Mandated Health Insurance Benefits

Legislative Counsel Bureau

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MANDATED HEALTH INSURANCE BENEFITS

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TABLE OF CONTENTS

SUMMARY OF RECOMMENDATIONS

STUDY OF MANDATED HEALTH INSURANCE BENEFITS

The Legislative Commission's Subcommittee to Study Mandated Health Insurance Benefits recommends that the Legislature:

1. **Repeal the requirement that all policies of health insurance sold in Nevada include coverage for treatment by psychologists, marriage and family therapists and social workers and cover the temporomandibular joint and home health care and hospice care.** (BDR 57-246)

2. **Enact legislation providing for the review of remaining mandated benefits during future interims.** (BDR R-247)

REPORT TO THE 67TH SESSION OF THE NEVADA LEGISLATURE
BY THE LEGISLATIVE COMMISSION'S SUBCOMMITTEE TO
STUDY MANDATED HEALTH INSURANCE BENEFITS

I. INTRODUCTION

During the past 25 years, health care costs have risen faster than the general cost of living. This growth has had far-reaching effects on society and the economy. Rising costs have made it necessary for most people to purchase health insurance. In its absence, a major medical emergency could wipe out a family by draining its savings, driving it into bankruptcy, or forcing it to assume a crushing load of debt.

At the same time, the cost of health insurance has also risen. For example, in 1970 in Nevada, a family of three or more persons could purchase a comprehensive health insurance policy from Blue Cross/Blue Shield for $40 to $60 per month. This policy had no deductible and no copayment. In 1991, a comparable policy cost $300 to $325 per month and required a substantial deductible and copayment.

Many causes have contributed to the rise in health insurance costs. These include advances in medical technology, expansion of Federal health care programs, and increases in the general cost of living. Mandated health insurance benefits have also played a part.

II. MANDATED BENEFITS IN NEVADA

Until 1971, Nevada had no mandated benefits. Since that time, the Legislature has added at least one new mandated benefit each session, as the following table shows.

A Chronology of Mandated Benefits

1971	Hospice Care Home Health Care
1973	Continued Coverage for Handicapped Dependent Children
1975	Coverage of New Born and Newly Adopted Children

1977	Complications of Pregnancy
1979	Treatment by Psychologist Treatment for Alcohol and Drug Abuse
1981	Treatment by Chiropractor
1983	Mastectomy and Reconstructive Surgery
1985	Treatment by Certain Nurses
1987	Treatment by Marriage and Family Therapist Treatment by Social Worker
1989	Coverage of Temporomandibular Joint (TMJ) Binding Arbitration Cytologic Screening and Mammograms Reimbursement to Provider of Medical Transportation
1991	Acupuncture

Nevada was by no means the only state to enact a large number of mandated benefits. Almost every state followed the same pattern, each choosing a unique set of items which all health insurance policies were required to cover.

III. THE 1989-91 INTERIM STUDY

In 1989, the Legislature, prompted by growing concerns about the price and availability of health insurance, passed Senate Concurrent Resolution No. 58 (File No. 198, *Statutes of Nevada 1989*, pages 2375-2376). This measure directs the Legislative Commission to conduct a study of mandated health insurance benefits. In accordance with this resolution, a subcommittee was appointed and four hearings were held. A more detailed account of the proceedings and the subcommittee's recommendations may be found in *Study of Health Insurance Benefits Required by Law*, Legislative Counsel Bureau Bulletin No. 91-4, September 1990.

Several of the proposals resulting from this study were considered and adopted by the Legislature during its

1991 Session. For example, Senate Bill 503 (Chapter 648, *Statutes of Nevada 1991*, pages 2152-2155) authorizes insurers to establish a health insurance plan for small employers. Eligibility for this program was limited to employers who are self-employed or have fewer than 26 employees and have been without health insurance for 6 months. In establishing such plans, insurers were required to utilize a preferred provider organization, implement various cost-reduction strategies and offer optional deductibles ranging from $200 to $1,000 per year. These policies were exempted from the insurance premium tax.

