THE NINETY-FOURTH DAY

CARSON CITY (Wednesday), May 8, 2019

Assembly called to order at 11:48 a.m.

Mr. Speaker presiding.

Roll called.

All present except Assemblyman Hambrick, who was excused, and one vacant.

Prayer by the Chaplain, Rabbi Evon J. Yakar.

Good morning and I express my gratitude to each and every one of you serving the state of Nevada and its citizens in this 80th Session of the Legislature.

On this day, Jewish Nevadans are gathered here in the state capital to support the crucial work of governance and to mark our modern holidays that commemorate the Holocaust, Israel's Memorial Day, and Israel's Independence Day. These three days help us honor and rejoice in the existence of the modern State of Israel, our partner in democracy. Foundational to both the great state of Nevada and our United States of America is the ability and the promise of religious freedoms. These religious freedoms and the cultural opportunities that we treasure as a state, and as a nation, enrich all of us. And, as we have seen in recent months, we also know that religious communities of all denominations in our country are vulnerable. We pray that such days are behind us.

Today, on Israel's Memorial Day, I pray for the souls of the 23,741 fallen soldiers of Israel and the 3,150 victims of terror. May their memories forever be a blessing. And while Jewish communities around the globe, and certainly around the state of Nevada, gather to honor them, we also know there is always work to be done to preserve life, to honor their memories in the ways we continue to build our future. Tonight, Jews everywhere turn immediately to celebrate Israel's Independence Day. In our prayers for those lost, we also recognize a commitment to tomorrow. We recognize that is the work of leaders everywhere: to honor what has come before, to mourn the unnecessary loss of life, and to commit to better days ahead.

May this be our collective prayer this morning and every day: that in our preservation and honoring of those who have sacrificed everything anywhere are honored and not forgotten. We pray: *HaMakom* – May the One who is ever present, grant us the strength to commit to building a future that continues to honor everyone, every community, and celebrates the best of who we are as people and citizens of the great state of Nevada.

AMEN.

Pledge of allegiance to the Flag.

Assemblywoman Benitez-Thompson moved that further reading of the Journal be dispensed with and the Speaker and Chief Clerk be authorized to make the necessary corrections and additions.

Motion carried.

REPORTS OF COMMITTEES

Mr. Speaker:

Your Committee on Government Affairs, to which was referred Senate Bill No. 225, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

EDGAR FLORES, *Chair*

Mr. Speaker:

Your Committee on Growth and Infrastructure, to which was rereferred Senate Bill No. 426, has had the same under consideration, and begs leave to report the same back with the recommendation: Do pass.

DANIELE MONROE-MORENO, *Chair*

Mr. Speaker:

Your Committee on Judiciary, to which were referred Senate Bills Nos. 9, 45, 137, 173, 223, 433, has had the same under consideration, and begs leave to report the same back with the recommendation: Do pass.

STEVE YEAGER, *Chair*

Mr. Speaker:

Your Committee on Ways and Means, to which was referred Assembly Bill No. 517, has had the same under consideration, and begs leave to report the same back with the recommendation: Amend, and do pass as amended.

MAGGIE CARLTON, *Chair*

MESSAGES FROM THE SENATE

SENATE CHAMBER, Carson City, May 7, 2019

To the Honorable the Assembly:

I have the honor to inform your honorable body that the Senate on this day passed Assembly Bills Nos. 22, 27, 29, 45, 49, 85, 89, 124, 137, 177, 181, 231, 337, 344, 455, 467, 471, 484.

Also, I have the honor to inform your honorable body that the Senate amended, and on this day passed, as amended, Assembly Bill No. 170, Amendment No. 655; Assembly Bill No. 377, Amendment No. 650, and respectfully requests your honorable body to concur in said amendments.

SHERRY RODRIGUEZ
Assistant Secretary of the Senate

MOTIONS, RESOLUTIONS AND NOTICES

Senate Concurrent Resolution No. 5

Assemblyman Smith moved the adoption of the resolution.

Remarks by Assemblyman Smith.

ASSEMBLYMAN SMITH:

Senate Concurrent Resolution 5 expresses support for the critical role of science in preserving the irreplaceable environmental and ecological conditions in the Lake Tahoe Basin. The resolution also recognizes the role of the Tahoe Bi-State Executive Committee and the Tahoe Science Advisory Council in providing the best available scientific resources to help guide decision-making regarding natural resources and environmental improvement projects in the Basin.

