

THE NINETY-SECOND DAY

CARSON CITY (Monday), May 6, 2019

Senate called to order at 12:16 p.m.

President Marshall presiding.

Roll called.

All present.

Prayer by the Chaplain, Pastor Louis J. Locke.

Let us pray. Thank You, Lord, for another beautiful Nevada day. We ask You for Your grace and peace. We pray for wisdom and discernment for our Legislators as they serve the people of Nevada. We pray for Assemblyman Tyrone Thompson's family and friends as they mourn his loss, and we ask for Your comfort in the midst of his passing. Bless and protect those serving in the military, law enforcement and fire protection.

I also pray for the men and women of this Senate, their families and staff.

In the Name of the Most High God, I pray.

AMEN.

Pledge of Allegiance to the Flag.

By previous order of the Senate, the reading of the Journal is dispensed with, and the President and Secretary are authorized to make the necessary corrections and additions.

REPORTS OF COMMITTEE

Madam President:

Your Committee on Education, to which were referred Assembly Bills Nos. 342, 461, 464, has had the same under consideration, and begs leave to report the same back with the recommendation: Do pass.

MOISES DENIS, *Chair*

Madam President:

Your Committee on Judiciary, to which were referred Assembly Bills Nos. 8, 16, 61, 126, 266, 418, 480, 481, 482, has had the same under consideration, and begs leave to report the same back with the recommendation: Do pass.

NICOLE J. CANNIZZARO, *Chair*

INTRODUCTION, FIRST READING AND REFERENCE

By the Committee on Finance:

Senate Bill No. 533—AN ACT making an appropriation to the Office of Finance for the statewide expansion plan for the Northern and Southern Museum of Arts; and providing other matters properly relating thereto.

Senator Woodhouse moved that the bill be referred to the Committee on Finance.

Motion carried.

By the Committee on Finance:

Senate Bill No. 534—AN ACT making an appropriation from the State General Fund to the Office of Finance for the replacement of the Nevada State Radio System; and providing other matters properly relating thereto.

Senator Woodhouse moved that the bill be referred to the Committee on Finance.

Motion carried.

By the Committee on Finance:

Senate Bill No. 535—AN ACT relating to gaming; revising provisions governing the financial support for programs for the prevention and treatment of problem gambling; and providing other matters properly relating thereto.

Senator Woodhouse moved that the bill be referred to the Committee on Finance.

Motion carried.

By the Committee on Finance:

Senate Bill No. 536—AN ACT relating to energy; expanding the authorized uses of money in the Account for Renewable Energy, Energy Efficiency and Energy Conservation Loans; and providing other matters properly relating thereto.

Senator Woodhouse moved that the bill be referred to the Committee on Finance.

Motion carried.

By the Committee on Finance:

Senate Bill No. 537—AN ACT relating to deceptive trade practices; extending the prospective expiration of the Consumer Affairs Unit of the Department of Business and Industry; and providing other matters properly relating thereto.

Senator Woodhouse moved that the bill be referred to the Committee on Finance.

Motion carried.

SECOND READING AND AMENDMENT

Assembly Bill No. 22.

Bill read second time and ordered to third reading.

Assembly Bill No. 27.

Bill read second time and ordered to third reading.

Assembly Bill No. 29.

Bill read second time and ordered to third reading.

Assembly Bill No. 45.

Bill read second time and ordered to third reading.

Assembly Bill No. 49.

Bill read second time and ordered to third reading.

Assembly Bill No. 85.

Bill read second time and ordered to third reading.

Assembly Bill No. 89.

Bill read second time and ordered to third reading.

Assembly Bill No. 124.

Bill read second time and ordered to third reading.

Assembly Bill No. 131.

Bill read second time and ordered to third reading.

Assembly Bill No. 137.

Bill read second time and ordered to third reading.

Assembly Bill No. 170.

Bill read second time.

The following amendment was proposed by the Committee on Health and Human Services:

Amendment No. 655.

~~ASSEMBLYWOMEN~~ ASSEMBLYMEN SPIEGEL ~~AND~~, FRIERSON, CARLTON, ASSEFA, BACKUS, BILBRAY-AXELROD, FUMO, MARTINEZ, MUNK, NGUYEN, PETERS, SMITH AND WATTS

JOINT SPONSORS: SENATORS RATTI, CANNIZZARO, CANCELA, SPEARMAN, KIECKHEFER, HAMMOND, HARDY, SCHEIBLE, SEEVERS GANSERT, WASHINGTON AND WOODHOUSE

SUMMARY—Revises provisions relating to health insurance coverage. (BDR 57-278)

AN ACT relating to insurance; requiring an insurer to provide certain information relating to accessing health care services to the Office of Consumer Health Assistance; requiring the Governor's Consumer Health Advocate to submit a report of such information to the Legislature; requiring an insurer to offer a health benefit plan regardless of health status; requiring the Advocate to take certain actions to assist consumers in accessing health care services; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law: (1) establishes the Office for Consumer Health Assistance within the Department of Health and Human Services; and (2) requires the Director of the Department to appoint the Governor's Consumer Health Advocate to head the Office. (NRS 232.458) Existing law requires the Advocate to perform certain duties to assist consumers of health care services in obtaining health care services and enforcing their rights under health care plans. (NRS 232.459) Section 4.5 of this bill requires a health carrier which offers or issues a network plan to provide to the Office the contact information for a navigator, case manager or facilitator employed by the health carrier to assist covered persons in accessing health care services. Section 30.5 of this bill requires the Advocate to assist consumers with accessing a navigator, case manager or facilitator to help the consumer obtain health care services. Section 30.5 also requires the Advocate to assist consumers with:

- (1) scheduling an appointment with an in-network provider of health care; and
- (2) filing complaints against health carriers.

Section 4.5 requires a health carrier which offers or issues a network plan to report to the Office certain information relating to access to health care services and resolution of cases by navigators, case managers or facilitators. Section 30.5 of this bill requires the Advocate to compile and submit to the Legislature a report aggregating the information submitted by health carriers. Sections 6.3-6.9 of this bill make conforming changes.

