Members present:

Chairman Jeffrey
Vice Chairman Robinson
Assemblyman Bennett
Assemblyman Bremner
Assemblyman Chaney
Assemblyman Horn
Assemblyman Sena
Assemblyman FitzPatrick
Assemblyman Rusk
Assemblyman Tanner
Assemblyman Weise

The meeting was called to order at 7:12 a.m.

AB 753: Rennie Ashleman, Nevada Mortgage Brokers Assoc., stated that the association is in favor of the bill as amended by amendment number 897. He stated that the purposes of the bill was to establish some guidelines or qualifications for licensure; to increase the number allowed on the boards of the larger companies in order to gain more control; and to provide for the advance payment of itemized expenses so that legitimate business can collect for items such as travel and appraisal fees which must be advanced prior to the loan committment (this would be a modification of the Advance Payments Act).

Jim Wadhams, Director of Commerce, stated that he had spoken to the Commissioner of Savings Associations and felt that he was in favor of the bill. Mr. Goddard was not present at this point in the meeting.

Mr. Tanner told Mr. Ashleman that he felt the advance payments portion of the bill should be more specific and that there should be an escrow established which could provide that as soon as there was a loan committment or any activity, specific itemized funds could be released. After a brief discussion, Mr. Ashleman stated that he did not feel legitimate companies were going to chance being charged with a gross misdemeanor for such small sums (relatively) and that there are also other current provisions in the licensure laws which preclude taking money without it being itemized for the client. He stated that NRS 645 and 205 both have provisions in this area.

Don Brodeen, Weyerhauser Mortgage, stated that if a company can't collect their fees in advance to offset some of their expenses, then they will not get the appraisal work done in order to see if they want to make loans.

COMMITTEE ACTION: AB 753: Mr. Rusk moved to AMEND AND DO PASS, Mr. Tanner seconded the motion and it carried unanimously; however due to comments made subsequently by Mr. Lester Goddard, the committee was made aware that Mr. Goddard would seek to have the bill further amended in the Senate. Mr. Goddard's comments are attached and marked as Exhibit "A".

AB 776: Virgil Wedge, attorney representing Raley's Stores of California and Nevada, stated that this bill would cause havoc with their pricing pocedures and that it would also being an absolute nightmare to regulate and enforce. He stated that the function of filling shelves would be practically impossible if you had to verify which cans you had received prior to your last price increase so that you would not mark one can incorrectly. He stated that though he knew there had been abuses by some companies in this area, he did not feel it was something that could be regulated in this fashion.

COMMITTEE ACTION: AB 776: Mr. Weise moved to INDEFINITELY POSTPONE the bill, Mr. Tanner seconded the motion and it carried unanimously with Mr. Bremner and Mr. Horn not being present to vote.

AB 792: Mr. Rennie Ashleman, representing Nevada First Thrift, stated that this was an agency bill and that since his clients are probably most effected by the bill and have no objections to it, he would urge passage of it.

COMMITTEE ACTION: AB 792: Mr. Jeffrey told the committee that he had an amendment to the bill which resolved a conflict with SB 171. Mr. Weise moved to adopt the amendment and AMEND AND DO PASS the bill, Mr. Tanner seconded the motion and it carried unanimously with Mr. Bremner and Mr. Horn not present to vote.

AB 793: James Wadhams, Director of Commerce, stated that this bill was the result of a request from a member of the Ways and Means committee who asked the commissioner of savings and loans to exempt mortgage bankers from the provisions of Chapter 645. He stated that he was not for or against the bill. He stated that he felt the change on page 1, lines 17-19, was a very good idea because he did not feel that whether or not a company used public advertising should have anything to do with their being closely regulated. He stated that the reason for the change on page 2, lines 9-11, was because there were already federal rules and regulations covering the Federal National Mortgage Association companies and they, therefore, perhaps did not need regulation by the state too.

COMMITTEE ACTION: AB 793: Mr. Weise moved to amend the bill by deleting the brackets on lines 9-11, page 2 and to AMEND AND DO PASS, Mr. Rusk seconded the motion and it carried unanimously; however due to comments made subsequently by Mr. Lester Goddard, the committee was made aware that Mr. Goddard would seek to have the bill further amended in the Senate.

AB 594: Assemblyman Bennett, as sponsor of the bill, stated that this bill is aimed at allowing people who leave employment where group medical insurance was provided to be able to conver that coverage so that they will continue to have some kind of medical insurance protection. He stated that there are some states which already allow this type of conversion and also some employers in

Nevada which also allow for the conversion. He said that this is extremely important to older people who would not qualify under another plan because of age or health, but this would provide these people with some coverage which would be better than nothing, even if the premium were higher and the benefits less.

In answer to a question from Mr. Weise, Mr. Bennett stated that those people who were past retirement age would also be eligible for Medicare and that others would be paying higher rates for coverage and he did not think that there would be a great impact on the insurers.

Assemblyman FitzPatrick stated that the reason he had co-sponsored the bill was because he felt this would help many people who changed employers to be covered in the interim by paying the premiums themselves. He also stated that the insurers also figure into the premiums a risk factor for future illness and these people would be paying higher rates that the group insured employee.

Georgia Masey submitted to the committee proposed amendments to the bill and they are attached and marked as Exhibit "B". She reviewed these proposed amendments with the committee.

Milos Terzich, American Counsel of Life Insurance, submitted to the committee a letter from that organization together with a model law which coveres group insurance conversions and that information is attached and marked as Exhibit "C". He discussed their views concerning this issue with the committee.

Also submitted to the committee for their information regarding this bill was a letter from Vivian Osbon on behalf of Central Telephone Company stating their position against the bill and that is attached and marked as Exhibit "D".

Richard Garrod, Farmers Insurance, stated that their company was opposed to use of the provisions outlined in the model law reviewed by Mr. Terzich because their company had gone out of business in group insurance type coverage in the states where this type of conversion was used.

Dave Byington, Nevada State Underwriters Association, stated that they were in support of conversions provisions and that the law concerning conversion varies from state to state. He stated that both the holder of the master contract (the employer) and the participant (employee) are protected against those converting causeing the premiums to go up because ususally there is a built in provision protecting them against charge backs caused by people withdrawing from the plan who have subsequent medical claims. He stated that he would be willing to help in any subcommittee to resolve conflicts on this type of conversion plan. He also pointed out that 80% of the larger companies providing this type of coverage currently have conversion provisions available, but that most conversion plans are limited and have a higher premium.

Chairman Jeffrey excused Mr. Bennett and Mr. FitzPatrick from the meeting at this point to begin work on this with the various people present as a sub-committee to work out proposed amendments to the bill which would be agreeable to all.

There was a brief recess from 8:40 to 8:55.

AB 723: James Wadhams, Director of Commerce, submitted to the committee an amendment which is attached and marked as Exhibit "E". He stated that the Department would be in favor of the bill with that amendment. He stated that this bill only applies to fees of resident agents and adjusters. He reviewed the amendments with the committee. He pointed out to the committee that he had been in contact with members of the industry and that they had agreed with the changes made by the bill in their fee structure. He stated that this change was necessary because they were beginning to use pre-prepared testing materials which would have to be purchased from a national testing system and which would be more scientific than those which had been given by the department. He stated that, therefore, they needed to be able to base the fees on the costs of those pre-prepared tests.

He stated that effectively what they wanted to do was eliminate the entire bill and go with the language in the amendment and bill which deals directly with those fee changes.

Milos Terzich, representing the American Cousel of Life Insurance Companies, stated that he concurred with Mr. Wadhams regarding this bill as it would be amended.

COMMITTEE ACTION: AB 723: Mr. Tanner moved to AMEND AND DO PASS, Mr. Weise seconded the motion and it carried with Mr. Horn, Mr. FitzPatrick, Dr. Robinson, and Mr. Bremner not present to vote.

AB 814: Assemblyman Marvel, stated that he wished to testify on behalf of the bill along with Russ Pike, first vice-president of First Federal Savings and Loan and legal counsel.