The subcommittee also proposed that the Legislature establish a process for reviewing proposed mandates. The Legislature adopted Joint Rule No. 17[A] (Senate Concurrent Resolution No. 8, File No. 40, *Statutes of Nevada 1991*, page 2510) which set forth specific criteria which standing committees of the Senate and Assembly must follow when considering any bill which would add a new mandated benefit. A copy of this rule is included in Appendix B.

Finally, the subcommittee proposed that mandates which had been enacted previously should be reviewed to determine whether they should be retained, modified or repealed. The subcommittee members originally anticipated that the Senate Committee on Commerce and Labor and the Assembly Committee on Commerce would conduct these reviews during the course of the legislative session. However, the pressure of legislative business dictated that this review should instead be delegated to a special interim body created for that purpose. The result was the passage of Senate Concurrent Resolution No. 9 (File No. 199, *Statutes of Nevada 1991*, pages 2657-2658).

In response to this resolution, the Legislative Commission appointed the following legislators to form the subcommittee:

Senator Randolph J. Townsend, Chairman
Assemblyman Morse Arberry, Jr., Vice Chairman
Senator Leonard V. Nevin
Senator Ann O'Connell
Senator John M. Vergiels
Assemblyman Rick Bennett
Assemblyman Joe Elliott
Assemblyman James W. McGaughey

Legislative Counsel Bureau (LCB) staff services were provided by:

Paul Mouritsen, Senior Research Analyst (principal staff)
Jan K. Needham, Principal Deputy Legislative Counsel
Ellen R. Nelson, Senior Research Secretary

Senate Concurrent Resolution No. 9 directs the Legislative Commission to appoint a subcommittee to study at least six current mandated benefits. The Legislative Commission directed the subcommittee to review the following mandates:

1. Reimbursement for treatment by a licensed psychologist;

2. Reimbursement for treatment by a licensed marriage and family therapist;

3. Reimbursement for treatment by a licensed Associate in Social Work, Social Worker, Independent Social Worker, or Clinical Social Worker;

4. Coverage of the temporomandibular joint (TMJ);

5. Home health care; and

6. Hospice care.

In response to the charge given by the Legislative Commission, the subcommittee held four meetings. At the first two meetings, one of which was held in Las Vegas and the other in Reno, testimony regarding the three mandates affecting providers of mental health care was provided. The third meeting was held in Carson City, but was transmitted over the Legislature's video teleconference system which enabled witnesses and legislators in Las Vegas to participate. At that meeting, testimony was taken regarding mandated coverage for home health care, hospice care and TMJ. The fourth meeting, a work session, was also held in Carson City and transmitted over the video teleconference system.

Arguments Against Mandated Benefits

Opponents of mandated benefits argue that mandates substantially raise the cost of health insurance. This

increase discourages businesses from purchasing health insurance for their employees and increases the number of persons who lack insurance coverage.

Unfortunately, although much of the controversy regarding mandated benefits hinges on the issue of cost, there is relatively little data regarding the effect which the individual mandates in Nevada law have on health insurance premiums. During the course of the 1989-90 interim study cited above, several insurers provided data on the cost of specific mandates. However, this data did not cover all mandates and was difficult to interpret because of differences in the way in which companies classify claims (see Appendix B of *Study of Health Insurance Benefits Required by Law*, LCB Bulletin No. 91-4, September 1990).

The increase in insurance premiums which results from mandated benefits leads many large employers to self-insure. Self-insured employers are not subject to State insurance laws and need not provide the mandated benefits. The self-insurance option is not open to smaller companies, since they have too few employees over which to spread the risk. Self-insured plans tend to be less financially stable than those which are backed by an insurance company. In addition, self-insured employers are not required to pay insurance premium taxes, resulting in a substantial loss of revenue for the State.