Existing law prohibits an insurer from denying, limiting or excluding a benefit provided by a health care plan in certain limited circumstances, including when a person has contracted for a blanket policy of accident or health insurance or in certain cases relating to adoption. (NRS 689B.0265, 689B.500, 689C.190, 695A.159, 695B.193, 695C.173, 695F.480) The federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148, as amended) prohibits an insurer from establishing rules that limit eligibility for a health care plan based on certain health status factors, including, without limitation, preexisting conditions, claims history or genetic information of the insured and also prohibits an insurer from charging a higher premium, deductible or copay based on those health status factors. (42 U.S.C. § 300gg-4) Sections 7, 12, 15, 19, 20, 24, 25, 29, 30, 31 and 32 of this bill: (1) align Nevada law with federal law and require all insurers to offer a health benefit plan regardless of the health status of a person; and (2) prohibit an insurer from denying, limiting or excluding a covered benefit or requiring an insured to pay a higher premium, deductible, coinsurance or copay based on the health status of the insured or the covered spouse or dependent of the insured. Sections 9, 10, 12, 13, 16-18, 21, 23, 26, 27 and 35 of this bill remove partially duplicative provisions from existing law.

Federal regulations authorize a group health benefit plan to include a wellness program that offers discounts based on health status under certain conditions. (45 C.F.R. §146.121) Sections 12, 15, 20, 24, 29 and 30 of this bill authorize group health plans issued in this State to include such wellness programs under the same conditions as prescribed in federal regulations.

Existing law authorizes certain retired public officers and employees or the surviving spouse of such a retired officer or employee who is deceased to reinstate health insurance provided by the employer. If such an insurance plan is considered a grandfathered plan under the Patient Protection and Affordable Care Act, existing law authorizes such reinstatement to exclude claims for expenses for certain preexisting conditions. (NRS 287.0205) The Patient Protection and Affordable Care Act prohibits a grandfathered group plan from imposing such an exclusion. (42 U.S.C. §§ 300gg-3, 18011(a)(4)(B)) Section 33 of this bill removes authorization for certain government insurance plans to exclude claims for preexisting conditions for reinstated coverage in conformance with federal law and sections 12 and 31 of this bill. Section 31.5 of this bill authorizes such an insurance plan for only retired officers and employees to exclude claims for preexisting conditions under the same

conditions as previously authorized for grandfathered plans. Sections 11, 14, 22 and 35 of this bill remove other provisions of existing law that reference exclusions based on a preexisting condition. Sections 8 and 28 of this bill make other conforming changes.

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

Section 1. Chapter 687B of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 4.5, inclusive, of this act.

Sec. 2. (Deleted by amendment.)

Sec. 3. (Deleted by amendment.)

Sec. 4. (Deleted by amendment.)

Sec. 4.5. 1. *A health carrier which offers or issues a network plan shall:*

(a) *Provide to the Office for Consumer Health Assistance at least annually the telephone number and electronic mail address of a navigator, case manager or facilitator employed by the health carrier and update that information when the information changes.*

(b) *On or before December 31 of each year, submit to the Office for Consumer Health Assistance, for the immediately preceding 12 months, for each type of provider of health care in the applicable network:*

(1) *The number of times covered persons reported difficulty accessing health care services;*

(2) *The number of times covered persons used a navigator, case manager or facilitator to assist in accessing health care services;*

(3) *The number of cases described in subparagraph (2) that were resolved by navigators, case managers or facilitators; and*

(4) *The average period between when a covered person reports difficulty accessing health care services to the resolution of the case by a navigator, case manager or facilitator.*

2. *As used in this section:*

(a) *"Navigator, case manager or facilitator" means an employee of a health carrier whose duties include assisting covered persons in accessing health care services.*

(b) *"Office for Consumer Health Assistance" means the Office for Consumer Health Assistance established by NRS 232.458.*

Sec. 5. (Deleted by amendment.)

Sec. 6. (Deleted by amendment.)

Sec. 6.3. NRS 687B.600 is hereby amended to read as follows:

687B.600 As used in NRS 687B.600 to 687B.850, inclusive, *and section 4.5 of this act*, unless the context otherwise requires, the words and terms defined in NRS 687B.605 to 687B.665, inclusive, have the meanings ascribed to them in those sections.

Sec. 6.6. NRS 687B.670 is hereby amended to read as follows:

687B.670 If a health carrier offers or issues a network plan, the health carrier shall, with regard to that network plan:

1. Comply with all applicable requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~{}~~, *and section 4.5 of this act*;

2. As applicable, ensure that each contract entered into for the purposes of the network plan between a participating provider of health care and the health carrier complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~{}~~, *and section 4.5 of this act*; and

3. As applicable, ensure that the network plan complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive ~~{}~~, *and section 4.5 of this act*.

Sec. 6.9. NRS 687B.830 is hereby amended to read as follows:

687B.830 1. A contract entered into for the purposes of a network plan between a participating provider of health care and the health carrier must not contain a provision that conflicts with any provision in the network plan or any requirement set forth in NRS 687B.600 to 687B.850, inclusive ~~{}~~, *and section 4.5 of this act*.

2. At the time a participating provider of health care signs a contract described in subsection 1, the health carrier and, if applicable, the intermediary shall notify the participating provider of health care of all provisions of the contract and all documents incorporated by reference in the contract.

3. While a contract described in subsection 1 is in force, the health carrier shall provide timely notice to the participating provider of health care of any changes to the provisions of the contract or the documents incorporated by reference in the contract that would result in a material change in the contract.

4. For the purposes of subsection 3, the contract must define what is to be considered timely notice and what is to be considered a material change.

Sec. 7. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

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

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

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

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

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

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

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

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

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

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

Sec. 8. 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 7 of this act.

Sec. 9. NRS 689A.417 is hereby amended to read as follows:

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

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

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

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

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

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

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

3. As used in this section:

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

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

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

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

Sec. 10. NRS 689B.069 is hereby amended to read as follows:

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

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

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

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

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

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

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

3. As used in this section:

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

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

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

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

Sec. 11. NRS 689B.275 is hereby amended to read as follows:

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

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

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

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

(d) Provisions relating to renewability; *and*

(e) ~~Provisions relating to preexisting conditions; and~~
~~(f)~~ Other information that the Commissioner finds necessary for full and fair disclosure of the provisions of the policy.