Mr. Pike stated that they favored the bill because last session a provision was made for deposit of public funds to all state chartered associations, but it excluded mutual associations. He stated that due to their history of providing mortgage funds to the state of Nevada, they are asking for an opportunity to participate in state funds, in hopes that they may be reinvested within the state. He stated that this bill would modify current law so that deposits to a mutual association would be evidenced by an instrument which would acknowledge that the state is not a member of the association by virtue of the deposit. Mr. Jeffrey pointed out that under current constitutional and statute provisions the state is prohibited from putting monies into an association where it would have a vote and this bill would allow them to make deposits without becoming a member of the association. He also asked Mr. Pike if it might also be necessary for First Federal to change their charter to allow the state to be able to make these deposits without becoming members and Mr. Pike stated that it was

the case. That concluded testimony on this bill.

COMMITTEE ACTION: AB 814: Mr. Rusk moved to DO PASS, Mr. Weise seconded the motion and it carried with Mr. Bremner, Mr. Horn and Mr. FitzPatrick not present to vote.

AB 808: It was pointed out by Dr. Robinson that there was a bracket missing from line 15, page 1, belonging just before the word "prior".

Assemblyman Virgil Getto introduced Joe Reynolds and Curt Tuck who would be speaking in opposition to the bill.

Joe Reynolds, of Reno and representing four surety companies engaged in the bail business and which represents approximately 75 - 80% of this type of business written in the state at this time, stated that surety contracts are different from other types of casualty contracts because they have the ability to collect from the person who is being insured, if they have to forfeit a bond on behalf of that person or his co-signer, if any. He also pointed out that there are other people involved as co-signers with most bonds; mothers, grandmothers, friends, etc. and this bill would not allow the court to exonerate the forfeit of that bond unless certain very strict criteria were met. He gave the committee examples of how people, innocently and with good intentions, could be taken in and lose substantial amounts by putting up security for these people who needed to get bailed out. He stated that often, the bailbondsmen know these people even better than their relatives or friends and they see people who put up security for these bonds lose that security (automobiles and homes, etc.) over and over again. He stated that if all bonds were written to bail someone out for murder, rape or robbery, maybe someone losing a great amount of security would be justified; however, many are lost because people skip out on relatives and friends who have posted bonds for DUI's, drunkedness, etc. He stated that due to his work with the commerce department, insurance division, he was aware of the abuses which had been occurring in this area, but he felt it was going to be extremely difficult for people to get bonding because there had to be some latitude for the court to make discretionary adjustments. Dr. Robinson pointed out that this bill was introduced because some bailbondsmen had made "deals" with some judges and not all bondsment were being treated equally and fairly. Mr. Reynolds stated that regardless of whether or not the bill passed, if a bondsman wanted to be unscrupulous and obtain a favored position, he would be able to find a way to do that, irregardless of any law.

Senator Wilson appeared to speak in favor of the bill and stated that the idea had originally been presented to address the contributions made by bailbondsmen to campaigns of judges, but that it was changed because the original idea was not uniform in application. He said that they finally came up with this bill which deals with exoneration of bail by tightening up the present law. He stated that this bill would help encourage getting the defendant to court, even if the bail had been forfeited.

He also stated that the bill provided for showing of good cause which would result in the relaxing of the hardship provisions as to exonerating that forfeiture. He stated that the bill as currently written provides a showing of cause and why there ought to be relief (which is sometimes appropriate). He further stated that if there are no exonerating circumstances, then the bail should be forfeited and not set aside.

The committee discussed what circumstances whould be taken into account regarding hardship cases and extenuating circumstances with Mr. Reynolds, Mr. Getto and Senator Wilson.

Curtis Tuck, bailbondsman from Fallon, explained to the committee that many people lose their money which they posted for an acquaintance or friend because the bondsman doesn't have the time to go get the defendant, sometimes even if they know approximately where they have gone, so that they can appear in court. He also pointed out that even under the proposed bill, the bondsman could lie to the judge and say that the defendant was ill and get the forfeiture set aside. After a discussion of the various aspects of this issue, Mr. Reynolds stated that he felt there should be a differentiation in the bill between failure to appear and delayed or late appearances. He also mentioned that Cal Dunlap had stated in the Senate hearings that there should perhaps be some way for the bondsmen to get reimbursed to offset their out of pocket costs for having to retrieve a defendant so that appearance would be possible.

Jay MacIntosh, insurance agent who writes primarily bail bonds, stated that insurance companies, in general, do not lose much money because these policies are collateralized; however, he said that this bill would make it more difficult to underwrite these kinds of policies because of the 45 day limit and the inability of the courts to set aside forfeiture in the event of just cause, and other reasons. He stated that even if the bail is forfeited, there is still a criminal loose and that there should be an incentive for the bondsman to bring him back to justice. He stated that he would support the suggestion made earlier that it remain at 90 days.

Chairman Jeffrey appointed Mr. Weise to work with Mr. Reynolds and Senator Wilson on amendments for this bill which would make it more palatable to all concerned.

AB 807: Jack Sheehan, speaking on behalf of the Wine and Spirits Wholesalers of Nevada, stated that they supported the bill because they felt it was very important to them as it would solidify the nature of the liquor business which is a franchised area and provides more security for both the wholesalers, retailers and consumers in that it provides uniformity in the methods used for distribution of the commodity. He stated that the bill would provide, in effect, that a wholesaler who has a franchised area for a particular brand, could not sell outside his franchised area to a retailer having business outside that area without first securing the written consent of the supplier of that brand and the

wholesaler who has the franchised area in which the retailer anticipates selling the commodity. He stated that the bill was drafted based on statutes from other states. He also pointed out that it is very easy to get a liquor license in this state and that leads to unscrupulous people getting a license and then obtaining the liquor and selling it a very low prices to retailers within the state, undercutting established dealers, and then skipping out before paying taxes, etc. Mr. Art Sinini, Beacon Liquor, explained to Mr. Tanner that the the distillers are unwilling to get involved in the protection of distribution areas for franchisees. In answer to a question from Mr. Weise, Mr. Sinini stated that he knew of no other parallel industry within the state which needed the same kind of regulatory protection, but that the liquor industry was unique in many of its problems and that due to the laws passed four years ago they are in a somewhat better situation than they were prior to that time. Mr. Sinini discussed various aspects of the industry with the committee.

Pete Barengo, Sierra Wine & Liquor, stated that the liquor business is a privilege business and that they, as an industry, are very heavily taxed and needed this type of regulation because the suppliers are very reluctant to tell the distributors, wholesalers or any body else what they can or cannot do for fear of getting into trouble themselves. He also stated that the only thing a franchise agreement does for the wholesaler is allow him to invest in inventory and sometimes those agreements are very vague and are, at times, only verbal agreements. In answer to a question from Mr. Tanner, Mr. Barengo stated that it is against federal law to sell liquor across state lines. He stated that he felt this bill would be good for all concerned in the state.

Mr. C. Watkins, Southern Wine and Spirits, also spoke on behalf of the bill and stated that its provisions were needed to help their industry. This concluded the testimony on this bill.

AB 818: Jim Joyce, Savings and Loan League of Nevada, introduced Mr. Chuck Wagner, counsel for the league, and Ray Gregor, President of First Western Savings. Mr. Joyce stated that the legislature had passed a law in 1975 to allow public funds to be deposited in savings and loan associations and he noted that AB 814 addresses an oversight in that law which, in effect, excluded federally chartered institutions from participation.

Chuck Wagner stated that the 1975 law has worked well and had enabled a lot of money to stay in Nevada which otherwise may have gone outside the state, but that there were certain hardships in that law, i.e. the deposits must be secured by bonds if in excess of the FDIC limits on those deposits; no other securities can be used under current law. He stated that this makes it extremely difficult in times of tight money, as experienced currently. He pointed out that this bill would provide more flexibility in this area so that the money could stay within the state and be secured by other means, i.e. notes, first deeds of trust and first mortgages, and would free up virtually millions of dollars which would be available for home loans and benefit all of Nevada.

Ray Gregor stated that passage of this measure would free up millions of dollars in the home mortgage area. After discussion of the ratio of security for dollars available to loan it was agreed that that ratio should be 2:1 on page 2, line 32, section 7. The committee discussed with Mr. Gregor what types of security should be accepted due to the current market on various types of paper, notes, deeds of trust, etc. and how the economic climate in various areas at different times effect that investment market. He stated, too, that in discussing this proposed bill with the commissioner of savings and loans, that he had not expressed any opposition to the bill, nor had he indicated support either.

