1. Except as otherwise provided in this section, if* any evidence of coverage provides coverage for treatment of an illness which is within the authorized scope of the practice of a qualified psychologist, the insured is entitled to reimbursement for treatments by a psychologist who is licensed pursuant to chapter 641 of NRS.

*2. The provisions of this section do not apply to a health care plan issued pursuant to section 55 of this act.*

**Sec. 67.** NRS 695C.1773 is hereby amended to read as follows:

695C.1773 **[**If**]** *1. Except as otherwise provided in this section, if* any evidence of coverage provides coverage for treatment of an illness which is within the authorized scope of the practice of a licensed marriage and family therapist, the insured is entitled to reimbursement for treatment by a marriage and family therapist who is licensed pursuant to chapter 641A of NRS.

*2. The provisions of this section do not apply to a health care plan issued pursuant to section 55 of this act.*

**Sec. 68.** NRS 695C.1775 is hereby amended to read as follows:

695C.1775 **[**If**]** *1. Except as otherwise provided in this section, if* any evidence of coverage provides coverage for treatment of an illness which is within the authorized scope of the practice of a licensed associate in social work, social worker, independent social worker or clinical social worker, the insured is entitled to reimbursement for treatment by an associate in social work, social worker, independent social worker or clinical social worker who is licensed pursuant to chapter 641B of NRS.

*2. The provisions of this section do not apply to a health care plan issued pursuant to section 55 of this act.*

**Sec. 69.** NRS 695C.178 is hereby amended to read as follows:

695C.178 1. **[**If**]** *Except as otherwise provided in this section, if* any evidence of coverage provides coverage for treatment of an illness which is

within the authorized scope of practice of a qualified chiropractor, the insured is entitled to reimbursement for treatments by a chiropractor who is licensed pursuant to chapter 634 of NRS.

2. The terms of the policy must not limit:

(a) Coverage for treatments by a chiropractor to a number less than for treatments by other physicians.

(b) Reimbursement for treatments by a chiropractor to an amount less than that charged for similar treatments by other physicians.

*3. The provisions of this section do not apply to a health care plan issued pursuant to section 55 of this act.*

**Sec. 70.** NRS 695C.179 is hereby amended to read as follows:

695C.179 1. **[If]** *Except as otherwise provided in this section, if* any evidence of coverage provides coverage for services which are within the authorized scope of practice of a registered nurse who is authorized pursuant to chapter 632 of NRS to perform additional acts in an emergency or under other special conditions as prescribed by the state board of nursing, and which are reimbursed when provided by another provider of health care, the insured is entitled to reimbursement for services provided by such a registered nurse.

2. The terms of the evidence of coverage must not limit:

(a) Coverage for services provided by such a registered nurse to a number of occasions less than for services provided by another provider of health care.

(b) Reimbursement for services provided by such a registered nurse to an amount less than that reimbursed for similar services provided by another provider of health care.

3. An insurer is not required to pay for services provided by such a registered nurse which duplicate services provided by another provider of health care.

*4. The provisions of this section do not apply to a health care plan issued pursuant to section 55 of this act.*

**Sec. 71.** NRS 695C.1795 is hereby amended to read as follows:

695C.1795 1. Except as otherwise provided in subsection 3, every evidence of coverage amended, delivered or issued for delivery in this state after October 1, 1989, that provides coverage for medical transportation, must contain a provision for the direct reimbursement of a provider of medical transportation for covered services if that provider does not receive reimbursement from any other source.

2. The enrollee or the provider may submit the claim for reimbursement. The provider shall not demand payment from the enrollee until after that reimbursement has been granted or denied.

3. Subsection 1 does not apply to [any] *:*

*(a) Any* agreement between a health maintenance organization and a provider of medical transportation for the direct payment by the organization for the provider's services.

*(b) An evidence of coverage for a health care plan issued pursuant to section 55 of this act.*

**Sec. 72.** NRS 695C.265 is hereby amended to read as follows:

695C.265 1. If a health maintenance organization, for any final determination of benefits or care, requires an independent evaluation of the medical or chiropractic care of any person for whom such care is provided under the evidence of coverage:

(a) The evidence of coverage must include a procedure for binding arbitration to resolve disputes concerning independent medical evaluations pursuant to the rules of the American Arbitration Association **[**;**]** , *unless the evidence of coverage is for a health care plan issued pursuant to section 55 of this act;* and

(b) Only a physician or chiropractor who is certified to practice in the same field of practice as the primary treating physician or chiropractor or who is formally educated in that field may conduct the independent evaluation.

2. The independent evaluation must include a physical examination of the patient, unless he is deceased, and a personal review of all X-rays and reports prepared by the primary treating physician or chiropractor. A certified copy of all reports of findings must be sent to the primary treating physician or chiropractor and the insured person within 10 working days after the evaluation. If the insured person disagrees with the finding of the evaluation, he must submit an appeal to the insurer pursuant to the procedure for binding arbitration set forth in the evidence of coverage within 30 days after he

receives the finding of the evaluation. Upon its receipt of an appeal, the insurer shall so notify in writing the primary treating physician or chiropractor.