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

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

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

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

Sec. 12. NRS 689B.500 is hereby amended to read as follows:

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

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

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

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

(c) Genetic information relating to the insured; and

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

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

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

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

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

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

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

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

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

(d) The carrier ensures that the full discount under the wellness program is available to all similarly situated insureds by providing a reasonable alternative standard by which an insured may qualify for the discount which,

if based on health status, must accommodate the recommendations of the physician of the insured; and

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

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

Sec. 13. NRS 689B.550 is hereby amended to read as follows:

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

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

- (a) Health status.
- (b) Medical condition, including physical and mental illnesses, or both.
- (c) Claims experience.
- (d) Receipt of health care.
- (e) Medical history.
- (f) Genetic information.
- (g) Evidence of insurability, including conditions which arise out of acts of domestic violence.
- (h) Disability.

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

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

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

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

~~—5.] This section does not:~~

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

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

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

Sec. 14. NRS 689C.159 is hereby amended to read as follows:

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

Sec. 15. NRS 689C.190 is hereby amended to read as follows:

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

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

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

(c) Genetic information relating to the insured; and

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

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

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

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

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

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

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

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

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

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

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

Sec. 16. NRS 689C.193 is hereby amended to read as follows:

689C.193 1. A carrier shall not place any restriction on a small employer or an eligible employee or a dependent of the eligible employee as a condition of being a participant in or a beneficiary of a health benefit plan that is inconsistent with NRS 689C.015 to 689C.355, inclusive.

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

- (a) Health status.
- (b) Medical condition, including physical and mental illnesses, or both.
- (c) Claims experience.
- (d) Receipt of health care.
- (e) Medical history.
- (f) Genetic information.
- (g) Evidence of insurability, including conditions which arise out of acts of domestic violence.

(h) Disability.

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

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

~~5.1~~ Nothing in this section:

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

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

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

~~6.1~~ 5. As used in this section:

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

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

Sec. 17. NRS 689C.198 is hereby amended to read as follows:

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

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

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

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

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

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

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

3. As used in this section:

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

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

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

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

Sec. 18. NRS 689C.220 is hereby amended to read as follows:

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

Sec. 19. Chapter 695A of NRS is hereby amended by adding thereto a new section to read as follows:

1. *A society shall offer and issue a health benefit plan to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:*

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

Sec. 20. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 21. 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 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 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. ~~{A corporation shall not restrict the coverage of a dependent child adopted or placed for adoption solely because of a preexisting condition the child has at the time the child would otherwise become eligible for coverage pursuant to that contract. Any provision relating to an exclusion for a preexisting condition must comply with NRS 689C.190.~~

~~—5.—~~ 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. 22. NRS 695B.2555 is hereby amended to read as follows:

695B.2555 A converted contract ~~{must not exclude a preexisting condition not excluded by the group contract, but a converted contract}~~ may provide that any hospital, surgical or medical benefits payable under it may be reduced by the amount of any benefits payable under the group contract after his or her termination. A converted contract may provide that during the first contract year the benefits payable under it, together with the benefits payable under the group contract, must not exceed those that would have been payable if the subscriber's coverage under the group contract had remained in effect.

Sec. 23. NRS 695B.317 is hereby amended to read as follows:

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

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

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

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

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

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

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

3. As used in this section:

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

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

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

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

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

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 25. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

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

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

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to

recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

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

Sec. 26. 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 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. ~~[A health maintenance organization shall not restrict the coverage of a dependent child adopted or placed for adoption solely because of a preexisting condition the child has at the time the child would otherwise become eligible for coverage pursuant to that plan. Any provision relating to an exclusion for~~

~~a preexisting condition must comply with NRS 689B.500 or 689C.190, as appropriate.~~

~~5.]~~ 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. 27. NRS 695C.207 is hereby amended to read as follows:

695C.207 1. A health maintenance organization shall not:

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

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

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

~~(1) Whether whether the enrollee or any member of the family of the enrollee has taken a genetic test. ~~the~~ or~~

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

2. As used in this section:

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

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

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

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

Sec. 28. NRS 695C.330 is hereby amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 29. Chapter 695F of NRS is hereby amended by adding thereto a new section to read as follows:

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 30. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

(e) The plan discloses in all plan materials describing the terms of the wellness program, and in any disclosure that an insured did not satisfy the

initial standard to be eligible for the discount, the availability of a reasonable alternative standard described in paragraph (d).

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

Sec. 30.5. NRS 232.459 is hereby amended to read as follows:

232.459 1. The Advocate shall:

(a) Respond to written and telephonic inquiries received from consumers and injured employees regarding concerns and problems related to health care and workers' compensation;

(b) Assist consumers and injured employees in understanding their rights and responsibilities under health care plans, including, without limitation, the Public Employees' Benefits Program, and policies of industrial insurance;

(c) Identify and investigate complaints of consumers and injured employees regarding their health care plans, including, without limitation, the Public Employees' Benefits Program, and policies of industrial insurance and assist those consumers and injured employees to resolve their complaints, including, without limitation:

(1) Referring consumers and injured employees to the appropriate agency, department or other entity that is responsible for addressing the specific complaint of the consumer or injured employee; and

(2) Providing counseling and assistance to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program, and policies of industrial insurance;

(d) Provide information to consumers and injured employees concerning health care plans, including, without limitation, the Public Employees' Benefits Program, and policies of industrial insurance in this State;

(e) Establish and maintain a system to collect and maintain information pertaining to the written and telephonic inquiries received by the Office for Consumer Health Assistance;

(f) Take such actions as are necessary to ensure public awareness of the existence and purpose of the services provided by the Advocate pursuant to this section;

(g) In appropriate cases and pursuant to the direction of the Advocate, refer a complaint or the results of an investigation to the Attorney General for further action;

(h) Provide information to and applications for prescription drug programs for consumers without insurance coverage for prescription drugs or pharmaceutical services;

(i) Establish and maintain an Internet website which includes:

(1) Information concerning purchasing prescription drugs from Canadian pharmacies that have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328;

(2) Links to websites of Canadian pharmacies which have been recommended by the State Board of Pharmacy for inclusion on the Internet website pursuant to subsection 4 of NRS 639.2328; and

(3) A link to the website established and maintained pursuant to NRS 439A.270 which provides information to the general public concerning the charges imposed and the quality of the services provided by the hospitals and surgical centers for ambulatory patients in this State; ~~and~~

(j) Assist consumers with accessing a navigator, case manager or facilitator to help the consumer obtain health care services;

(k) Assist consumers with scheduling an appointment with a provider of health care who is in the network of providers under contract to provide services to participants in the health care plan under which the consumer is covered;

(l) Assist consumers with filing complaints against health care facilities and health care professionals ~~[. As used in this paragraph, "health care facility" has the meaning ascribed to it in NRS 162A.740.]~~ ;

(m) Assist consumers with filing complaints with the Commissioner of Insurance against issuers of health care plans; and

(n) On or before January 31 of each year, compile a report of aggregated information submitted to the Office for Consumer Health Assistance pursuant to section 4.5 of this act, aggregated for each type of provider of health care for which such information is provided and submit the report to the Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the Legislative Committee on Health Care; and

(2) In odd-numbered years, the next regular session of the Legislature.