Mr. Gregor said that the savings and loan associations have to meet certain liquidity requirements; meaning that they must set aside a percentage of each dollar which is received and invest that portion of the deposits in government obligations. And, only when that percentage exceeds 6-10% can they use that excess to pledge against the deposits they want to have from the state or municpalities, which results in an exchange of liquid items. He stated that this results in a practice called "arbitrage" and ultimately allows them to pick up some 25 to 30 additional points on their investments because of the higher risk factor. He said that it did not allow them to actually lend more money, but that it did allow them to earn additional income from the investments.

Mr. Wagner stated that this bill was fashioned after the California statute which had been working well in that state since 1976. That concluded testimony on this bill.

The committee recessed at 11:00 and reassembled at 11:30 for the following business.

SB 90: William Swackhamer, Secretary of State, stated that this bill had come about at the request of a Las Vegas patent and trademark attorney and it had been taken from model laws pertaining to this area from other states. He said that the bill would really help in their trademark section because it would eliminate much of the cumbersome volume which is now present and unnecessary.

He stated that trademarks are currently perpetual and they have thousands registered, of which 75-80% are not being used at this time or, in fact, for decades. He told the committee that the National Trademark Association is in favor of the bill.

He stated that they would be sending notification of the change in the law and renewal requirements to each of the last known addresses of the people holding the trademarks and they would also be publishing notices in the newspapers to make the people aware of the requirements. He stated that they felt the benefits brought about by those changes would outweigh any problems which might occur as the result of someone not being notified.

The bill would require that add trademarks be renewed every 10

years and that each renewal be accompanied by a $25.00 fee which would cover the renewal and updating of records.

COMMITTEE ACTION: SB 90: Mr. Rusk moved to DO PASS the bill, Mr. Bennett seconded the motion and it carried unanimously except that Mr. Chaney was not present to vote.

SB 464: Reese Taylor, attorney from Carson City, stated that this bill is the result of work which has been done recently by a group trying to establish a state regulated development corporation to function in the state. He stated that a development corporation would act as an investment catalist to arrange and negotiate government guarantees for new and existing business enterprises which require long-term and start-up financing which is not available through normal banking channels (which used to be available through brokerage houses and secondary offerings which are no longer available). He stated that he felt this would solidly benefit the state. This bill would change NRS 670.100 so that it would allow these corporations to be covered under the chapter without being members of six state banks, national banks or savings banks, and also to put them in accord with the federal agencies which they would be working with in arranging for government guarantees. The government agencies would require that they be licensed in the state, examined by the state and supervised by the superintendent of banks, the same as is required of banks and trust companies. He told the committee that it is estimated that there is currently $16,000,000,000 available for lending in this area through various programs and agencies, i.e. Energy Department, Economic Development Agnecy, Farm Home Loan, Maritime Administration, Small Business Association, and others and passage of this bill would allow Nevada to be in line for these funds. It would also attract more business into the state, help with the tax reserves and aid employment. He stated that it was their intent to make this a Nevada enterprise and that through the provisions of the bill, none of the offices could be outside of Nevada, as well as the majority of the incorporators and stockholders being Nevadans. Mr. Joseph Sevigny also pointed out that the majority of the board of directors must also be Nevadans as the organization would have to be guided by the same regulations in this respect as applies to banks and trust companies and he could include them by regulation, if necessary.

Mr. Bill Ridgeway stated that when this concept was developed in 1958, the idea was that all the government guaranteeing agencies would be operating unilaterally (they couldn't exchange their loans between those agencies, i.e. SBA and Farm Home Loan, etc) and that if the individual states adopted a state development company, which this bill proposes, then that development would be the top agency for all the government guaranteeing agencies, but that development agency would only be able to function and operate within each individual state. He stated that the law is changing in this area and that by the end of this year, only banks and development companies will be able to participate in obtaining these funds. He told the committee that prior to this time it has also been the practice for insurance companies to participate to some extent.

Mr. Sevigny stated that they had discussed the impact of the development corporations on the private sector and they had decided that this would not adversely effect that area.

The meeting was again recessed at 11:55 a.m. and reassembled at 4:45 p.m.

AB 781: John Madole, Associated General Contractors, stated that this bill would do three things: 1)it would raise the bond required by licensed contractors in the state, 2) it would provide that securities could be posted in lieu of a bond, 3) it removes the section in the law which currently allows the contractors board not to require a bond after two years (because they felt a cash bond or deposit was necessary for everyone in business to protect the public). In answer to a question from Mr. Tanner, Mr. Madole stated that these requirements may be tougher on the contractor, but that they felt it was very necessary for the protection of the public and materialsmen who have had very little recourse in the past. The committee discussed the merits of making a contractor continually post bond. In answer to a question from Mr. Jeffrey, Mr. Madole stated that those contractors who are currently licensed and not bonded would have to post a bond when they renewed their license.

SB 145: Pat Gothberg, Nevada Nurses' Association, stated that this bill was requested by a group in Elko and had not come from the association. She stated that this was the end result of hours of meetings between the association and the State Nurses' Board and the Pharmacy Board and the Pharmacy Association and the Medical Examiners and the Board of Medical Examiners and that they had all agreed that it was currently a good bill. Mr. George Bennett, secretary for the State Board of Pharmacy, agreed with Miss Gothberg's comments. Further testimony was dispensed with.

COMMITTEE ACTION: SB 145: Mr. Bremner moved to DO PASS, Mr. Chaney seconded the motion and it carried with Mr. Bremner, Dr. Robinson, Mr. Horn not present to vote.

AB 818: Lester Goddard, Commissioner of Savings Associations, stated that he felt this bill should be limited to apply only to single family or owner occupied residences. He stated he felt this would add a safeguard to the secured amount.

COMMITTEE ACTION: AB 818: Mr. Weise moved to AMEND AND DO PASS, Mr. Rusk seconded the motion and it carried unanimously with the same members not present to vote.

AB 716: Chairman Jeffrey reviewed the proposed amendment with the committee and Mr. Rusk moved to AMEND AND DO PASS, Mr. Weise seconded the motion and it carried with the same members not present to vote.

AB 781: Mr. Weise move to adopt the amendment which would remove the brackets from lines 26-36, page 2, and to AMEND AND DO PASS, Mr. Tanner seconded the motion and it carried.

AB 807: Mr. Bremner moved to DO PASS, Mr. Sena seconded the motion and it carried.

SB 75: Chairman Jeffrey stated that he had received a letter from Frank Daykin stating that this was strictly an optional coverage with each employer. Mr. Rusk moved to DO PASS, Mr Chaney seconded the motion; however there were insufficient votes to pass the motion and it FAILED.

SB 348: Mr. Weise moved to DO PASS, Mr. Tanner seconded the motion; however there were insufficient votes to pass the motion and it FAILED.

SB 464: Mr. Tanner moved to DO PASS, Mr. Bremner seconded the motion and it carried with Mr. Sena, Mr. Bremner and Dr. Robinson not present to vote on the motion.

AB 710: Mr. Horn moved to AMEND AND DO PASS, Mr. Tanner seconded the motion and it carried with the same people not present to vote.

SB 231: Mr. Horn moved to AMEND AND DO PASS, Mr. Rusk seconded the motion; however there were insufficient votes to pass the motion and it FAILED.

SB 137: Mr. FitzPatrick moved to INDEFINITELY POSTPONE the bill, Mr. Tanner seconded the motion and it carried with the same people not present to vote.

SJR 23: Joe Manos, Department of Energy, stated that they had originally asked for a stronger bill; however they felt this would do for them what they desired. He stated that this would allow them to get money for experimentation and testing in Nevada for geothermal projects. He stated that currently federal monies are being put into adjoining states and he felt Nevada should be getting more of these funds to work with. There were no questions nor was there any action on this bill.

There being no further business to come before the committee, the meeting was adjourned at 6:10 p.m.

Respectfully submitted,

Linda D Chandler

Linda D. Chandler
Secretary

Note: Also attached are proposed amendments to AB 808, submitted by Las Vegas City Attorney, and marked as Exhibit "F".