In addition to the problem of cost, mandated benefits make it more difficult for employers to tailor health insurance plans to meet the needs of their employees. Opponents argue that the present list of mandated benefits is not a rational enumeration of a basic health insurance policy. Instead, current mandates are a haphazard series of enactments adopted in response to political pressures from particular groups, especially groups of health care providers.

Finally, opponents contend that if mandated benefit laws were repealed, businesses would still provide adequate insurance coverage. Many of the present mandated benefits, those which have proven to be cost-effective, would continue to be included in group insurance policies.

Arguments For Retaining Mandated Benefits

Those who favor requiring that all policies provide certain benefits argue that the principal issue is freedom of choice. Decisions regarding which benefits will be offered under a group insurance plan are generally made by employers, not by the employees who are covered by the plan. If the employer chooses not to provide coverage for certain types of treatment, employees who prefer those types of treatment will be required to pay for it themselves. In many cases, employees will be unable to meet that expense. As a consequence, their ability to choose the kind of medical treatment which they prefer would be abridged.

In other cases, employers may choose not to provide coverage for the treatment of certain conditions, such as substance abuse or mental illness. Employees may then be forced to forego needed treatment.

This problem is particularly acute for those conditions which may require professional counseling. A large portion of the population will suffer, at some time in their life, from mental disorders or chemical dependency. If these persons are not able to afford treatment because their insurance will not cover it, they may be forced to utilize public mental health programs, adding to the financial burdens of the State.

Spokesmen for the counseling professions also contend that the availability of mental health services helps to reduce the demand for medical care. There is significant evidence that many common medical problems have a psychological component. Persons who have access to appropriate counseling may make less use of other health services.

Proponents of the mandates for coverage of home health care and hospice care also contend that these services help to reduce medical costs. They present evidence that treatment in such settings is less costly than comparable care in hospitals.

Finally, arguments in favor of mandated coverage for the treatment of the temporomandibular joint expressed that it is inappropriate to allow insurers to exclude certain parts of the body from coverage.

Subcommittee Action

After consideration of the testimony presented by both the opponents and the proponents of mandated benefits, the subcommittee voted to recommend that the Legislature:

> **Repeal the requirement that all policies of health insurance sold in Nevada include coverage for treatment by psychologists, marriage and family therapists and social workers and cover the temporomandibular joint and home health care and hospice care.** (BDR 57-246)

The subcommittee was also of the opinion that the Legislature should continue to review the remaining mandated benefits to determine whether they should be retained. Therefore, the subcommittee further recommended that the Legislature:

> **Enact legislation providing for the review of remaining mandated benefits during future interims.** (BDR R-247)

Treatment of Psychological Disorders in Children

During its deliberations, the subcommittee became aware of the need to identify and treat children who suffer from psychological disorders. Representatives of the counseling professions who testified before the subcommittee spoke of the need for early intervention to assist such children and their families in dealing with disorders which, if left untreated, may lead to criminal misconduct or chronic mental illness in later years.

IV. CONCLUSION

Mandated health insurance benefits have been a continuing source of controversy in Nevada. After hearing extensive testimony and after careful deliberation, the subcommittee recommends that the six mandates under review should be repealed. In addition, it recommends that the Legislature continue to examine other existing mandates to determine whether they should be repealed or retained.

V. APPENDICES

APPENDIX A

Senate Concurrent Resolution No. 9
(File No. 199, *Statutes of Nevada 1991*,
Pages 2657-2658)

Senate Concurrent Resolution No. 9—Committee on Commerce and Labor

FILE NUMBER...199

SENATE 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.