2. The Advocate may adopt regulations to carry out the provisions of this section and NRS 232.461 and 232.462.

3. As used in this section:

(a) "Health care facility" has the meaning ascribed to it in NRS 162A.740.

(b) "Navigator, case manager or facilitator" has the meaning ascribed to it in section 4.5 of this act.

Sec. 31. NRS 287.010 is hereby amended to read as follows:

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

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

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

compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.

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

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

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

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

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

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political

subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

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

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

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

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

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

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

Sec. 31.5. NRS 287.0205 is hereby amended to read as follows:

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

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

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

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

(a) Giving written notice of the intent of the public officer or employee or surviving spouse to reinstate the insurance to the last public employer of the public officer or employee 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) Except as otherwise provided in paragraph (b) of subsection 4 of NRS 287.023, paying any portion of the premiums or contributions of the public employer's program or plan of insurance, in the manner set forth in NRS 1A.470 or 286.615, which is due from the date of reinstatement and not paid by the public employer.

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

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

4. ~~If a plan is considered grandfathered under the Patient Protection and Affordable Care Act, Public Law 111-148, reinstatement of insurance pursuant to subsection 1 may exclude claims for expenses for any condition for which medical advice, treatment or consultation was rendered within 12 months before reinstatement unless the reinstated insurance has been in effect more than 12 consecutive months.]~~ *If a plan provides coverage only to retired public officers and employees and dependents thereof, reinstatement of insurance pursuant to subsection 1 may exclude claims for expenses related to any condition for which medical advice, treatment or consultation was rendered within 12 months before the reinstatement.*

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

Sec. 32. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 687B.409, 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, *and section 30 of this act* in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 33. Section 15 of chapter 453, Statutes of Nevada 2011, at page 2746, is hereby amended to read as follows:

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

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

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

Sec. 34. The provisions of sections 7, 12, 15, 19, 20, 24, 29 and 30 of this act apply to any contract, agreement, network plan, policy of health insurance,

policy of group health insurance, health benefit plan, benefit contract, contract for hospital or medical service and health care plan that is delivered, issued for delivery or renewed on or after January 1, 2020.

Sec. 34.5. The provisions of subsection 1 of NRS 218D.380 do not apply to any provision of this act which adds or revises a requirement to submit a report to the Legislature.

Sec. 35. NRS 689A.523, 689A.585, 689B.450, 689C.082, 695A.159 and 695F.480 are hereby repealed.

Sec. 36. *This act becomes effective:*

1. *Upon passage and approval for the purpose of performing any preparatory administrative tasks that are necessary to carry out the provisions of this act; and*

2. *On January 1, 2020, for all other purposes.*

LEADLINES OF REPEALED SECTIONS

689A.523 "Exclusion for a preexisting condition" defined.

689A.585 "Preexisting condition" defined.

689B.450 "Preexisting condition" defined.

689C.082 "Preexisting condition" defined.

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

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

Senator Ratti moved the adoption of the amendment.

Remarks by Senator Ratti.

Amendment No. 655 to Assembly Bill No. 170 adds various sponsors to the bill.

Amendment adopted.

Bill ordered reprinted, re-engrossed and to third reading.

Assembly Bill No. 177.

Bill read second time and ordered to third reading.

Assembly Bill No. 181.

Bill read second time and ordered to third reading.

Assembly Bill No. 231.

Bill read second time and ordered to third reading.

Assembly Bill No. 337.

Bill read second time and ordered to third reading.

Assembly Bill No. 344.

Bill read second time and ordered to third reading.

Assembly Bill No. 377.

Bill read second time.

The following amendment was proposed by the Committee on Growth and Infrastructure:

Amendment No. 650.

SUMMARY—Revises provisions governing weight and length limits on certain vehicles. (BDR 43-802)

AN ACT relating to vehicles; authorizing an exemption to certain weight and length limits on certain vehicles operating in this State; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law provides exceptions to the weight limits imposed on vehicles using the highways of this State for vehicles such as snowplows and fire apparatus. (NRS 484D.600) Section 1 of this bill adds exemptions for certain heavy-duty tow trucks and certain other heavy emergency vehicles.

Existing law also provides some exceptions to the length limits imposed on vehicles using the highways of this State. (NRS 484D.615) Section 2 of this bill adds an exemption for a towaway trailer transporter combination, which consists of a vehicle towing empty trailers, provided that the combination does not exceed 82 feet in length or 26,000 pounds in weight.

Existing law provides the same formula for calculating the maximum weight of vehicles that can be operated or moved upon any public highway in this State as is provided in federal law regarding the apportionment to each state of federal highway funds, which results, in most cases, in a maximum weight of 80,000 pounds. (23 U.S.C. § 127(a)(2); NRS 484D.635) Federal law also provides an exception for a vehicle that is operated by an engine fueled primarily by natural gas, which is authorized to exceed the 80,000 pound limit by up to 2,000 pounds, the exact amount allowed being equal to the difference between the weight of the vehicle attributable to the natural gas tank and fueling system and the weight of a comparable diesel tank and fueling system. An exception of up to 550 pounds is also provided in federal law for a vehicle equipped with certain technology that reduces long-duration idling. (23 U.S.C. § 127(s)) Section ~~1~~ 3 of this bill authorizes, to the extent authorized by federal law, a vehicle that is : (1) powered by an engine fueled primarily by natural gas or by one or more electric motors to exceed the existing weight limit by not more than 2,000 pounds ~~1~~; and (2) equipped with idle reduction technology to exceed the existing weight limit by not more than 550 pounds.

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

Section 1. NRS 484D.600 is hereby amended to read as follows:

484D.600 1. Except as otherwise provided in this section, a person shall not drive, move, stop or park any vehicle or combination of vehicles, and an owner shall not cause or knowingly permit any vehicle or combination of vehicles to be driven, moved, stopped or parked, on any highway if the vehicle or combination of vehicles exceeds in size or weight or gross loaded weight the maximum limitation specified by law for that size, weight and gross loaded

weight unless the person or owner is authorized to drive, move, stop or park the vehicle or combination of vehicles by a special permit issued by the proper public authority.