State of Nevada
Commissioner of Savings Associations
Capitol Complex
406 East Second Street
Carson City, Nevada 89710
(702) 885-4259

Robert List
Governor

Lester O. Goddard
Commissioner

May 4, 1979

TO: Assembly Commerce Committee

FROM: Lester O. Goddard, Commissioner of Savings Associations

SUBJ: AB 753 (Mortgage Companies, Chapter 645B)

I have the following comments to make as to three sections:

Section 1, page 1, lines 5-9

I would recommend the following substitution:

(b) verify that he or the principal operating officer has had a minimum of four years of active mortgage loan experience in a responsible capacity within the prior seven years, either in a financial institution or as a licensed real estate broker.

Section 2, page 2, line 13

Changing the initial surety bond requirement from $10,000 to $50,000 may be too severe, as insurance companies are reluctant to write bonds this size, and charge high annual fees. On the other hand, $10,000 is probably too low and is too easy to obtain.

Section 4, page 4, lines 12-18

Should be eliminated.

EXHIBIT "A"

State of Nevada
Commissioner of Savings Associations
Capitol Complex
406 East Second Street
Carson City, Nevada 89710
(702) 885-4259

Robert List
Governor

Lester O. Goddard
Commissioner

January 19, 1979

TO: All licensed mortgage companies

FROM: Lester O. Goddard, Commissioner LOG

SUBJ: Annual statistical comparisons, 1973-1978

For your information, the growth of the mortgage brokerage business in Nevada over recent years is indicated by the following statistical summary of loans made or arranged by those mortgage companies licensed under NRS 645B since its inception July 1, 1973:

	Number Reporting Loans	Number of Loans	Amount	Average per loan
1973 (6 mos)	6	102	$ 4,694,279	$46,022
1974 (12 mos)	15	689	14,636,875	21,244
1975 (12 mos)	21	970	18,805,130	19,387
1976 (12 mos)	39	1,626	24,397,402	15,004
1977 (12 mos)	39	2,219	35,821,280	16,143
1978 (12 mos)	58	3,499	81,276,922	23,229

A summary by number of loans arranged over the past two years is as follows:

	Number of loans	Number of licensees 1977	1978
A)	100 or more	7	9
B)	40 to 99	3	7
C)	15 to 39	14	16
D)	1 to 14	24	22
E)	None	34	25

Robert List
Governor

State of Nevada
Commissioner of Savings Associations
Capitol Complex
406 East Second Street
Carson City, Nevada 89710
(702) 885-4259

Lester O. Goddard
Commissioner

January 19, 1979

TO: All licensed mortgage companies

FROM: Lester O. Goddard, Commissioner

SUBJ: Statistical summary, year 1978

	North	South	Out/State	Total
First Quarter				
Number reporting loans	13	25	1	39
Number of loans	256	463	3	722
Amount of loans	$7,219,740	$8,385,089	$55,000	$15,659,829
Average per loan	$28,202	$18,110	$18,333	$21,690
Second Quarter				
Number reporting loans	15	25	1	41
Number of loans	261	577	2	840
Amount of loans	$4,714,360	$12,843,634	$32,000	$17,589,994
Average per loan	$18,063	$22,259	$16,000	$20,940
Third Quarter				
Number reporting loans	21	26	0	47
Number of loans	273	639	0	912
Amount of loans	$7,345,528	$17,094,201	0	$24,439,729
Average per loan	$26,907	$26,751	0	$26,798
Fourth Quarter				
Number reporting loans	22	27	0	49
Number of loans	318	707	0	1,025
Amount of loans	$7,969,948	$15,617,422	0	$23,587,370
Average per loan	$25,063	$22,090	0	$23,012
Combined Total*				
Number of loans	1,108	2,386	5	3,499
Amount of loans	$27,249,576	$53,940,346	$87,000	$81,276,922
Average per loan	$24,593	$22,607	$17,400	$23,229

Note 1: If we exclude a few large commercial loans, the loans would average considerably less.

Note 2: Number of licensees as of 12/31/78: (including 6 branches)

North	42
South	47
Out/State	0
	89

*Cf year 1977:

Number of loans	703	1,513	3	2,219
Amount of loans	$10,170,862	$24,571,618	$1,078,800	$35,821,280
Average per loan	$14,468	$16,240	$359,600	$16,143

TO Assemblyman Jeffrey - Chairman - Committee on Commerce

Memo

FROM Georgia Massey - Assistant Supervisor - Life & Health
Nevada Insurance Division

DATE 04-03-79

SUBJECT Assembly Bill 594
Conversion privilege - Group Coverage

Attached you will find an amendment to AB 594. The purpose of the amendment is to provide various language changes as well as provide more protection. The addition to the proposed bill mandates the conversion privilege in group coverage as regulated by 695B. entitled Medical Service Corporation.

If you or any of your committee should have questions concerning the attached please contact the Insurance Division 885-4270.

GM:rs

attachment

EXHIBIT "B"

The Nevada Insurance Division would like to propose the following amendments to A.B. 594:

(1) Line 15, page 1, after the word policyholder insert "and/or agent".

(2) Line 20, page 2, change the word "its" to "his".

(3) Line 16, page 3, change the word "its" to "his".

(4) Lines 26 and 27, page 3, change to read:

"3. For those insureds eligible for medicare, the insurer may provide for a supplement to medicare as part of the conversion privilege."

(5) Lines 40 and 41, page 3, delete "qualified family member under" and insert "dependent as defined by".

(6) Line 44, page 3, delete "qualified family member under" and insert "dependent as defined by".

(7) Line 16, page 4, insert after "coverage" the words "under the group policy".

(8) Line 22, page 4, delete entirely and add the attached.

SECTION 15. Chapter 695B of NRS is hereby amended by adding thereto the provisions set forth as section 16 to 29 inclusive, of this act.

SECTION 16. 1. All group subscriber contracts delivered or issued for delivery in this state providing for hospital, surgical or major medical coverage, or any combination of these coverages, on a service basis and/or expense-incurred basis must contain a provision that the employee or member is entitled to have issued to him a subscriber contract of health coverage when the employee or member is no longer covered by the group subscriber contract.

2. The requirement in subsection 16 does not apply to contracts providing benefits only for specific diseases or accidental injuries, and it applies to other contracts only if:

(a) The termination of coverage under the group contract is not due to termination of the group contract itself unless the termination of the group contract has resulted from failure of the contract holder and/or agent to remit the required premiums;

(b) The termination is not due to failure of the employee or member to remit any required contributions;

(c) The employee or member has been continuously covered under the group contract for at least 3 consecutive months immediately before the termination; and

(d) The employee or member applies in writing for the converted contract and pays his first premium to the medical service corporation no later than 31 days after the termination.

SECTION 17. The medical service corporation shall:

1. Issue the converted contract without evidence of insurability;

2. Base the cost of the initial and renewal premiums for the converted contract upon standard morbidity assumptions applicable to:

(a) Individually underwritten risks;

(b) The age of the person to be covered; and

(c) The type and amount of the coverage to be provided.

The experience of converted contract shall not be the sole basis for establishing rates. The frequency of premium payments shall be the same as is customarily required by the medical service corporation for the contract form and plan selected except that premium payments shall not be required more often than quarterly.

3. Provide that the effective date of the converted contract is 12:01 a.m. on the day after the termination of coverage under the group contract; and

4. Provide that the converted contract covers the employee or member and his dependents who were covered by the group contract on the date of his termination. At the option of the insurer, a separate converted contract may be issued to cover any dependent.

SECTION 18. 1. The medical service corporation is not required to issue a converted contract to any person who:

(a) Is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy, a hospital or medical service subscriber contract, a medical practice or other prepayment plan, or by any other kind of plan or program;

(b) Is eligible to be covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(c) Has similar benefits provided for or available under the requirements of any state or federal law,

if any benefits provided under the sources listed in this subsection, together with the benefits to be provided by the converted contract, would result in overinsurance according to the medical service corporation's standards.

2. Before denying a converted contract to an applicant because he has coverage as described in paragraph (a) of subsection 1, the medical service corporation shall notify him that the converted contract will be issued only if the other coverage is canceled.

SECTION 19. 1. A converted contract issued under section 16 of this act may include a provision permitting the medical service corporation to request from the applicant, in advance of any premium due date, information as to whether he is covered for similar benefits under any of the sources listed in section 18 of this act.