3. The insurer shall not limit or deny coverage for care related to a disputed claim while the dispute is in arbitration, except that, if the insurer prevails in the arbitration, the primary treating physician or chiropractor may not recover any payment from either the insurer, insured person or the patient for services that he provided to the patient after receiving written notice from the insurer pursuant to subsection 2 concerning the appeal of the insured person.

**Sec. 73.** NRS 287.010 is hereby amended to read as follows:

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

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

2. Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of such insurance

in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.

3. Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as a trust and agency fund as defined by NRS 354.580. The trust funds must be deposited in a state or national bank authorized to transact business in the State of Nevada. The trust instrument must be approved by the commissioner of insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this state. The provisions of NRS 689B.030 to 689B.050, inclusive, apply to coverage provided pursuant to this subsection. *The provisions of section 19 of this act do not apply to coverage provided pursuant to this subsection.*

4. Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The funds for contributions must be budgeted for in accordance with the laws governing the county, school district,

municipal corporation, political subdivision, public corporation or other public agency of the State of Nevada.

SUMMARY--Amends Joint Rules of Senate and Assembly for 66th session to establish criteria for reviewing bills that require policies of health insurance to provide coverage for certain treatment or services. (BDR R-267)

CONCURRENT RESOLUTION--Amending the Joint Rules of the Senate and Assembly for the 66th legislative session to establish criteria for reviewing bills that require policies of health insurance to provide coverage for certain treatment or services.

RESOLVED BY THE OF THE STATE OF NEVADA, THE CONCURRING, That the Joint Rules of the Senate and Assembly as adopted by the 66th session of the Legislature are amended by the following addition:

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**Criteria For Reviewing Bills That Require Policies of Health Insurance to Provide Coverage for Certain Treatment or Services.**

*Any standing committee of the Senate or Assembly to which a bill is referred requiring a policy of health insurance delivered or issued for delivery in this*

*state to provide coverage for any treatment or service shall review the bill giving consideration to:*

*1. The level of public demand for the treatment or service for which coverage is required and the extent to which such coverage is needed in this state;*

*2. The extent to which coverage for the treatment or service is currently available;*

*3. The extent to which the required coverage may increase or decrease the cost of the treatment or service;*

*4. The effect the required coverage will have on the cost of obtaining policies of health insurance in this state;*

*5. The effect the required coverage will have on the cost of health care provided in this state; and*

*6. Such other considerations as are necessary to determine the fiscal and social impact of requiring coverage for the treatment or service.*

SUMMARY--Amends Joint Rules of Senate and Assembly for 66th session to provide for legislative review of certain benefits required by state to be provided by policies of health insurance. (BDR R-271)

CONCURRENT RESOLUTION--Amending the Joint Rules of the Senate and Assembly for the 66th legislative session to provide for the review of certain benefits required by state law to be provided by policies of health insurance.

RESOLVED BY THE OF THE STATE OF NEVADA, THE CONCURRING, That the Joint Rules of the Senate and Assembly as adopted by the 66th session of the Legislature are amended by the following addition:

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**Review of Benefits Required by State Law to be Provided by Policies of Health Insurance.**

*1. During the 67th, 68th and 69th sessions of the Nevada Legislature, each benefit required by state law to be provided by policies of health insurance must be reviewed for a determination of whether the mandated benefit should be continued, amended or repealed. At the beginning of those legislative sessions,*

*the Majority Leader of the Senate and the Speaker of the Assembly shall choose at least five mandated benefits for review.*

*2. The review must be conducted by a joint committee of the Legislature composed of the members of the Senate Committee on Commerce and Labor and the Assembly Committee on Commerce.*

*3. The joint committee shall review a mandated benefit giving consideration to:*

*(a) The level of public demand for the benefit and the extent to which the required coverage is needed in this state;*

*(b) The extent to which such coverage is currently available;*

*(c) The extent to which the mandated benefit may increase or decrease the cost of the treatment or service for which coverage is required;*

*(d) The effect the required coverage will have on the cost of health care provided in this state; and*

*(e) Such other considerations as are necessary to determine the fiscal and social impact of the mandated benefit.*

*4. Upon the completion of the review, the joint committee shall report the results of the review and any recommended legislation to the Legislature as a whole.*

*5. The provisions of this rule apply to benefits required by state law to be provided by policies of health insurance on January 1, 1993. If a mandated benefit is repealed by the Legislature before it is chosen for review, it is not required to be reviewed. All such mandated benefits must be reviewed pursuant*

*to the provisions of this rule by the adjournment of the 69th session of the Nevada Legislature sine die.*