2. If the Department of Transportation or a local law enforcement agency determines that an emergency exists, the Department or the local law enforcement agency may authorize a person to drive, move, stop or park a vehicle or combination of vehicles without obtaining a special permit pursuant to subsection 1. Such an authorization may be given orally and may, if requested by a local law enforcement agency or a public safety agency, include driving or moving the vehicle or combination of vehicles to and from the site of the emergency. If a person receives such an authorization, the person shall, on the next business day after receiving the authorization, obtain a special permit pursuant to subsection 1.

3. This section does not apply to:

(a) Fire apparatus, highway machinery, ~~for~~ snowplows *or other emergency vehicles* temporarily moved upon a highway.

(b) An implement of husbandry temporarily moved upon a highway other than an interstate highway or a controlled-access highway.

(c) A covered heavy-duty tow and recovery vehicle moved upon a highway to remove a disabled heavy vehicle from the highway or the shoulder of the highway to the nearest appropriate repair facility or other safe location where the load may be divided.

4. As used in this section:

(a) "Covered heavy-duty tow and recovery vehicle" has the meaning ascribed to it in 23 U.S.C. § 127.

(b) "Emergency vehicle" has the meaning ascribed to it in 23 U.S.C. § 127.

Sec. 2. NRS 484D.615 is hereby amended to read as follows:

484D.615 1. Except as otherwise provided in subsection 2, the length of a bus may not exceed 45 feet and the length of a motortruck may not exceed 40 feet.

2. A passenger bus which has three or more axles and two sections joined together by an articulated joint with a trailer which is equipped with a mechanically steered rear axle may not exceed a length of 65 feet.

3. Except as otherwise provided in subsections 4, 7 and 9, no combination of vehicles, including any attachments thereto coupled together, may exceed a length of 70 feet.

4. The Department of Transportation, by regulation, shall provide for the operation of combinations of vehicles in excess of 70 feet in length. The regulations must establish standards for the operation of such vehicles which must be consistent with their safe operation upon the public highways and with the provisions of 23 C.F.R. § 658.23. Such standards must include:

- (a) Types and number of vehicles to be permitted in combination;
- (b) Horsepower of a motortruck;
- (c) Operating speeds;
- (d) Braking ability; and

(e) Driver qualifications.

↪ The operation of such vehicles is not permitted on highways where, in the opinion of the Department of Transportation, their use would be inconsistent with the public safety because of a narrow roadway, excessive grades, extreme curvature or vehicular congestion.

5. Combinations of vehicles operated under the provisions of subsection 4 may, after obtaining a special permit issued at the discretion of, and in accordance with procedures established by, the Department of Transportation, carry loads not to exceed the values set forth in the following formula: $W=500 [LN/(N-1) + 12N + 36]$, wherein:

(a) W equals the maximum load in pounds carried on any group of two or more consecutive axles computed to the nearest 500 pounds;

(b) L equals the distance in feet between the extremes of any group of two or more consecutive axles; and

(c) N equals the number of axles in the group under consideration.

↪ The distance between axles must be measured to the nearest foot. If a fraction is exactly one-half foot, the next largest whole number must be used. The permits may be restricted in such manner as the Department of Transportation considers necessary and may, at the option of the Department, be cancelled without notice. No such permits may be issued for operation on any highway where that operation would prevent this State from receiving federal money for highway purposes.

6. Upon approving an application for a permit to operate combinations of vehicles pursuant to subsection 5, the Department of Transportation shall withhold issuance of the permit until the applicant has furnished proof of compliance with the provisions of NRS 706.531.

7. The load upon any motor vehicle operated alone, or the load upon any combination of vehicles, must not extend beyond the front or the rear of the vehicle or combination of vehicles for a distance of more than 10 feet, or a total of 10 feet both to the front or the rear, and a combination of vehicles and load thereon may not exceed a total of 75 feet without having secured a permit pursuant to subsection 4 or NRS 484D.600. The provisions of this subsection do not apply to the booms or masts of shovels, cranes or water well drilling and servicing equipment carried upon a vehicle if:

(a) The booms or masts do not extend by a distance greater than two-thirds of the wheelbase beyond the front tires of the vehicle.

(b) The projecting structure or attachments thereto are securely held in place to prevent dropping or swaying.

(c) No part of the structure which extends beyond the front tires is less than 7 feet from the roadway.

(d) The driver's vision is not impaired by the projecting or supporting structure.

8. Lights and other warning devices which are required to be mounted on a vehicle pursuant to this chapter must not be included in determining the length of a vehicle or combination of vehicles and the load thereon.

9. This section does not apply to:

- (a) Vehicles used by a public utility for the transportation of poles;
- (b) A combination of vehicles consisting of a truck-tractor drawing a semitrailer that does not exceed 53 feet in length;
- (c) A combination of vehicles consisting of a truck-tractor drawing a semitrailer and a trailer, neither of which exceeds 28 1/2 feet in length; ~~for~~
- (d) A driveway saddle mount with full mount vehicle transporter combination that does not exceed 97 feet in length ~~for~~; or
- (e) A towaway trailer transporter combination that does not exceed:
 - (1) Eighty-two feet in length; and
 - (2) Twenty-six thousand pounds in weight.

10. As used in this section:

- (a) "Driveaway saddle mount with full mount vehicle transporter combination" means a vehicle combination designed and specifically used to tow up to three trucks or truck-tractors, each connected by a saddle to the frame or fifth wheel of the forward vehicle of the truck-tractor in front of it.
- (b) "Motortruck" has the meaning ascribed to it in NRS 482.073.
- (c) "Towaway trailer transporter combination" has the meaning ascribed to it in 49 U.S.C. § 31111.

~~Section 1.~~ *Sec. 3.* NRS 484D.635 is hereby amended to read as follows:

484D.635 1. Except as otherwise provided in *this section and* NRS 484D.600, 484D.625, 484D.640, 484D.645 and 484D.660, a vehicle may be operated or moved upon any public highway if:

- (a) The maximum weight on any single axle does not exceed 20,000 pounds.
- (b) The maximum weight on any tandem axle does not exceed 34,000 pounds.
- (c) The maximum weight per tire, measured by pounds per inch of tire width, does not exceed 600 pounds per inch for a steering axle and 500 pounds per inch for all other axles.
- (d) Except for a steering axle and axles that weigh less than 10,000 pounds, each axle has at least four tires if the tire width of each tire on the axle is less than or equal to 14 inches. If the maximum weight per tire does not exceed 500 pounds per inch of tire width, an axle may be equipped with tires that have a width of more than 14 inches.