2. The medical service corporation may not refuse to renew the contract or the coverage of any person unless:

(a) Benefits provided under the sources listed in subsection 1 of section 18 of this act, together with the benefits provided by the converted contract would result in overinsurance according to the medical service corporation's standards;

(b) The holder of the converted contract has refused to provide requested information as to such sources; or

(c) Fraud was committed in applying for any benefits under the converted contract.

3. Before refusing to renew a converted contract because of overinsurance, the medical service corporation shall notify the subscriber that the converted contract will be renewed only if the other coverage is c nceled.

SECTION 20. A medical service corporation is not required to issue a converted contract which provides benefits in excess of those provided under the group contract from which conversion is made, and a converted contract may contain any exclusion or benefit limitation contained in the group contract.

SECTION 21. A converted contract must not exclude a pre-existing 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 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.

SECTION 22. 1. A person who is entitled to a converted contract must be given his choice of at least three types of contracts offering benefits on a service and/or expense-incurred basis.

2. The converted contract must include major medical or catastrophic benefits if they were provided under the group contract.

3. For those subscribers eligible for Medicare, the medical service corporation may provide for a supplement to Medicare as part of the conversion privilege

SECTION 23. Subject to the conditions set forth in sections 16 to 28, inclusive, of this act, the converstion privilege must also be made available:

1. To the surviving spouse, if any, upon the death of the employee or member, with respect to the spouse and any child whose coverage under the group contract is terminated by reason of such death, or if there is no surviving spouse, to each surviving child whose coverage under the group contract terminates by reason of such death, or, if the group contract provides for continuation of dependents' coverage following the employee's or member's death, at the end of the continued coverage;

2. To the spouse of the employee or member upon termination of coverage of the spouse while the employee or member remains covered under the group contract if the spouse ceases to be a dependent as defined by the group contract, and to any child whose coverage under the group contract terminates at the same time; or

3. To a child solely with respect to himself upon termination of his coverage because he ceases to be a dependent as defined by the group contract, if a conversion privilege is not otherwise provided with respect to the termination.

SECTION 24. The medical service corporation may elect to provide group coverage in lieu of the issuance of a converted individual contract.

SECTION 25. A notification of the conversion privilege must be included in each certificate of coverage. A written notice of the existence of the conversion privilege must also be given to the employee or member at least 15 days before the expiration of the 31 days permitted a person to make a written application for the converted contract. If written notice of the right to convert is not given as required under this section, an additional period must be allowed the person to apply for the converted contract. The additional period expires 15 days after written notice of the conversion privilege has been given, or 60 days after the expiration of the 31-day period, whichever is earlier.

SECTION 26. A converted contract which is to be delivered outside this state must be in such form as would be deliverable in the other jurisdiction as a converted contract if the group contract had been issued in that jurisdiction.

SECTION 27. The medical service corporation may elect to extend coverage of a subscriber under the existing group contract for a period not to exceed 3 months following the day of the person's eligibility for a converted contract if the conversion privilege is offered upon termination of the extended coverage under the group contract.

SECTION 28. The medical service corporation may continue coverage indentical to that provided under the group contract instead of issuing a converted contract. Coverage may be offered by amending the group certificate or by issuing an individual contract and must otherwise comply with every requirement of sections 16 to 28, inclusive, of this act.

SECTION 29. This act shall become effective on January 1, 1980.-

American Council of Life Insurance

1850 K Street, N.W.
Washington, D.C. 20006
(202) 862-4228

April 5, 1979

Franklin H. Young
Associate General Counsel

put in Study Committee
(IXSA will present)

Milos Terzich, Esq.
Breen, Young, Whitehead & Hoy
Round Hill Village Mall
P. O. Box 379
Zephyr Cove, Nevada 89448

RE: Assembly Bill 594

Dear Milos:

This is a mandatory conversion law for group health insurance and appears to be a hybrid version between the NAIC Model and the HIAA Model. Like other hybrids, it has no counterpart anywhere else. We oppose it for this reason alone.

Also, there are several very key provisions that need substantial revision.

Enclosed is a copy of the HIAA Model Group Health Insurance Continuation and Conversion Law, which we support. This Model is in three parts — Part A is Definitions, Part B is Continuation of the Group Coverage and Part C is Conversion to Individual Policies. It is a combination of continuation and conversion of group coverage, with continuance permitted for up to six months after termination of employment or membership in the covered group. Experience has shown that most persons acquire other health insurance coverage within that six month period and do not use the conversion process; hence, continuation of the group coverage during this period until that coverage has been replaced is more efficient, less expensive and more convenient for all concerned.

Continuation coverage in the HIAA Model Bill appears on pages 2 through 4, while A.B. 594 uses 9 lines in Section 13 and 14 of the bill to permit up to three months continuation. We definitely need the detail from the HIAA Model Bill.

Pricing of the converted coverage is very important. A.B. 594's pricing provision is in paragraph 2 of section 3 on page 2 of the bill. It requires standard morbidity assumptions. However, experience shows that claims ratios under converted policies usually run 120% or higher. People do not convert if they can get coverage elsewhere, so that only those in poor health convert, i.e., adverse selection. We need the HIAA Model version which appears in paragraph 3 of Part C on page 5 of the Model Bill in order to protect other policyholders.

EXHIBIT "C"

Section 8 of A.B. 594, which requires the individual be given a choice of three types of policies, is completely devoid of any standards. By contrast, the HIAA Model sets forth the necessary details in paragraphs 9 and 10 of Part C, appearing on pages 7 through 11 of the Model Bill. This material, and maybe paragraphs 11 and 12 also, should be substituted for section 8.

I have not yet had the opportunity to determine the extent to which the above substitutions from the HIAA Model Bill can be inserted into A.B. 594 without requiring substantial rewriting of the remaining portions of A.B. 594. Maybe the substitutions can be made relatively easily, but more likely, at least some, perhaps much redrafting will be necessary.

This is a volatile and emotional subject. Many group writing companies are, either on their own initiative or at the request of the policyholder, are offering continuation and/or conversion benefits. The states seem to be going off in all directions with little uniformity. Quite frankly, if any problems arise either in acceptance of the concepts in the substitute HIAA language or in redrafting, it may be desirable to have the bill put into an interim study committee.

Best personal regards.

Sincerely,

Franklin H. Young

Enclosure:

FHY/dt

cc: Dave Byington
Caroll Callaway
Ben Dasher

APPENDIX II B

HIAA MODEL GROUP HEALTH INSURANCE CONTINUATION AND CONVERSION LAW

A. Definitions* - As used in this Act:

1. "Group policy" means a group health insurance policy issued by an insurance company and a group contract issued by a health service corporation or health maintenance organization or similar corporation or organization.

2. "Individual policy" or "converted policy" means an individual health insurance policy issued by an insurance company or an individual health services contract issued by a health service corporation or health maintenance organization or similar corporation or organization.

3. "Insurer" means the entity issuing a group policy or an individual or converted policy.

4. "Insurance", "Insures" and "Insured" refer to coverage under a group policy, individual policy or converted policy on a premium-paying basis, and do not include coverage provided solely as an accrued liability or by reason of a disability extension.

5. "Premium" includes any premium or other consideration payable for coverage under a group or individual policy.

6. "Medicare" means Title XVIII of the United States Social Security Act as amended or superseded.

*Each jurisdiction should determine the advisability of inserting language to incl uninsured plans.

B. Termination of Employment or Membership. - A group policy delivered or issued for delivery in this state which insures employees or members for hospital, surgical or major medical insurance on an expense incurred or service basis, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose insurance under the group policy would otherwise terminate because of termination of employment or membership shall be entitled to continue their hospital, surgical and major medical insurance under that group policy, for themselves and their eligible dependents, subject to all of the group policy's terms and conditions applicable to those forms of insurance and to the following conditions:

1. Continuation shall only be available to an employee or member who has been continuously insured under the group policy (and for similar benefits under any group policy which it replaced) during the entire three months' period ending with such termination.
2. Continuation shall not be available for any person who is or could be covered by Medicare. Neither shall continuation be available for any person who is or could be covered by any other insured or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination.
3. Continuation need not include dental, vision care or prescription drug benefits, or any other benefits provided under the group policy in addition to its hospital, surgical or major medical benefits.
4. An employee or member who wishes continuation of coverage must request such continuation in writing within the ten day period following the later of (i)

the date of such termination, or (ii) the date the employee is given notice of the right of continuation by either his employer or the group policyholder. In no event, however, may the employee or member elect continuation more than 31 days after the date of such termination.

