SENATE BILL NO. 394–SENATORS SPEARMAN, SEGERBLOM, DENIS, MANENDO, PARKS; CANCELA, CANNIZZARO, FORD AND WOODHOUSE

MARCH 20, 2017

JOINT SPONSORS: ASSEMBLYMEN NEAL; ARAUJO, DIAZ AND THOMPSON

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to Medicaid managed care and required coverage provided by health insurers. (BDR 38-950)

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

CONTAINS UNFUNDED MANDATE (§§ 5, 6)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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

AN ACT relating to health care; requiring the Director of the Department of Health and Human Services to make coverage through the Medicaid managed care program available for purchase on the Silver State Health Insurance Exchange by persons who are not otherwise eligible for Medicaid under certain conditions; requiring the Director to seek any necessary waivers from the Federal Government to provide such coverage and to provide certain incentives to persons who purchase such coverage; requiring insurers to offer health insurance coverage regardless of the health status of a person; requiring insurers to provide coverage for certain essential health benefits without an annual, lifetime or other maximum limit on coverage; requiring insurers to allow the covered adult child of an insured to remain covered by the health insurance of the insured until 26 years of age; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) provides a refundable federal income tax credit and cost-sharing reductions to certain eligible persons who earn not more than 400 percent of the federally designated poverty level in order to offset the cost of certain health care plan premiums. (26 U.S.C. § 36B, 42 U.S.C. § 18071; 45 C.F.R. § 155.305) The Act further requires that such credits and cost-sharing reductions only be made available to purchase health insurance which is offered on a state health insurance exchange, which includes, without limitation, the Silver State Health Insurance Exchange established by this State in 2011. (26 U.S.C. § 36B, 42 U.S.C. § 18071; NRS 695I.200) Existing federal law authorizes the Secretary of the United States Department of Health and Human Services to waive certain Medicaid requirements or provisions of the Act to promote state health care innovation. (42 U.S.C. §§ 1315, 18052)

Existing federal law states that the purpose of the Medicaid program is to promote access to health insurance for certain low-income persons. (42 U.S.C. § 1396) Existing law authorizes this State to enroll Medicaid recipients in a managed care program provided by a health maintenance organization pursuant to a contract with the Nevada Department of Health and Human Services. (42 U.S.C. § 1396u-2; NRS 422.273) Existing federal law also authorizes a state to receive its Federal Medical Assistance Percentage (FMAP) allotment of money from the Federal Government to reimburse providers of health care for medical services which are provided as part of a managed care program. (42 U.S.C. §§ 1396d, 1396u-2) Existing law requires this State to develop a State Plan for Medicaid which includes, without limitation, a list of the medical services provided to Medicaid recipients. (42 U.S.C. § 1396a; NRS 422.063) Existing law also prohibits a state from using FMAP or other federal Medicaid money to reimburse a provider of health care for medical services which are provided to a person who earns more than 138 percent of the federally designated poverty level or for administrative expenses which are unrelated to the administration of Medicaid. (42 U.S.C. §§ 1396a, 1396b(a)(7); 42 C.F.R. 433.15(b))

Section 2 of this bill requires the Director of the Nevada Department of Health and Human Services to seek any necessary waiver of certain provisions of federal law to allow a Medicaid managed care program to be offered for purchase through the Silver State Health Insurance Exchange to persons who are otherwise ineligible for Medicaid. **Section 48** of this bill revises the definition of "qualified health plan" to include the Medicaid managed care program so that it may be offered for purchase in the same manner as other health plans through the Silver State Health Insurance Exchange. Additionally, **section 2** of this bill requires the Director to seek a federal waiver to allow persons to use the federal income tax credit and cost-sharing reductions authorized by the Act to purchase coverage through a Medicaid managed care program which is made available by the Silver State Health Insurance Exchange.

To the extent allowed by federal law or if any necessary waiver is granted by the Secretary of the United States Department of Health and Human Services pursuant to **section 2**, **section 3** of this bill allows any person who is not otherwise eligible for Medicaid to purchase coverage through the Medicaid managed care program. **Section 3** requires the Director of the Nevada Department of Health and Human Services to set the annual premium to be paid by a person who purchases such coverage. **Section 3** further requires that the benefits offered in such a Medicaid managed care program be the same as those provided to other Medicaid recipients. Finally, **section 3** prohibits the Nevada Department of Health and Human Services from using any federal money to offer such coverage through the Medicaid managed care program.