(e) Except as otherwise provided in subsection 2, the maximum overall gross weight on any group of two or more consecutive axles does not exceed the values set forth in the following formula: $W=500 [LN/(N-1) + 12N + 36]$ wherein:

- (1) W equals the maximum load in pounds carried on any group of two or more consecutive axles computed to the nearest 500 pounds;
- (2) L equals the distance in feet between the extremes of any group of two or more consecutive axles; and
- (3) N equals the number of axles in the group under consideration.

2. Two consecutive sets of tandem axles may carry a gross load of 34,000 pounds each if the distance between the first and last axles of the consecutive sets of axles is 36 feet or more.

3. *To the extent authorized by federal law, a vehicle ~~powered~~ :*

(a) Powered primarily by one or more electric motors or by an engine fueled primarily by natural gas may exceed the limits of this section by not more than 2,000 pounds.

(b) Equipped with idle reduction technology, including, without limitation, an auxiliary power unit, may exceed the limits of this section by not more than 550 pounds.

4. As used in this section ~~[, "tire]~~ :

(a) "Auxiliary power unit" has the meaning ascribed to it in 42 U.S.C. § 16104.

(b) "Idle reduction technology" has the meaning ascribed to it in 49 U.S.C. § 16104.

(c) "Tire width" means the width set by the manufacturer of the tire and inscribed on the sidewall of the tire.

Senator Cancela moved the adoption of the amendment.

Remarks by Senator Cancela.

Amendment No. 650 makes three changes to Assembly Bill No. 377. The amendment adds an exemption for certain heavy-duty tow trucks and certain other heavy emergency vehicles from the maximum weight of vehicles that can use the highways. It also adds an exemption to the length limits imposed on vehicles using the highways for a tow-away trailer-transporter combination, which consists of a vehicle towing empty trailers, provided the combination does not exceed 82 feet in length or 26,000 pounds in weight. Finally, it adds a vehicle equipped with long-duration idling may exceed the maximum weight limitation of vehicles operating on a highway by up to 550 pounds to account for the weight of the technology.

Amendment adopted.

Bill ordered reprinted, engrossed and to third reading.

Assembly Bill No. 455.

Bill read second time and ordered to third reading.

Assembly Bill No. 467.

Bill read second time and ordered to third reading.

Assembly Bill No. 471.

Bill read second time and ordered to third reading.

Assembly Bill No. 484.

Bill read second time and ordered to third reading.

GENERAL FILE AND THIRD READING

Assembly Bill No. 11.

Bill read third time.

Remarks by Senator Parks.

Assembly Bill No. 11 makes various changes concerning veterans services including expanding the duties of the Director of the State Department of Veteran Services to operate cemeteries and veterans homes; requiring the Director ensure volunteers serving as advocates for veterans are

assigned to a veteran service officer employed by the Department; requiring a veteran service officer to assist veterans with any claim for any benefit under the laws of the United States or another state; adding domestic partners to the list of services eligible family members; requiring the Director to provide formal State training and certification for veteran service officers; removes the requirement the Department pay a portion of the operating costs for an office of Coordinator of Services for Veterans created by a county. Finally, the bill designates the Director as the primary public advocate for veterans in Nevada.

Roll call on Assembly Bill No. 11:

YEAS—21.

NAYS—NONE.

Assembly Bill No. 11 having received a constitutional majority, Madam President declared it passed, as amended.

Bill ordered transmitted to the Assembly.

REMARKS FROM THE FLOOR

Senator Cannizzaro requested that the following remarks be entered in the Journal.

SENATOR CANNIZZARO:

That smile, that enthusiasm, that encouragement ever present, steady as a rock. You could not turn off his smile. It was not hard to see his incredible caring and commitment to service. Hear him describe how his grandmother inspired him to education. Safe to say he has inspired others. He volunteered his time as a Court Appointed Special Advocate for our children in foster care. Those kids needed him. One of the well-liked and most dedicated people ever in public office. He was an incredible leader, fierce advocate and kindest person who fought for our community. There are no words to express how kind, funny, thoughtful and driven to make this world and Nevada a better place. He helped voices be heard. He stood larger than life because of his selfless service to his fellow Nevadans. Your kindness and humor and passion and knowledge and, well, everything; you will be missed. He was the nicest and most patient leader you would have ever met. Three things he taught me: make your boss look good, change starts where you are, do not just show up, step up, even when you are not ready.

Today, I am in tears because I am sad to lose one of the most important people in my life. But, I am also in tears because I am privileged to have these lessons from you and fond memories of you. I am doing all I can to pay it forward by being a change agent where it matters most. While you lived, you wrote an incredible legacy, one of service to the community of kindness and impact. You will forever be one of the greatest.

Nevada has lost a wonderful native son. He was a true advocate for his State and community. I am proud to have served with him. Our loss is Heaven's gain. He was one of the most kind, selfless people I ever met. Well before his career in elected public service, he was committed to helping children, the homeless and society's most vulnerable. He was not just a colleague but a dear friend and a kind man. He loved his community and every single person in it. He was a role model, shaping decision makers to make fair judgements in improving the quality of life for our entire community. He nurtured, challenged and encouraged us all to do better, be better.

His kindness was infectious. He was a mentor, a leader and a champion for his community. His legacy is a true believer in the strength, wisdom and power of youth. He was compassionate and passionate. His ability to inspire others was evident by the testimony of those he influenced. He had an infectious personality. He could smile amidst a tremendously stressful and difficult atmosphere, and his smile made the people around him feel better than they did before they had seen him.

I have never known someone more obviously created in this world to serve others than Tyrone. When Maya Angelou said, "I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel." This described Tyrone to anyone who ever met him.