Resolution adopted and ordered to the Senate.

SECOND READING AND AMENDMENT

Assembly Bill No. 508.

Bill read second time.

The following amendment was proposed by the Committee on Ways and Means:

Amendment No. 664.

SUMMARY—Makes appropriations to the Department of Corrections for ~~[the replacement of]~~ **certain** medical equipment. (BDR S-1185)

AN ACT making appropriations to the Department of Corrections, Prison Medical Care, for ~~[the replacement of]~~ **certain** medical equipment; 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. 1. There is hereby appropriated from the State General Fund to the Department of Corrections, Prison Medical Care, the sum of $114,700 for the replacement of medical equipment.

2. There is hereby appropriated from the State General Fund to the Department of Corrections, Prison Medical Care, the sum of $385 for a ~~[bladder scanner and a portable diagnostic]~~ **deep vascular** scanner.

Sec. 2. Any remaining balance of the appropriations made by section 1 of this act must not be committed for expenditure after June 30, 2021, by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of the appropriated money remaining must not be spent for any purpose after September 17, 2021, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 17, 2021.

Sec. 3. This act becomes effective upon passage and approval.

Assemblywoman Carlton moved the adoption of the amendment.

Remarks by Assemblywoman Carlton.

Amendment adopted.

Bill ordered reprinted, engrossed and to third reading.

Senate Bill No. 17.

Bill read second time and ordered to third reading.

Senate Bill No. 18.

Bill read second time and ordered to third reading.

Senate Bill No. 46.

Bill read second time.

The following amendment was proposed by the Committee on Judiciary:

Amendment No. 653.

AN ACT relating to gaming; revising the definition of "gross revenue"; prohibiting a person from performing an act that requires registration without being registered; ~~[revising the definition of "interactive gaming service provider";]~~ revising the definition of "service provider"; providing for the registration, rather than licensure, of service providers; authorizing the Attorney General or district attorney of any county to apply for a court order to intercept communications during an investigation involving certain offenses

relating to gaming; providing a penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires the Nevada Gaming Commission to charge and collect from each licensee a license fee based upon all the gross revenue of the licensee. (NRS 463.370) Under existing law, "gross revenue" does not include cash received as entry fees for contests or tournaments in which patrons compete for prizes, except for a contest or tournament conducted in conjunction with an inter-casino linked system. (NRS 463.0161) **Section 3** of this bill revises the definition of "gross revenue" to include cash received as entry fees for all contests or tournaments, with the exception of all cash and the cost of any noncash prizes paid out to participants which does not exceed the total compensation received for the right to participate in the contests or tournaments.

Existing law provides that it is unlawful for a person to perform certain acts relating to gaming without having first procured, and thereafter maintaining in effect, all federal, state, county and municipal gaming licenses as required by statute, regulation or ordinance or by the governing board of any unincorporated town. (NRS 463.160) **Section 4** of this bill extends this prohibition to performing such acts related to gaming without first having procured, and thereafter maintained, all federal, state, county or municipal gaming registrations, if applicable.

Existing law authorizes the Commission to provide by regulation for the licensing and operation of service providers and all persons, locations and matters associated therewith. Existing law defines "service provider" as a person who: (1) acts on behalf of a person who holds a nonrestricted gaming license, who assists, manages, administers or controls wagers or games or its software or hardware and who is authorized to share revenue from the games without being licensed to conduct a gaming establishment; (2) is an interactive gaming service provider; (3) is a cash accessing and wagering instrument service provider; or (4) meets certain criteria established by the Commission. Existing law defines "interactive gaming service provider" as a person who acts on behalf of an establishment licensed to operate interactive gaming and: (1) manages, administers or controls wagers initiated, made or received on an interactive gaming system; (2) manages, administers or controls the games with which wagers are initiated, received or made on such a system; (3) maintains or operates the software or hardware of such a system; or (4) provides products, services, information or assets to an interactive gaming establishment and receives a percentage of such an establishment's interactive gaming revenue. (NRS 463.677)

Section 5 of this bill revises the definition of ~~["interactive gaming service provider" to mean a person who acts on behalf of an establishment licensed to operate interactive gaming and who assists, manages, administers or controls wagers or games, or maintains or operates software or hardware on behalf of such a licensed person and who is authorized to share the revenue from such~~

~~games under certain circumstances. Section 5 also revises the definition of~~] "service provider" to mean a person who: (1) is a cash access and wagering instrument service provider; or (2) meets certain criteria established by the Commission. **Sections 5-7** of this bill revise various sections of NRS to provide for: (1) the licensure of an interactive gaming service provider; and (2) the registration, rather than licensure, of service providers.