Existing Nevada law provides that an insurer may not deny, limit or exclude a benefit provided by a health care plan in certain limited circumstances, including, without limitation, when a person has contracted for a blanket policy of accident or health insurance or in certain cases relating to adoption. (NRS 689B.500, 689C.190, 695A.159, 695B.193, 695C.173, 695F.480) The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) prohibits an insurer from establishing eligibility rules for a health care plan based on certain health status factors, including, without limitation, preexisting conditions, claims history or genetic information, and also prohibits an insurer from charging a higher premium, deductible or copay based on these health status factors. (42 U.S.C. § 300gg-4) **Sections 8, 15, 19, 24, 28, 34, 41 and 45** of this bill align Nevada law with federal law and require that all insurers offer health insurance coverage regardless of the health status of a person and prohibit an insurer from denying, limiting or excluding a 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.

The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) prohibits an insurer from imposing an annual or lifetime limit on the monetary value of certain essential health benefits which must be covered under a health care plan, including, without limitation, outpatient services, pregnancy, maternity, and newborn care and certain contraceptive drugs, devices and services. (42 U.S.C. § 300gg-11) The Act also authorizes the Secretary of the United States Department of Health and Human Services to specify the services which must be covered as part of an essential health benefit. (42 U.S.C. § 18022(b)(2)) **Sections 9, 13, 25, 29, 35, 42 and 46** of this bill align Nevada law with federal law in this manner, and require the Nevada Department of Health and Human Services to issue regulations that determine the services which must be covered as an essential health benefit by an insurer, including, without limitation, the services currently required to be covered under the Act.

The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) requires all insurers to extend coverage for the covered adult child of an insured until such child reaches 26 years of age. (42 U.S.C. § 300gg-14) **Sections 10, 14, 26, 30, 36, 43 and 47** of this bill align Nevada law with federal law in this manner.

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

Section 1. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. ***The Director shall apply to the Secretary of the United States Department of Health and Human Services for any necessary waiver pursuant to 42 U.S.C. § 1315 or § 18052, as applicable, to:***

1. Allow the Medicaid managed care program authorized by NRS 422.273 to be made available to a person who is otherwise ineligible for Medicaid through the Silver State Health Insurance Exchange established by NRS 695I.200; and

2. Allow a person who is determined eligible for advance payments of the premium tax credit and cost-sharing reductions

pursuant to 45 C.F.R. § 155.305 to use such credits and reductions to pay for coverage through the Medicaid managed care program.

Sec. 3. ***1. To the extent allowed by federal law or if the Secretary of the United States Department of Health and Human Services grants any necessary waiver described in section 2 of this act, the Director shall make coverage through the Medicaid managed care program available for purchase on the Silver State Health Insurance Exchange.***

2. The Director shall determine the amount to charge for the annual premium for coverage through the Medicaid managed care program. The annual premium must be set at an amount that does not require any federal or state money to be used to provide coverage.

3. A person who enrolls in a Medicaid managed care program pursuant to this section must receive the same benefits as those received by other recipients of Medicaid.

4. The Department must not use any federal money to carry out the requirements of this section.

5. The Director may adopt such regulations as deemed necessary to carry out the provisions of this section.

Sec. 4. NRS 422.273 is hereby amended to read as follows:

422.273 1. For any Medicaid managed care program established in the State of Nevada, the Department shall contract only with a health maintenance organization that has:

(a) Negotiated in good faith with a federally-qualified health center to provide health care services for the health maintenance organization;

(b) Negotiated in good faith with the University Medical Center of Southern Nevada to provide inpatient and ambulatory services to recipients of Medicaid; and

(c) Negotiated in good faith with the University of Nevada School of Medicine to provide health care services to recipients of Medicaid.

➥ Nothing in this section shall be construed as exempting a federally-qualified health center, the University Medical Center of Southern Nevada or the University of Nevada School of Medicine from the requirements for contracting with the health maintenance organization.

2. During the development and implementation of any Medicaid managed care program, the Department shall cooperate with the University of Nevada School of Medicine by assisting in the provision of an adequate and diverse group of patients upon which the school may base its educational programs.

3. The University of Nevada School of Medicine may establish a nonprofit organization to assist in any research necessary for the

development of a Medicaid managed care program, receive and accept gifts, grants and donations to support such a program and assist in establishing educational services about the program for recipients of Medicaid.