When I was thinking of what to say about the kind, generous, impactful spirit of Assemblyman Tyrone Thompson, I just could not help but come back to the words that have echoed the tributes of him from friends, family and colleagues, and no one could say it better than those who knew him and loved him. Here at the Legislature, he was beloved not only by his colleagues but also by staff and lobbyists alike and by people across all political spectrums. What seemingly every person who has ever known him, from his time at Valley High School and as class president to his leadership as the Chair of the Assembly Education Committee, what everyone has echoed over and over again was that he was compassionate, kind, generous, deeply invested in his community, dedicated to service, willing to fight against homelessness, fight for education, mentor youth and foster children, and no one will forget the way he made people feel, his contagious smile or forget how he could brighten your day in a single minute. I know we all recognize the best of us was taken far too soon.

While we mourn the loss of a truly incredible and dedicated public servant, we must remember that Tyrone would have wanted us to continue to serve the communities we all represent with dignity and passion. He would want us to keep fighting for our youth and education. He would want us to remember that our service here is more about the difference in the lives of others than anything else. He would want us to step up, every day. He would want us to continue to smile.

I will miss the charismatic energy Assemblyman Thompson seemed to have no matter the time of day, where he was or what he was doing. I am honored to have the privilege of knowing such a wonderful human and grateful for being able to serve with him. If you look carefully around the building, we hope you will see a piece of him within each of us.

And, thank you, Madame President, for the opportunity to acknowledge his impactfulness here, today, and to honor his memory.

SENATOR SETTELMAYER:

I echo the words of my colleague, the Majority Leader. It is such a shock, his passage. I do not know what to say. I remember talking to one of our fellow colleagues who happens to be a doctor. As he says, "Not supposed to die." Every time I think of Thompson, all I can think of is his smile. You close your eyes and think about him; it always comes back to me to me. Even at times, to tell you the truth, he probably should not have been smiling. Sometimes, we did not always agree politically. We would have a bill in front of us, poking some holes in the bill, he would still be smiling, getting along, always kind, gentle. I never saw him become aggravated or agitated in any way, just always there. Again, his smile resonated throughout the building. He was always worried about the children.

All I can say, my thoughts and prayers are with his family and friends. The State has lost an advocate, a statesman, a true Nevadan.

SENATOR HARDY:

I think this is a moment where we all get to reminisce about people we have lost. My sister died during Session '11. I made a trip to the funeral just as Session '11 ended. Everywhere I went, I stopped; people said, "Where are you going?" I said, "Well, I am going to my sister's funeral." The universal comment was, "She is in a better place." I believe we all understand, on different levels, where we go.

Tyrone Thompson, we miss you, and as we miss you, you are being greeted by loved ones in a more spiritual realm. You have been separated from your family in your mortal body, yet you are a spiritual person, as you well know. This will be the person who lives on. We, who are left behind, remember you as that, literally a glowing person and personality. We look forward to the opportunity we have to pass on knowing we will see you again and have, as you, as immortal body through the resurrection. We will not only be able to hug as spirits but also be able to feel again in the physical sense as well as a spiritual sense. We appreciate you as a person and recognize your gifts and hope we can in some way follow your suit and example of a pleasant, gregarious person of this world who has brightened our lives.

Senator Cannizzaro moved that the Senate recess until 4:45 p.m.

Motion carried.

Senate in recess at 12:59 p.m.

SENATE IN SESSION

At 4:58 p.m.

President Marshall presiding.

Quorum present.

REPORTS OF COMMITTEE

Madam President:

Your Committee on Health and Human Services, to which were referred Assembly Bills Nos. 133, 156, 228, has had the same under consideration, and begs leave to report the same back with the recommendation: Do pass.

JULIA RATTI, *Chair*

MOTIONS, RESOLUTIONS AND NOTICES

Senator Cannizzaro moved that the following persons be accepted as accredited press representatives, and that they be assigned space at the press table and allowed the use of appropriate media facilities: BIG TV: Jeremy Robbins; THE FALLON POST: Rachel Dahl; KOLO-TV: Rebecca Kitchen, Denise (Little) Wong; MISS USA: Eric Bini, Matt Bockal, Isaac Brooks, Michael Churtin, Justin Marting, Greg Mezey, Shane Pederson, Bridie Rubino, Katy Savard, Antonio Woods.

Motion carried.

Madam President announced that if there were no objections, the Senate would recess subject to the call of the Chair.

Senate in recess at 4:59 p.m.

SENATE IN SESSION

At 5:04 p.m.

President Marshall presiding.

Quorum present.

The Sergeant at Arms announced that Assemblyman Smith and Assemblywoman Titus were at the bar of the Senate. Assemblyman Smith invited the Senate to meet in Joint Session with the Assembly to hear Representative Steven Horsford.

Madam President announced that if there were no objections, the Senate would recess subject to the call of the Chair.

Senate in recess at 5:05 p.m.

IN JOINT SESSION

At 5:09 p.m.

President Marshall presiding.

The Secretary of the Senate called the Senate roll.

All present.

The Chief Clerk of the Assembly called the Assembly roll.
All present except Assemblymen Carillo, Hambrick, Martinez and Neal.

Madam President appointed a Committee on Escort consisting of Senator Brooks and Assemblywoman Monroe-Moreno to wait upon the Honorable Representative Steven Horsford and escort him to the Assembly Chamber.

Representative Horsford delivered his message as follows:

MESSAGE TO THE LEGISLATURE OF NEVADA
80TH SESSION, 2019

I will not stand on ceremony today. One of God's angels, our colleague and dear friend Assemblyman Tyrone Thompson, has been called home. And so, the question for all of us today, what would Ty do? What does his example mean for those who hope to make the difference he has made, in his devotion to family, community and public service? Tyrone was always concerned about the needs and well-being of those around him. I believe he would want, in truth, expect all of us to carry on his work and to make life better for others. First is family. Ty would want us to do all we can to show our love, care and concern for family. He loved having his cousins join for family canvass of his district. For Ty, it was about bringing together the people he loved most and showing them how important they are to his work for the community he grew up in. How can we model this same commitment to those we care about, to show appreciation and recognition to those who have come before and who deserve our respect? We all can share a story about Ty's commitment to his community. For me, it was more than 20 years ago when I got to know Ty through a mutual friend, Shannon West, who went on to be memorialized at her passing for setting a course to eradicate homelessness in southern Nevada. The two were quite a pair, and you could not say no when they called and needed your help on a community initiative. Ty's passion for service and community was reinforced by action. He was on the frontlines advocating for children in family court as a CASA [Court Appointed Special Advocate] advocate. Through his life coaching and mentoring efforts, he spearheaded the annual Clark County Summer Business Institute, providing summer college and career exploration for high school students. When he was not in a classroom reading to elementary school children, he was volunteering with the Southern Nevada Homelessness Continuum of Care, assisting with the annual Point-in-Time count or working to connect efforts to address homeless challenges regionally. From improving funding for education in Nevada, addressing racial equity and inclusion, volunteering with Camp Anytown, supporting Project Homeless Connect and Family Connects to launching the My Brother's Keeper Initiative, Tyrone was consistently present leading the way to make our community and the people in it stronger. So, our charge now is to ensure this work is carried on and the vision for a strong community Ty cared so much about are realized. When Tyrone had the opportunity to be appointed and then elected to the Assembly in District 17, it was a dream come true for him. He wanted to be part of this honorable Body, to propose new ideas and move our State forward and bring an experienced and pragmatic voice to the challenges we face. He became a leader and champion to increase funding for a more equitable education for all students, to advocate for universal background checks and make our schools and communities safe from gun violence. And, as this Body works hard over the final 28 days of this Session, we can all take a lesson from Chairman Thompson, to listen to one another, to respect those on the other side of the argument and to achieve consensus so we can deliver for the people who elected us to serve them.