Existing law authorizes the Attorney General or the district attorney of any county to apply for a court order authorizing the interception of wire, electronic or oral communications by investigative or law enforcement officers having responsibility for the investigation of certain offenses. (NRS 179.460) Existing law also provides that it is unlawful for a person to: (1) perform certain actions relating to gaming without having first procured, and thereafter maintaining, all required gaming licenses; or (2) receive any compensation or reward, or any percentage or share of the money or property played, for performing certain actions relating to a bet or wager on the result of any event held at a track involving a horse or other animal, sporting event or other event, without having first procured, and thereafter maintaining, all required gaming licenses. (NRS 463.160, 465.086) **Section 8** of this bill adds those offenses to the list of offenses for which such an interception of communications may be ordered.

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

Section 1. (Deleted by amendment.)

Sec. 2. (Deleted by amendment.)

Sec. 3. NRS 463.0161 is hereby amended to read as follows:

463.0161 1. "Gross revenue" means the total of all:

(a) Cash received as winnings;

(b) ***Cash received as entry fees for contests and tournaments;***

(c) Cash received in payment for credit extended by a licensee to a patron for purposes of gaming; and

[~~(c)~~] ***(d)*** Compensation received for conducting any game, or any contest or tournament in conjunction with interactive gaming, in which the licensee is not party to a wager,

➥ less the total of all cash paid out as losses to patrons, ***all cash and the cost of any noncash prizes paid out to participants in contests or tournaments not to exceed the total compensation received for the right to participate in the contests or tournaments,*** those amounts paid to fund periodic payments and any other items made deductible as losses by NRS 463.3715. [~~For the purposes of this section, cash or the value of noncash prizes awarded to patrons in a contest or tournament are not losses, except that losses in a contest or tournament conducted in conjunction with an inter-casino linked system may be deducted to the extent of the compensation received for the right to participate in that contest or tournament.~~]

2. The term does not include:

(a) Counterfeit facsimiles of money, chips, tokens, wagering instruments or wagering credits;

(b) Coins of other countries which are received in gaming devices;

(c) Any portion of the face value of any chip, token or other representative of value won by a licensee from a patron for which the licensee can demonstrate that it or its affiliate has not received cash;

(d) Cash taken in fraudulent acts perpetrated against a licensee for which the licensee is not reimbursed;

(e) ~~[Cash received as entry fees for contests or tournaments in which patrons compete for prizes, except for a contest or tournament conducted in conjunction with an inter-casino linked system;~~

~~(f)]~~ Uncollected baccarat commissions; or

~~[(g)]~~ ***(f)*** Cash provided by the licensee to a patron and subsequently won by the licensee, for which the licensee can demonstrate that it or its affiliate has not been reimbursed.

3. As used in this section, "baccarat commission" means:

(a) A fee assessed by a licensee on cash paid out as a loss to a patron at baccarat to modify the odds of the game; or

(b) A rate or fee charged by a licensee for the right to participate in a baccarat game.

Sec. 4. NRS 463.160 is hereby amended to read as follows:

463.160 1. Except as otherwise provided in subsection 4 and NRS 463.172, it is unlawful for any person, either as owner, lessee or employee, whether for hire or not, either solely or in conjunction with others:

(a) To deal, operate, carry on, conduct, maintain or expose for play in the State of Nevada any gambling game, gaming device, inter-casino linked system, mobile gaming system, slot machine, race book or sports pool;

(b) To provide or maintain any information service;

(c) To operate a gaming salon;

(d) To receive, directly or indirectly, any compensation or reward or any percentage or share of the money or property played, for keeping, running or carrying on any gambling game, slot machine, gaming device, mobile gaming system, race book or sports pool;

(e) To operate as a cash access and wagering instrument service provider; or

(f) To operate, carry on, conduct, maintain or expose for play in or from the State of Nevada any interactive gaming system,

➥ without having first procured, and thereafter maintaining in effect, all federal, state, county and municipal gaming licenses ***or registrations*** as required by statute, regulation or ordinance or by the governing board of any unincorporated town.