4. For the purpose of contracting with a Medicaid managed care program pursuant to this section, a health maintenance organization is exempt from the provisions of NRS 695C.123.

5. The provisions of this section apply to any managed care organization, including a health maintenance organization, that provides health care services to recipients of Medicaid under the State Plan for Medicaid ***pursuant to section 3 of this act*** or the Children's Health Insurance Program pursuant to a contract with the Division. Such a managed care organization or health maintenance organization is not required to establish a system for conducting external reviews of adverse determinations in accordance with chapter 695B, 695C or 695G of NRS. This subsection does not exempt such a managed care organization or health maintenance organization for services provided pursuant to any other contract.

6. As used in this section, unless the context otherwise requires:

(a) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(b) "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

(c) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

Sec. 5. 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 sections 13 and 14 of this act*** and 689B.287 apply to coverage provided pursuant to this paragraph.

(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. 6. 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 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 sections 45, 46 and 47 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. 7. Chapter 689A of NRS is hereby amended by adding thereto the provisions set forth as sections 8, 9 and 10 of this act.

Sec. 8. ***1. An insurer shall offer or issue a policy of health insurance to any person regardless of the health status of the person, the spouse 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 policy of health insurance shall not:

(a) Deny, limit or exclude a 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 or the covered spouse or dependent of such an insured who does not have such a health status.

3. An insurer that offers or issues a policy of health insurance 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 spouse or dependent of the insured.

Sec. 9. *1. An insurer that offers or issues a policy of health insurance shall include in each policy coverage for all essential health benefits and shall not place an annual, lifetime or other maximum limit on coverage for such essential health benefits.*

2. The Department of Health and Human Services shall, by regulation, determine the essential health benefits that must be covered by an insurer pursuant to subsection 1. Such essential health benefits must include, without limitation:

(a) Outpatient services;

(b) Emergency care;

(c) Hospitalization;

(d) Pregnancy, maternity and newborn care;

(e) Services relating to mental health and substance use disorders, including, without limitation, treatment for behavioral health and inpatient services for behavioral and mental health;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and management of chronic diseases;

(j) Pediatric services, including, without limitation, oral and vision care for children;

(k) Contraceptive drugs, devices and services; and

(l) Breastfeeding support, counseling and supplies.

Sec. 10. *1. An insurer that offers or issues a policy of health insurance which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age.*

2. Nothing in this section shall be construed as requiring an insurer to make coverage available for a dependent of an adult child of an insured.

Sec. 11. 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 sections 8, 9 and 10 of this act.***

Sec. 12. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 13 and 14 of this act.

Sec. 13. ***1. An insurer that offers or issues a policy of group health insurance shall include in each policy coverage for all essential health benefits and shall not place an annual, lifetime or other maximum limit on coverage for such essential health benefits.***

2. The Department of Health and Human Services shall, by regulation, determine the essential health benefits that must be covered by an insurer pursuant to subsection 1. Such essential health benefits must include, without limitation:

(a) Outpatient services;

(b) Emergency care;

(c) Hospitalization;

(d) Pregnancy, maternity and newborn care;

(e) Services relating to mental health and substance use disorders, including, without limitation, treatment for behavioral health and inpatient services for behavioral and mental health;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and management of chronic diseases;

(j) Pediatric services, including, without limitation, oral and vision care for children;

(k) Contraceptive drugs, devices and services; and

(l) Breastfeeding support, counseling and supplies.

Sec. 14. ***1. An insurer that offers or issues a policy of group health insurance which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age.***

2. Nothing in this section shall be construed as requiring an insurer to make coverage available for a dependent of an adult child of an insured.

Sec. 15. 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. An insurer shall offer or issue a policy of group health insurance to any person regardless of the health status of the person, the spouse 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 policy of group health insurance shall not:

(a) Deny, limit or exclude a 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 or the covered spouse or dependent of such an insured who does not have such a health status.

3. An insurer that offers or issues a policy of group health insurance 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 spouse or dependent of the insured.

Sec. 16. Chapter 689C of NRS is hereby amended by adding thereto the provisions set forth as sections 17 and 18 of this act.