Ty's commitment to living his values is one of the most enduring lessons he has given us. It is not lost on me that Tyrone's unforeseen health complications are also a lesson to be heeded. At the age of 52, he still had so much more to offer, to his community, in public service and most importantly to his family. Tyrone's passing is a stark reminder that while the work we do is important, so is our health. We have to take care of ourselves in order to have the strength and good health to advocate for our constituents. This is a lesson I learned all too well when I had my own health scare and underwent a six-way heart bypass surgery. In part, it was hereditary and, in

part, it was a lack of knowledge about my own health challenges. I am fortunate; my life was saved. My heart surgery served as a wake-up call for me to take better care of myself. It also helped me better understand a challenge that many of our constituents face daily: the rising costs of prescription drugs. I rely on multiple pills I have to take daily, medications that I have watched increase in price month after month and year after year. Too many of our constituents are familiar with this disturbing trend, and they have encountered dire choices in the process. I have listened to these painful stories, and I know you have too.

This is why I introduced the SPIKE Act [Stopping the Pharmaceutical Industry from Keeping Drugs Expensive], bipartisan legislation to rein in the cost of drugs by holding pharmaceutical companies accountable for price gouging. Under the SPIKE Act, drug companies will have to justify and disclose big increases in drug prices. I am proud to have modeled the SPIKE Act after landmark legislation passed by this Body in 2017. Senator Yvanna Cancela authored that law to bring transparency to insulin pricing and help Nevadans with diabetes fight back against drug industry price gouging. Senator Cancela's bill attracted support from both sides of the aisle and was signed into law by former Republican Governor Brian Sandoval. This model has attracted the same bipartisan support at the national level where it recently passed the Ways and Means Committee on a unanimous, bipartisan vote of 40-0. As one of the six Nevadans sent to represent our State in Washington D.C., I will continue to work with members of this Body to ensure great policies like Senator Cancela's drug transparency model are getting the national hearing they deserve. My job is to make sure Nevadans are heard in Washington. That is the job you sent me to Washington to do. When I return to Nevada's 4th Congressional District, my job is to amplify the voices of community members across our State who need the help of our elected leaders. That is what each of us are elected to do and is what Tyrone did so effectively. I am truly honored to serve this great State, and I am blessed to serve alongside so many leaders at the federal, state and local levels who are committed to improving the lives of families across the Silver State.

In closing, I would like to thank Lieutenant Governor Marshall, Attorney General Ford, Senate President pro Tem Denis, Speaker Frierson, Majority Leaders Cannizzaro and Benitez-Thompson, Minority Leaders Settelmeyer and Wheeler, and all of the members of the Senate and Assembly for allowing me to address the Legislature this evening. Thank you to the Constitutional Officers for being here and for your continued stewardship of our great State. As we mourn the loss of our dear friend and colleague, let us recommit ourselves to the work he would want and expect us to lead, for family, for community, for service.

God bless you; God bless the State of Nevada, and God bless the United States of America.

Senator Parks moved that the Senate and Assembly in Joint Session extend a vote of thanks to Representative Horsford for his timely, able and constructive message.

Motion carried.

Senator Hammond moved that the Joint Session be dissolved.

Motion carried.

Joint Session dissolved at 5:24 p.m.

SENATE IN SESSION

At 5:28 p.m.

President Marshall presiding.

Quorum present.

UNFINISHED BUSINESS

SIGNING OF BILLS AND RESOLUTIONS

There being no objections, the President and Secretary signed Senate Bill No. 32; Assembly Bills Nos. 7, 9, 12, 24, 31, 63, 91, 98, 134, 189, 207, 221.

REMARKS FROM THE FLOOR

Ohrenschall requested that his remarks be entered in the Journal.

I am privileged to have with me today a constituent, Mr. Michael Dias. Since I first met Mr. Dias as a teenager, he has been a champion for southern Nevada, in general, but also for eastern Clark County, the area near Sunrise Mountain and Frenchman Mountain. Today, I want to present him with a proclamation. Mr. Dias is a trained architect and a tireless champion for our unique neighborhoods around Sunrise Mountain and Frenchman Mountain. I ask the Nevada Senate to recognize his achievements and accomplishments.

GUESTS EXTENDED PRIVILEGE OF SENATE FLOOR

On request of Senator Cannizzaro, the privilege of the floor of the Senate Chamber for this day was extended to Crystal Allen, Mario Arias, Joan Brockholt, Sara Conte, John J. Delibos, Susan Florian, Cecelia Gonzalez, Mari Hawley, Jessica James, Maura Kolinsky, Vivian Leal, Patti Mason, Mike Mattingly, Filey Navarro, Olga Riepe, Lonny Rimel, Jer Roberson-Strange, Joshua Rosoff, Deborah Shomsky, Samantha Singer, Jeana Svendsen and Nancy Thomas.

On request of Senator Ohrenschall, the privilege of the floor of the Senate Chamber for this day was extended to Michael Dias and Melanie Stambaugh.

Senator Cannizzaro moved that the Senate adjourn in memory of Assemblyman Tyrone Thompson, friend and colleague, until Tuesday, May 7, 2019, at 11:00 a.m.

Motion carried.

Senate adjourned at 5:29 p.m.

Approved:

KATE MARSHALL
President of the Senate

Attest: CLAIRE J. CLIFT
Secretary of the Senate