5. An employee or member electing continuation must pay to the group policyholder or his employer, on a monthly basis in advance, the amount of contribution required by the policyholder or employer, but not more than the group rate for the insurance being continued under the group policy on the date of each payment. The employee's or member's written election of continuation, together with the first contribution required to establish contributions on a monthly basis in advance, must be given to the policyholder or employer within thirty-one days of the date the employee's or member's insurance would otherwise terminate.

6. Continuation of insurance under the group policy for any person shall terminate when he fails to satisfy condition 2 above or, if earlier, at the first to occur of the following:

   (a) The date six months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or membership.

   (b) If the employee or member fails to make timely payment of a required contribution, the end of the period for which contributions were made.

   (c) The date on which the group policy is terminated or, in the case of an employee, the date his employer terminates participation under the group policy. However, if this (c) applies and the coverage ceasing by reason of such termination is replaced by similar coverage under another group policy, the following shall apply:

(i) The employee or member shall have the right to apply for coverage under that other group policy, for the balance of the period that he would have remained covered under the prior group policy in accordance with condition 6 had a termination described in this (c) not occurred.

(ii) The minimum level of benefits to be provided by the other group policy shall be the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy.

(iii) The prior group policy shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

7. A notification of the continuation privilege shall be included in each certificate of coverage.

C. Right to Obtain Individual Policy Upon Termination of Group Hospital, Surgical or Major Medical Coverage. - A group policy delivered or issued for delivery in this state which insures employees or members for hospital, surgical or major medical insurance on an expense incurred or service basis, other than for specific diseases or for accidental injuries only, shall provide that an employee or member whose insurance under the group policy has been terminated shall be entitled to have a converted policy issued to him by the insurer under whose group policy he was insured, without evidence of insurability, subject to the following terms and conditions:

1. A converted policy shall not be available to an employee or member if termination of his insurance under the group policy occurred:

(a) because of termination of employment or membership and either he was not entitled to continuation of group coverage under Section B

or failed to elect such continuation, or

(b) because he failed to make timely payment of any required contribution or

(c) for any other reason and he had not been continuously covered under the group policy (and for similar benefits under any group policy which it replaced) during the entire three months' period ending with such termination, or

(d) because the group policy terminated or an employer's participation terminated, and the insurance is replaced by similar coverage under another group policy within thirty-one days of the date of termination.

2. Written application and the first premium payment for the converted policy shall be made to the insurer not later than thirty-one days after such termination. Its effective date shall be the day following the termination of insurance under the group policy.

3. The premium for the converted policy shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.

4. The converted policy shall cover the employee or member and his dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

5. The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by Medicare. Furthermore, the insurer shall not be required to issue a converted policy covering any person if:

(a) (i) such person is covered for similar benefits by another individual policy, or

(ii) such person is or could be covered for similar benefits under any arrangement of coverage for individuals in a group, whether insur or uninsured, or

(iii) similar benefits are provided for or available to such person, by reason of any state or federal law, and

(b) the benefits under sources of the kind referred to in (i) above for such person, or benefits provided or available under sources of the kind referred to in (ii) and (iii) above for such person, together with the converted policy's benefits would result in overinsurance according to the insurer's standards for overinsurance.

6. A converted policy may provide that the insurer may at any time request information of any person covered thereunder as to whether he is covered for the similar benefits described in 5 (a) (i) above or is or could be covered for similar benefits described in 5 (a) (ii) and (iii) above. The converted policy may provide that as of any premium due date the insurer may refuse to renew the policy or the coverage of any insured person for the following reasons only:

(a) either those similar benefits for which such person is or could be covered, together with the converted policy's benefits, would result in overinsurance according to the insurer's standards for overinsurance, or the policyholder of the converted policy fails to provide the requested information;

(b) fraud or material misrepresentation in applying for any benefits under the converted policy;

(c) eligibility of the insured person for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy;

(d) other reasons which may be approved by the Commissioner of Insurance:

7. An insurer shall not be required to issue a converted policy providing benefits in excess of the hospital, surgical or major medical insurance under the group policy from which conversion is made.

8. The converted policy shall not exclude, as a preexisting condition, any condition covered by the group policy. However, the converted policy may provide for a reduction of its hospital, surgical or medical benefits by the amount of any such benefits payable under the group policy after the individual's insurance terminates thereunder. The converted policy may also provide that during the first policy year, the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect.

9. Subject to the provisions and conditions of this Act, if the group insurance policy from which conversion is made insures the employee or member for basic hospital or surgical expense insurance, the employee or member shall be entitled to obtain a converted policy providing, at his option, coverage on an expense incurred basis under any of the following plans:

Plan A

(a) Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semi-private rate charged in the

major metropolitan area of this state, for a maximum duration of seventy days,

(b) miscellaneous hospital expense benefits up to a maximum amount of ten times the hospital room and board daily expense benefits, and

(c) surgical expense benefits according to a surgical procedures schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of eight hundred dollars.

Plan B

Same as Plan A, except that (a) the maximum hospital room and board daily expense benefit is 75% of the corresponding Plan A maximum and (b) the surgical schedule maximum is six hundred dollars.

Plan C

Same as Plan A, except that (a) the maximum hospital room and board daily expense benefit is 50% of the corresponding Plan A maximum and (b) the surgical schedule maximum is four hundred dollars.

The maximum dollar amount for Plan A's hospital room and board daily expense benefits shall be determined by the Commissioner of Insurance and may be redetermined by him from time to time as to converted policies issued subsequent to such redetermination. Such redetermination shall not be made more often than once in three years. Such Plan A maximum, and the corresponding maximums in Plans B and C, shall be rounded to the nearest multiple of $10., provided that

rounding may be to the next higher or lower multiple of $10. if otherwise exactly midway between.

Subject to the provisions and conditions of this Act, if the group policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member shall be entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(a) A maximum benefit at least equal to either, at the option of the insurer, (i) or (ii) below:

(i) A maximum payment per covered person for all covered medical expenses incurred during that person's lifetime, equal to the smaller of:

(1) The maximum benefit provided under the group policy; or

(2) $250,000.

(ii) A maximum payment for each unrelated injury or sickness, equal to the smaller of:

(1) The maximum benefit provided under the group policy; or

(2) $250,000.

(b) Payment of benefits at the rate of 80% of covered medical expenses which are in excess of the deductible, until 20% of such expenses in a benefit period reaches $1,000., after which benefits will be paid at the rate of 100% during the remainder of such benefit period. Payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than 50%.

(c) A deductible for each benefit period which, at the option of the insurer,

shall be (i) the sum of the benefits deductible and $100., or (ii) the corresponding deductible in the group policy. The term "benefits deductible", as used herein, means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other group or individual hospita surgical, or medical insurance policy or medical practice or other prepayment plan, or any other plan or program whether insured or uninsured, or by reason of any state or federal law and if, pursuant to condition 11, the converted policy provides both basic hospital or surgical coverage and major medical coverage, the value of such ba benefits.

If the maximum benefit is determined by (a) (ii) above, the insurer m require that the deductible be satisfied during a period of not less th three months if the deductible is $100. or less, and not less than six months if the deductible exceeds $100.

(d) The benefit period shall be each calendar year when the maximum be is determined by (a) (i) above or twenty-four months when the maxim benefit is determined by (a) (ii) above.

(e) The term "covered medical expenses" as used above, shall include a least, in the case of hospital room and board charges, the dollar am in Plan A of condition 10, and at least twice such amount for charge an intensive care unit. Any surgical procedures schedule shall be consistent with those customarily offered by the insurer under group individual health insurance policies and must provide at least a $120 maximum benefit.

11. At the option of the insurer, such plans of benefits set forth in conditions 9 an 10 may be provided under one policy, or, in lieu thereof, the insurer may pro vide a policy of Comprehensive Medical Expense Benefits without first dollar coverage. Said policy shall conform to the requirements of condition 10, provided, however, that an insurer electing to provide such a policy shall make available a low deductible option, not to exceed $100., a high deductible option between $500. and $1000., and a third deductible option midway betwee the high and low deductible options. Alternatively, such a policy may provide for deductible options equal to the greater of the benefits deductible and the amount specified in the preceding sentence.