Sec. 17. ***1. A carrier that offers or issues a health benefit plan shall include in each plan coverage for all essential health benefits and shall not place an annual, lifetime or other maximum limit on coverage for such essential health benefits.***

2. The Department of Health and Human Services shall, by regulation, determine the essential health benefits that must be covered by a carrier pursuant to subsection 1. Such essential health benefits must include, without limitation:

(a) Outpatient services;

(b) Emergency care;

(c) Hospitalization;

(d) Pregnancy, maternity and newborn care;

(e) Services relating to mental health and substance use disorders, including, without limitation, treatment for behavioral health and inpatient services for behavioral and mental health;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and management of chronic diseases;

(j) Pediatric services, including, without limitation, oral and vision care for children;

(k) Contraceptive drugs, devices and services; and

(l) Breastfeeding support, counseling and supplies.

Sec. 18. ***1. A carrier that offers or issues a health benefit plan which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age.***

2. Nothing in this section shall be construed as requiring a carrier to make coverage available for a dependent of an adult child of an insured.

Sec. 19. NRS 689C.190 is hereby amended to read as follows:

689C.190 ~~[A carrier serving small employers that issues a health benefit plan shall not deny, exclude or limit a benefit for a preexisting condition.]~~

1. A carrier shall offer or issue a health benefit plan to any person regardless of the health status of the person, the spouse 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 carrier that offers or issues a health benefit plan shall not:

(a) Deny, limit or exclude a 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 or the covered spouse or dependent of such an 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 spouse or dependent of the insured.

Sec. 20. NRS 689C.270 is hereby amended to read as follows:

689C.270 1. The Commissioner shall adopt regulations which require a carrier to file with the Commissioner, for approval by the Commissioner, a disclosure offered by the carrier to a small employer. The disclosure must include:

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

(b) Any restrictions on payments for emergency care, including, without limitation, related definitions of an emergency and medical necessity;

(c) The provision of the health benefit plan concerning the carrier's right to change premium rates and the characteristics, other than claim experience, that affect changes in premium rates;

(d) The provisions relating to renewability of policies and contracts; ***and***

(e) ~~[The provisions relating to any preexisting condition; and~~

~~(f)]~~ Any other information that the Commissioner finds necessary to provide for full and fair disclosure of the provisions of a policy or contract of insurance issued pursuant to this chapter.

2. The disclosure must be written in language which is easily understood and must include a statement that the disclosure is a summary of the policy only, and that the policy itself should be read to determine the governing contractual provisions.

3. The Commissioner shall not approve any proposed disclosure submitted to the Commissioner pursuant to this section which does not comply with the requirements of this section and the applicable regulations.

4. The carrier shall make available to a small employer or a producer acting on behalf of a small employer, upon request, a copy of the disclosure approved by the Commissioner pursuant to this section for policies of health insurance for which that employer may be eligible.

Sec. 21. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, ***and sections 17 and 18 of this act*** to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 22. NRS 689C.440 is hereby amended to read as follows:

689C.440 1. The Commissioner shall adopt regulations which require a carrier to file with the Commissioner, for approval by the Commissioner, a disclosure offered by the carrier to a voluntary purchasing group. The disclosure must include:

(a) Any significant exception, prior authorization, reduction or limitation that applies to a contract;

(b) Any restrictions on payments for emergency care, including, without limitation, related definitions of an emergency and medical necessity;

(c) Any provision of a contract concerning the carrier's right to change premium rates and the characteristics, other than claim experience, that affect changes in premium rates;

(d) The provisions relating to renewability of contracts; ***and***

(e) ~~[The provisions relating to any preexisting condition; and~~

~~(f)]~~ Any other information that the Commissioner finds necessary to provide for full and fair disclosure of the provisions of a contract.

2. The disclosure must be written in a language which is easily understood and must include a statement that the disclosure is a summary of the contract only, and that the contract itself should be read to determine the governing contractual provisions.

3. The Commissioner shall not approve any proposed disclosure submitted to the Commissioner pursuant to this section which does not comply with the requirements of this section and the applicable regulations.

Sec. 23. Chapter 695A of NRS is hereby amended by adding thereto the provisions set forth as sections 24, 25 and 26 of this act.

Sec. 24. ***1. A society shall offer or issue a benefit contract to any person regardless of the health status of the person, the spouse 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 benefit contract shall not:

(a) Deny, limit or exclude a 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 or the covered spouse or dependent of such an insured who does not have such a health status.

3. A society that offers or issues a benefit contract 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 spouse or dependent of the insured.