WHEREAS, Nevada law currently requires health insurers and health maintenance organizations to provide coverage for the treatment of alcohol and drug abuse, complications of pregnancy, medical care for newly born children and numerous other types of coverage; and

WHEREAS, Operators of small businesses, insurers and others have contended that these mandated benefits increase the cost of health insurance and induce many larger employers to self-insure; and

WHEREAS, Self-insured employers do not always provide these benefits, although their employees may wish to have them; and

WHEREAS, It is desirable that the Legislature periodically review each mandated benefit to determine whether it should continue to be mandatory; 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 not less than six health insurance benefits required by law, as selected by the Legislative Commission, giving consideration to:

1. The level of public demand for each such benefit and the extent to which the required coverage is needed in this state;
2. The extent to which such coverage is currently available;
3. The extent to which the requirement of coverage affects the cost of the treatment or service involved;
4. The effect of the requirement of coverage on the cost of health care in this state; and
5. Such other factors as are deemed necessary to determine the fiscal and social effects of the mandated benefit;

and be it further

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

1. Four Senators who are members of the Senate Standing Committee on Commerce and Labor; and
2. Four 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 67th session of the Nevada Legislature.

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APPENDIX B

Joint Rule No. 17[A] (Senate Concurrent Resolution No. 8, File No. 40, *Statutes of Nevada 1991*)

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.

[Senate Concurrent Resolution No. 8 of 1991 Session (File No. 40)]

JR

APPENDIX C

SUGGESTED LEGISLATION

SUMMARY--Repeals requirements that policies of health insurance provide certain specified coverage. (BDR 57-246)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to health insurance; repealing mandated coverage for hospice care, health care performed in the home and treatment of temporomandibular joint; repealing mandated coverage for treatment by a licensed psychologist, family and marriage therapist and social worker; 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.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 *otherwise* 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"] *As used in this subsection, "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. [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.] 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. The policy must provide benefits for expense arising from hospice care.]

Sec. 2. 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] *8* of NRS 689A.030.

Sec. 3. NRS 689B.030 is hereby amended to read as follows:

689B.030 Each 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. [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.] 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. A provision for benefits for expenses arising from hospice care.]

Sec. 4. NRS 689B.036 is hereby amended to read as follows:

689B.036 1. The benefits provided by a group policy for health insurance, as required in subsection [5] *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.

Sec. 5. NRS 689B.080 is hereby amended to read as follows:

689B.080 Any insurer authorized to write health insurance in this state [shall have the power to] *may* issue blanket health insurance. No blanket policy, except as *otherwise* provided in subsection 4 of NRS 687B.120 , [(filing, approval of forms),] may be issued or delivered in this state unless a copy of the form thereof has been filed in accordance with NRS 687B.120. Every blanket policy must contain provisions which in the opinion of the commissioner are not less favorable to the policyholder and the individual insured than the following:

1. A provision that the policy, including endorsements and a copy of the application, if any, of the policyholder and the persons insured constitutes the entire contract between the parties, and that any statement made by the policyholder or by a person insured is in the absence of fraud a representation and not a warranty, and that no such statements may be used in defense to a claim under the policy, unless contained in a written application. The insured, his beneficiary or assignee has the right to make a written request to the

insurer for a copy of an application, and the insurer shall, within 15 days after the receipt of a request at its home office or any branch office of the insurer, deliver or mail to the person making the request a copy of the application. If a copy is not so delivered or mailed, the insurer is precluded from introducing the application as evidence in any action based upon or involving any statements contained therein.

2. A provision that written notice of sickness or of injury must be given to the insurer within 20 days after the date when the sickness or injury occurred. Failure to give notice within that time does not invalidate or reduce any claim if it is shown not to have been reasonably possible to give notice and that notice was given as soon as was reasonably possible.

3. A provision that the insurer will furnish either to the claimant or to the policyholder for delivery to the claimant such forms as are usually furnished by it for filing proof of loss. If the forms are not furnished before the expiration of 15 days after giving written notice of sickness or injury, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

4. A provision that in the case of a claim for loss of time for disability, written proof of the loss must be furnished to the insurer within 90 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of the disability must be furnished to the insurer at such intervals as the insurer may reasonably require,

and that in the case of a claim for any other loss, written proof of the loss must be furnished to the insurer within 90 days after the date of the loss. Failure to furnish such proof within that time does not invalidate or reduce any claim if it is shown not to have been reasonably possible to furnish proof and that the proof was furnished as soon as was reasonably possible.