12. The insurer may, at its option, offer alternative plans for group health conversion in addition to those required by this Act. Furthermore, if any insurer customarily offers individual policies on a service basis, that insure may, in lieu of converted policies on an expense incurred basis, make availa converted policies on a service basis which, in the opinion of the Commissio of Insurance, satisfy the intent of this Act.

13. In the event coverage would be continued under the group policy on an employ or member following his retirement prior to the time he is or could be cover by Medicare, the employee or member may elect, in lieu of such continuatio group insurance, to have the same conversion rights as would apply had that insurance terminated at retirement.

14. The converted policy may provide for reduction or termination of coverage o any person upon his eligibility for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy.

15. Subject to the conditions set forth above, the conversion privilege shall also be available (i) to the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death, otherwise to eac surviving child whose coverage under the group policy terminates by reason of such death, or if the group policy provides for continuation of dependents coverage following the employee's or member's death, at the end of such continuation, (ii) to the spouse of the employee or member upon termination of coverage of the spouse, by reason of ceasing to be a qualified family member under the group policy, while the employee or member remains insured under the group policy, including such children whose coverage under the group policy terminates at the same time, or (iii) to a child sole with respect to himself upon termination of his coverage by reason of ceas to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination

16. If the benefit levels required in conditions 9 and 10 above exceed the ben levels provided under the group policy, the converted policy may offer benefits which are substantially similar to those provided under the group policy in lieu of those required in conditions 9 and 10.

17. The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy.

18. A notification of the conversion privilege shall be included in each certifi of coverage.

A converted policy which is delivered outside this state may be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

The provisions of this Act shall take effect (insert a date not less than 12 months after the date of enactment) and shall apply to group policies delivered, issued for delivery or amended on or after said date.

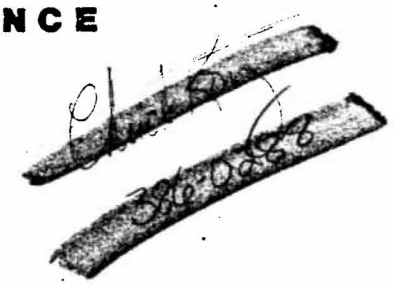
CENTEL

CENTRAL TELEPHONE COMPANY

SOUTHERN NEVADA DIVISION

S 414

DEPARTMENTAL CORRESPONDENCE



DATE : March 29, 1979

TO : Bruce Cecil

FROM : Vivian Osbon

SUBJECT: Assembly Bill No. 594, March 21, 1979, regarding group health insurance policies - conversion policies.

This bill proposes changes which would cause premiums for the conversion policy to be greatly increased due to the very nature of a conversion policy.

The primary reason for extending a conversion privilege is to provide a policy of benefits for hospital and medical expense for a terminating employee and his family which must be available regardless of the health of the individual or any eligible member of his family. The premium charged cannot be increased due to the poor health of any eligible applicant.

A conversion policy is a privilege for uninsurable individuals, ~~but it~~ is also a stop-gap protection for someone terminating to move to another job ~~and who will require hospital and medical protection for a brief period of time.~~ The resulting higher cost in premiums would no longer make the conversion policy a privilege and could create a hardship for those indivuduals for whom the policy is designed.

This Assembly Bill No. 594, as written, would not apply to our group insurance as it applies only to those policies delivered, or issued for delivery, in this state and there is no compliance paragraph requiring compliance by other insurance companies which are insuring individuals in this state under a master policy delivered in another state. Compliance of policies delivered in this state prior to the proposed effective date is also not addressed.

The Nevada Division group insurance is from a master policy delivered to the Centel Corporation in Lincoln Nebraska in the 1950's. That policy is affected by state laws of Nebraska primarily and by Nevada State law only if that law were to specifically set out a compliance requirement for master policies delivered outside the state.

EXHIBIT "D"

Assembly Bill No. 594

A review of the Assembly Bill No. 594, Summary develops the following thoughts for consideration:

Section 2.2 (c) At the present time only prerequisite to Nevada Division employees elegibility for the conversion policy available within 31 days of termination is to have been insured under the group policy at the time of termination.

Section 3.3 The effective date of the prudential conversion policy may be the later of (1) the day on which the application for such individual insurance policy is received by the insurance company at any of its Home or Head Offices, and (2) the day following the termination of employee's hospital expense insurance under the group policy.

Section 3.4 At the present time the converted policy may continue insurance on whomever the terminated employee chooses as long as they were eligible for and covered under the group policy with the employee at the time of his termination.

Section 8.1 The present plan which can be picked up under the conversion privilege contains benefits agreed to under the bargaining agreement.

Section 8.2 The present conversion plan gives very basic minimal coverage and does not include major medical benefits which are under the regular group plan.

Section 8.3 Nor is a medicare supplement conversion policy available. However, if terminating at age 65 or after, the company provides Medicare Supplement coverage at no cost to the terminating employee.

Section 9.2 This would also allow the divorced spouse the conversion privilege.

Section 10. A continuation of the group policy by self payment arrangement is allowed by some employers but is usually limited to a period of from one month to a maximum of six months. We do not have that provision.

Section 11. The conversion privilege advice is included in the Certificate of Insurance however, the 15 day requirement for notification is not included and would be a good idea in my opinion.

Section 13. This would allow self payments for a period of up to three months if the insurer elected to extend this privilege.

Copies of our Group Insurance Certificate, Conversion Privilege application and Plan description are enclosed.

NOTICE OF GROUP HEALTH CONVERSION PRIVILEGE

TO BE COMPLETED BY POLICYHOLDER			
Name of Insured	Location Code	Group Policy No.	Certificate No.

Group Health Coverage Terminating:	Reason for Termination:	Date of Termination of Group Coverage
☐ Employee only ☐ Employee and Dependent	☐ Termination of Employment ☐ Other–explain:	

Name of Policyholder	Signature (By person who maintains the Group Insurance Records)	Date

Under the privilege contained in the group policy and described in your certificate, the Prudential Insurance Company of America makes available individual Hospital and Surgical Expense insurance policies, subject to established rules, to employees whose group health insurance is terminated, provided the employee was covered under the group health insurance policy for at least three months. *Application for conversion must be made within 31 days from date of termination shown above.*

The benefits under the individual policy are:

1. Maximum Hospital Room & Board Daily Benefit $ 60
2. Maximum Duration of Benefit 70 Days
3. Maximum Miscellaneous Hospital Expense Benefits $600
4. Maximum Surgical Benefit $600

Quarterly premium rates at certain ages for these benefits are:

Age 20	$39.55 male	$61.70 female	Each child less than age 18: $26.26
Age 30	41.03 male	62.38 female	
Age 40	55.54 male	69.32 female	
Age 50	70.07 male	76.45 female	
Age 60	84.45 male	84.45 female	There are NO MATERNITY benefits.

Semi-annual and annual premium rates, and rates for other ages, will be furnished upon request.

Additional information about conversion is on the back of this form.

REQUEST FOR CONVERSION FORMS–TO BE COMPLETED BY INSURED

I am interested in converting my group health insurance to an individual policy. Please send me an application, premium rates, and instructions to my address below. My employer or an authorized representative of the Group Policyholder has completed the upper portion of this form.

Address _____

City _____ *State* _____ *Zip Code* _____

Date _____ *Signed* _____

MAIL COMPLETED FORM TO:

Group Administration Division
The Prudential Insurance Company of America
P.O. Box 1143
Minneapolis, Minnesota 55440

PRIVILEGE OF OBTAINING AN INDIVIDUAL INSURANCE POLICY UNDER CERTAIN CONDITIONS

If an Employee's hospital expense insurance under the Group Policy terminates by reason of termination of the Employee's employment or of the Employee's transfer out of the classes eligible for such insurance under the Group Policy, the Employee may, subject to the conditions hereinafter stated, obtain from the Insurance Company, without furnishing evidence of insurability, an individual insurance policy renewable at the option of the Insurance Company and affording coverage to the extent stated below by making written application and the first premium payment therefor to the Insurance Company at any of its Home or Head Offices not later than thirty-one days from the date of such termination of insurance. The availability of the individual insurance policy, the coverage thereunder, the person or persons covered under the policy, the initial premium payable under the policy, the form and all terms and conditions thereof shall be such as provided by the rules of the Insurance Company pertaining to insurance obtainable under the provisions of this section, determined on a basis precluding individual selection, which are in effect at the time the application for such individual insurance policy is made to the Insurance Company. The effective date of an individual insurance policy issued pursuant to the foregoing provisions shall be the later of (i) the day on which the application for such individual insurance policy is received by the Insurance Company at any of its Home or Head Offices, and (ii) the day following the termination of the Employee's hospital expense insurance under the Group Policy.