Sec. 25. *1. A society that offers or issues a benefit contract shall include in each contract coverage for all essential health benefits and shall not place an annual, lifetime or other maximum limit on coverage for such essential health benefits.*

2. The Department of Health and Human Services shall, by regulation, determine the essential health benefits that must be covered by a society pursuant to subsection 1. Such essential health benefits must include, without limitation:

(a) Outpatient services;

(b) Emergency care;

(c) Hospitalization;

(d) Pregnancy, maternity and newborn care;

(e) Services relating to mental health and substance use disorders, including, without limitation, treatment for behavioral health and inpatient services for behavioral and mental health;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and management of chronic diseases;

(j) Pediatric services, including, without limitation, oral and vision care for children;

(k) Contraceptive drugs, devices and services; and

(l) Breastfeeding support, counseling and supplies.

Sec. 26. *1. A society that offers or issues a benefit contract which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age.*

2. Nothing in this section shall be construed as requiring a society to make coverage available for a dependent of an adult child of an insured.

Sec. 27. Chapter 695B of NRS is hereby amended by adding thereto the provisions set forth as sections 28, 29 and 30 of this act.

Sec. 28. *1. A hospital or medical service corporation shall offer or issue a contract for hospital or medical service to any person regardless of the health status of the person, the spouse 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 hospital or medical service corporation that offers or issues a contract for hospital or medical service shall not:

(a) Deny, limit or exclude a 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 or the covered spouse or dependent of such an insured who does not have such a health status.

3. A hospital or medical service corporation that offers or issues a contract for hospital or medical service 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 spouse or dependent of the insured.

Sec. 29. *1. A hospital or medical service corporation that offers or issues a contract for hospital or medical service shall include in each contract coverage for all essential health benefits and shall not place an annual, lifetime or other maximum limit on coverage for such essential health benefits.*

2. The Department of Health and Human Services shall, by regulation, determine the essential health benefits that must be covered by a hospital or medical service corporation pursuant to subsection 1. Such essential health benefits must include, without limitation:

(a) Outpatient services;

(b) Emergency care;

(c) Hospitalization;

(d) Pregnancy, maternity and newborn care;

(e) Services relating to mental health and substance use disorders, including, without limitation, treatment for behavioral health and inpatient services for behavioral and mental health;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and management of chronic diseases;

(j) Pediatric services, including, without limitation, oral and vision care for children;

(k) Contraceptive drugs, devices and services; and

(l) Breastfeeding support, counseling and supplies.

Sec. 30. ***1. A hospital or medical service corporation that offers or issues a contract for hospital or medical service which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age.***

2. Nothing in this section shall be construed as requiring a hospital or medical service corporation to make coverage available for a dependent of an adult child of an insured.

Sec. 31. 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. 32. 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. 33. Chapter 695C of NRS is hereby amended by adding thereto the provisions set forth as sections 34, 35 and 36 of this act.

Sec. 34. ***1. A health maintenance organization shall offer or issue a health care plan to any person regardless of the health status of the person, the spouse 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 care plan shall not:

(a) Deny, limit or exclude a 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 or the covered spouse or dependent of such an enrollee who does not have such a health status.

3. A health maintenance organization that offers or issues a health care 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 spouse or dependent of the enrollee.

Sec. 35. *1. A health maintenance organization that offers or issues a health care plan shall include in each plan coverage for all essential health benefits and shall not place an annual, lifetime or other maximum limit on coverage for such essential health benefits.*

2. The Department of Health and Human Services shall, by regulation, determine the essential health benefits that must be covered by a health maintenance organization pursuant to subsection 1. Such essential health benefits must include, without limitation:

(a) Outpatient services;

(b) Emergency care;

(c) Hospitalization;

(d) Pregnancy, maternity and newborn care;

(e) Services relating to mental health and substance use disorders, including, without limitation, treatment for behavioral health and inpatient services for behavioral and mental health;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and management of chronic diseases;

(j) Pediatric services, including, without limitation, oral and vision care for children;

(k) Contraceptive drugs, devices and services; and

(l) Breastfeeding support, counseling and supplies.

Sec. 36. *1. A health maintenance organization that offers or issues a health care plan which provides coverage for dependent children shall continue to make such coverage available for an adult child of an enrollee until such child reaches 26 years of age.*

2. Nothing in this section shall be construed as requiring a health maintenance organization to make coverage available for a dependent of an adult child of an enrollee.

Sec. 37. 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.1735 to 695C.1755, inclusive, 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, 695C.1695, 695C.1708, 695C.1731, 695C.17345 and 695C.1757 ***and sections 34, 35 and 36 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. 38. 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. 39. 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, or 695C.207 ~~[.]~~ ***or sections 34, 35 and 36 of this act;***

(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;

(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. 40. Chapter 695F of NRS is hereby amended by adding thereto the provisions set forth as sections 41, 42 and 43 of this act.