5. A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of written proof of loss, and that, subject to proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of that period will be paid immediately upon receipt of proof.

6. A provision that the insurer at its own expense has the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy where it is not prohibited by law.

7. A provision, if applicable, setting forth the provisions of NRS 689B.035.

8. [A provision for 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.] A provision that no action at law or in equity may be brought to recover under the policy before the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the policy and

that no such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Sec. 6. 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. 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. [Unless the contract provides benefits for expenses incurred for hospice care.

10.] 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. 7. NRS 689A.0465, 689A.048, 689A.0483, 689A.0485, 689B.0379, 689B.038, 689B.0383, 689B.0385, 695B.1931, 695B.197, 695B.1973, 695B.1975, 695C.1755, 695C.176, 695C.177, 695C.1773 and 695C.1775 are hereby repealed.

LEADLINES OF REPEALED SECTIONS

689A.0465 Required provisions: Coverage of treatment of temporomandibular joint.

689A.048 Reimbursements for treatments by licensed psychologist.

689A.0483 Reimbursement for treatments by licensed marriage and family therapist.

689A.0485 Reimbursement for treatment by licensed associate in social work, social worker, independent social worker or clinical social worker.

689B.0379 Coverage concerning treatment of temporomandibular joint.

689B.038 Reimbursement for treatments by licensed psychologist.

689B.0383 Reimbursement for treatments by licensed marriage and family therapist.

689B.0385 Reimbursement for treatments by licensed associate in social work, social worker, independent social worker or clinical social worker.

695B.1931 Coverage relating to treatment of temporomandibular joint.

695B.197 Reimbursement for treatment by licensed psychologist.

695B.1973 Reimbursement for treatment by licensed marriage and family therapist.

695B.1975 Reimbursement for treatment by licensed associate in social work, social worker, independent social worker or clinical social worker.

695C.1755 Coverage relating to treatment of temporomandibular joint.

695C.176 Coverage for hospice care.

695C.177 Reimbursement for treatments by licensed psychologist.

695C.1773 Reimbursement for treatment by licensed marriage and family therapist.

695C.1775 Reimbursement for treatment by licensed associate in social work, social worker, independent social worker or clinical social worker.

SUMMARY--Directs Legislative Commission to conduct interim study to review certain benefits required by state to be provided by policies of health insurance. (BDR R-247)

SENATE CONCURRENT RESOLUTION--Directing the Legislative Commission to conduct an interim study to review certain benefits required by state law to be provided by policies of health insurance.

WHEREAS, Nevada law currently requires health insurers and health maintenance organizations to provide coverage for the treatment of alcohol and drug abuse, complications of pregnancy, medical care for newly born children and numerous other types of coverage; and

WHEREAS, Operators of small businesses, insurers and others have contended that these mandated benefits increase the cost of health insurance and induce many larger employers to self-insure; and

WHEREAS, Self-insured employers do not always provide these benefits, although their employees may wish to have them; and

WHEREAS, An interim study of six mandated benefits was conducted following the 66th legislative session to determine their effect on the health insurance system; and

WHEREAS, The previous study reviewed mandated benefits for treatment of the temporomandibular joint, health care at home, hospice care, and treatment by a licensed psychologist, marriage and family therapist or social worker; and

WHEREAS, It is desirable that the Legislature continue its review of each mandated benefit to determine whether it should continue to be mandatory; 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 not less than six health insurance benefits required by law, as selected by the Legislative Commission, excluding those reviewed following the 66th legislative session, giving consideration to:

1. The level of public demand for each such benefit and the extent to which the required coverage is needed in this state;

2. The extent to which such coverage is currently available;

3. The extent to which the requirement of coverage affects the cost of the treatment or service involved;

4. The effect of the requirement of coverage on the cost of health care in this state; and

5. Such other factors as are deemed necessary to determine the fiscal and social effects of the mandated benefit;

and be it further

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

1. Four Senators who are members of the Senate Standing Committee on Commerce and Labor; and

2. Four 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 68th session of the Nevada Legislature.