If an Employee's hospital expense insurance under the Group Policy terminates as a result of the Employee's death and on the date of such termination such Employee is insured under the Group Policy for hospital expense insurance with respect to a spouse, the privilege of obtaining an individual insurance policy under the conditions stated above may be exercised by the Employee's surviving spouse.

If an Employee's hospital expense insurance under the Group Policy terminates for any reason specified in the preceding paragraphs and on the date of such termination such Employee is insured for hospital expense insurance under the Group Policy with respect to a child who is eighteen or more years of age, such child shall also have the privilege of obtaining an individual insurance policy under the conditions stated above, provided such Employee or spouse, if surviving, exercises the privilege of obtaining an individual insurance policy which is available to such person under the conditions stated above.

In the event hospital expense insurance under the Group Policy with respect to an Employee's child terminates solely because such child marries or attains the limiting age for qualified dependent children with respect to whom insurance is provided under such hospital expense insurance provisions, such child shall have the privilege of obtaining an individual insurance policy under the same conditions as would apply to the Employee were he then terminating employment.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

ORD 23664 ED 1-53

Printed in U. S. A.

Amend AB 723 as follows:

1. On page 2, change item 5, line 1 through 3 inclusive, to read:

   (a) Application for original resident agent's and adjustor's license and continuation thereof will be set by regulation in an amount not to exceed the actual cost of processing, examination and issuance of the license.

2. Delete on page 2, line 41 through line 49, inclusive.

3. Delete on page 3, line 9 through line 11, inclusive.

TO: Committee on Commerce
State Assembly

Memo

FROM: Don Heath - Commissioner of Insurance
Nevada Insurance Division

DATE 05-03-79

SUBJECT: Assembly Bill 723

We propose the following amendment to AB 723.

EXHIBIT "E"

E

ASSEMBLY BILL NO. 723—ASSEMBLYMEN MELLO AND JEFFREY

APRIL 6, 1979

Referred to Committee on Commerce

SUMMARY—Increases certain fees collected by commissioner of insurance. (BDR 57-1693)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State or on Industrial Insurance: No.

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is material to be omitted.

AN ACT relating to insurance; increasing certain fees collected by the commissioner of insurance; and providing other matters properly relating thereto.

The People of the State of Nevada, represented in Senate and Assembly, do enact as follows:

SECTION 1. NRS 680B.010 is hereby amended to read as follows:

680B.010 The commissioner shall collect in advance and receipt for, and persons so served shall pay to the commissioner, fees, licenses and miscellaneous charges as follows:

1. Insurer's certificate of authority:

(a) Issuance, and each annual continuation:

(1) For any one kind of insurance as defined in NRS 681A.010 ot 681A.080, inclusive ..... [$100] *$200*

(2) For two or more kinds of insurance as so defined ..... [200] *300*

(b) Reinstatement (NRS 680A.180), 50 percent of the annual continuation fee otherwise required.

(c) Registration of additional title (NRS 680A.240) 25

Annual renewal 25

2. Charter documents (other than those filed with application for certificate of authority). Filing amendments to articles of incorporation, charter, bylaws, power of attorney (as to reciprocal insurers), and other constituent documents of the insurer, each document $10

3. Annual statement of insurer. For filing annual statement $25

4. Service of process:

(a) Filing of power of attorney $5

(b) Acceptance of service of process 5

EXHIBIT E

5. Agents' licenses and appointments:		
(a) Application for original resident agent's license and issuance of license, if issued	[$5]	$10
(b) Appointment of resident agent:		
(1) Each insurer	[2]	5
(2) Annual continuation of appointment, each insurer	[2]	5
(c) Temporary license	[3]	5
(d) Limited license (NRS 683A.260), each insurer, each year	[2]	5
(e) Nonresident agents:		
(1) Nonresident agent's license, other than as specified in paragraph (f), application and issuance, if issued		25
(2) Appointment of such agent, each insurer		25
(3) Annual continuation of appointment, each insurer		25
(f) Nonresident agent's license qualifying under subsection 3 of NRS 683A.340; same as for resident agent license under paragraphs (a) and (b).		
6. Brokers:		
(a) Resident broker's license:		
(1) Application for original resident broker's license and issuance of license, if issued		$25
(2) Annual continuation		25
(b) Nonresident broker's license:		
(1) Nonresident broker's license (other than as specified in paragraph (c) below), application for original license and issuance, if issued		75
(2) Annual continuation		75
(c) Nonresident broker's license, qualifying under subsection 4 of NRS 683A.340; same as for resident broker's license under paragraph (a).		
(d) Surplus lines broker's license:		
(1) Surplus lines broker's license, application and issuance, if issued	[$10]	$25
(2) Annual continuation	[10]	25
7. Solicitors:		
(a) Application for original license and issuance of license, if issued	[$2]	$5
(b) Annual continuation	[2]	5
8. Managing general agents. Annual continuation, each insurer	[$5]	$10
9. Adjusters:		
(a) Adjuster's license:		
(1) Application for original adjuster's license and issuance of license, if issued		$10
(2) Annual continuation of license		10
(b) Associate adjuster's license:		
(1) Associate adjuster's license (NRS 684A.030), application and issuance of license, if issued	[5]	10
(2) Annual continuation	[5]	10

10. Motor vehicle physical damage appraisers:		
(a) Application for original license and issuance of license, if issued		$
(b) Annual continuation of license		
11. Life insurance analysts:		
(a) Application for original license and issuance of license, if issued		$
(b) Annual continuation of license		
~~12.~~ Examination for license:		
(a) Filing application for each examination, other than life insurance analyst, each kind of insurance	[$10]	$
12(b) Life insurance analysts, filing application, each examination		
13. Additional title, property insurers (NRS 680A.240):		
(a) Original registration		$
(b) Annual continuation of registration		
14. Insurance vending machines:		
(a) Filing application for license and issuance, if issued, each machine	[$20]	$
(b) Annual continuation of license, each machine	[20]	
15. Securities solicitation permit:		
(a) Application for permit		$10
(b) Extension of permit		5
16. Securities salesman, domestic insurers:		
(a) Filing application for license and issuance, if issued	[$10]	$2
(b) Annual continuation of license	[10]	2
17. Rating organizations:		
(a) Filing application for license and issuance, if issued	[$100]	$15
(b) Annual continuation of license	[100]	15
18. Life and health insurance administrator:		
(a) Filing application for registration and certificate, if issued		$2
(b) Annual continuation of certificate		2
19. Insurance laws, each copy, not less than cost.		
20. Certified copy of insurer certificate of authority or of any license issued under this code	[$2]	$
21. Copies of other documents on file in the division: A reasonable charge as fixed by the commissioner; and for certifying and affixing official seal	[$1]	$
22. Letter of clearance as to agent or broker	[$2]	$
23. Certificate of license status, agent or broker	[$2]	$

EXHIBIT 1529

AB 808 PROPOSED AMENDMENTS

submitted by the Las Vegas City Attorney's Office

1. Page 2, line 23 which states that "...the defendant is unable to appear because: (2) He is ill;..." The City of Las Vegas feels that subsection 2 should be amended to read "He is permanently ill," or "He is seriously ill." This change is in keeping with line 2, page 2 which will be deleted by this bill.

2. Page 3, line 3 should be amended to read: "1. The surety submits a written application to set it aside on the ground that the defendant:....." This change would also apply to page 2, line 20.

3. Page 2, line 18 should be changed to read "(a) The defendant appears before the court and the court, upon hearing the matter, determines that the defendant has presented satisfactory excuse [or] and that the surety did not in any way cause or aid the absence of the defendant; or..."

EXHIBIT "F"