Sec. 41. ***1. A prepaid limited health service organization shall offer or issue evidence of coverage to any person regardless of the health status of the person, the spouse 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 evidence of coverage shall not:

(a) Deny, limit or exclude a 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 or the covered spouse or dependent of such an enrollee who does not have such a health status.

3. A prepaid limited health service organization that offers or issues evidence of coverage 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 spouse or dependent of the enrollee.

Sec. 42. ***1. A prepaid limited health service organization that offers or issues evidence of coverage shall include coverage for all essential health benefits and shall not place an annual, lifetime or other maximum limit on coverage for such essential health benefits.***

2. The Department of Health and Human Services shall, by regulation, determine the essential health benefits that must be covered by a prepaid limited health service organization pursuant to subsection 1. Such essential health benefits must include, without limitation:

(a) Outpatient services;

(b) Emergency care;

(c) Hospitalization;

(d) Pregnancy, maternity and newborn care;

(e) Services relating to mental health and substance use disorders, including, without limitation, treatment for behavioral health and inpatient services for behavioral and mental health;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and management of chronic diseases;

(j) Pediatric services, including, without limitation, oral and vision care for children;

(k) Contraceptive drugs, devices and services; and

(l) Breastfeeding support, counseling and supplies.

Sec. 43. *1. A prepaid limited health service organization that offers or issues evidence of coverage which provides coverage for dependent children shall continue to make such coverage available for an adult child of an enrollee until such child reaches 26 years of age.*

2. Nothing in this section shall be construed as requiring a prepaid limited health service organization to make coverage available for a dependent of an adult child of an enrollee.

Sec. 44. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 45, 46 and 47 of this act.

Sec. 45. *1. A managed care organization shall offer or issue a health care plan to any person regardless of the health status of the person, the spouse 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 care plan shall not:

(a) Deny, limit or exclude a 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 or the covered spouse or dependent of such an insured who does not have such a health status.

3. A managed care organization that offers or issues a health care 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 spouse or dependent of the insured.

Sec. 46. *1. A managed care organization that offers or issues a health care plan shall include in each plan coverage for all essential health benefits and shall not place an annual, lifetime or other maximum limit on coverage for such essential health benefits.*

2. The Department of Health and Human Services shall, by regulation, determine the essential health benefits that must be covered by a managed care organization pursuant to subsection 1. Such essential health benefits must include, without limitation:

(a) Outpatient services;

(b) Emergency care;

(c) Hospitalization;

(d) Pregnancy, maternity and newborn care;

(e) Services relating to mental health and substance use disorders, including, without limitation, treatment for behavioral health and inpatient services for behavioral and mental health;

(f) Prescription drugs;

(g) Rehabilitative and habilitative services and devices;

(h) Laboratory services;

(i) Preventive and wellness services and management of chronic diseases;

(j) Pediatric services, including, without limitation, oral and vision care for children;

(k) Contraceptive drugs, devices and services; and

(l) Breastfeeding support, counseling and supplies.

Sec. 47. *1. A managed care organization that offers or issues a health care plan which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age.*

2. Nothing in this section shall be construed as requiring a managed care organization to make coverage available for a dependent of an adult child of an insured.

Sec. 48. NRS 695I.080 is hereby amended to read as follows:

695I.080 Except as otherwise provided in NRS 695I.370, "qualified health plan" ~~[has the meaning ascribed to it in]~~ ***means:***

1. A health plan which meets the requirements of § 1301 of the Federal Act ~~[.]~~ ***; or***

2. The Medicaid managed care program to the extent that it is made available as described in section 3 of this act.

Sec. 49. The amendatory provisions of sections 5 to 48, inclusive, of this act only apply to a policy of health insurance, policy of group health insurance, health benefit plan, benefit contract, contract for hospital or medical service, health care plan or evidence of coverage which is issued or renewed on or after January 1, 2018.

Sec. 50. NRS 689A.523, 689A.585, 689B.450, 689C.082, 695A.159 and 695F.480 are hereby repealed.

Sec. 51. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 52. 1. This section and sections 1 and 2 of this act become effective upon passage and approval.

2. Sections 3 to 51, inclusive, of this act become effective upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act and on January 1, 2018, 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.

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