2. The licensure of an operator of an inter-casino linked system is not required if:

(a) A gaming licensee is operating an inter-casino linked system on the premises of an affiliated licensee; or

(b) An operator of a slot machine route is operating an inter-casino linked system consisting of slot machines only.

3. Except as otherwise provided in subsection 4, it is unlawful for any person knowingly to permit any gambling game, slot machine, gaming device, inter-casino linked system, mobile gaming system, race book or sports pool to be conducted, operated, dealt or carried on in any house or building or other premises owned by the person, in whole or in part, by a person who is not licensed pursuant to this chapter, or that person's employee.

4. The Commission may, by regulation, authorize a person to own or lease gaming devices for the limited purpose of display or use in the person's private residence without procuring a state gaming license.

5. For the purposes of this section, the operation of a race book or sports pool includes making the premises available for any of the following purposes:

(a) Allowing patrons to establish an account for wagering with the race book or sports pool;

(b) Accepting wagers from patrons;

(c) Allowing patrons to place wagers;

(d) Paying winning wagers to patrons; or

(e) Allowing patrons to withdraw cash from an account for wagering or to be issued a ticket, receipt, representation of value or other credit representing a withdrawal from an account for wagering that can be redeemed for cash,

➥ whether by a transaction in person at an establishment or through mechanical means, such as a kiosk or similar device, regardless of whether that device would otherwise be considered associated equipment. A separate license must be obtained for each location at which such an operation is conducted.

6. As used in this section, "affiliated licensee" has the meaning ascribed to it in NRS 463.430.

Sec. 5. NRS 463.677 is hereby amended to read as follows:

463.677 1. The Legislature finds that:

(a) Technological advances have evolved which allow licensed gaming establishments to expose games, including, without limitation, system-based and system-supported games, gaming devices, mobile gaming systems, interactive gaming, cashless wagering systems or race books and sports pools, and to be assisted by ***an interactive gaming service provider or*** a service provider ***, as applicable,*** who provides important services to the public with regard to the conduct and exposure of such games.

(b) To protect and promote the health, safety, morals, good order and general welfare of the inhabitants of this State, and to carry out the public policy declared in NRS 463.0129, it is necessary that the Board and Commission have the ability to ~~[license]~~ ***:***

(1) License interactive gaming service providers;

(2) Register service providers ~~[by maintaining]~~ ***; and***

(3) Maintain strict regulation and control of the operation of such ***interactive gaming service providers or*** service providers ***, respectively,*** and all persons and locations associated therewith.

2. Except as otherwise provided in subsection ~~[3.]~~ ***4,*** the Commission may, with the advice and assistance of the Board, provide by regulation for the ~~[licensing]~~ ***:***

(a) Licensing of an interactive gaming service provider;

(b) Registration of a service provider; and ~~[operation]~~

(c) Operation of ***such*** a service provider ***or interactive gaming service provider, respectively,*** and all persons, locations and matters associated therewith. ~~[Such]~~

3. The regulations ***pursuant to subsection 2*** may include, without limitation:

(a) Provisions requiring ~~[the]~~ ***:***

(1) The interactive gaming service provider to meet the qualifications for licensing pursuant to NRS 463.170, in addition to any other qualifications established by the Commission ~~[,]~~ and to be licensed regardless of whether the ***interactive gaming*** service provider holds any ~~[other]~~ license.

(2) The service provider to be registered regardless of whether the service provider holds any license.

(b) Criteria regarding the location from which the ***interactive gaming service provider or*** service provider ***, respectively,*** conducts its operations, including, without limitation, minimum internal and operational control standards established by the Commission.

(c) Provisions relating to ~~[the]~~ ***:***

(1) The licensing ***of persons owning or operating an interactive gaming service provider, and any person having a significant involvement therewith, as determined by the Commission.***

(2) The registration of persons owning or operating a service provider, and any persons having a significant involvement therewith, as determined by the Commission.

(d) A provision that a person owning, operating or having significant involvement with ***an interactive gaming service provider or*** a service provider, ***respectively,*** as determined by the Commission, may be required by the Commission to be found suitable to be associated with licensed gaming, including race book or sports pool operations.

(e) Additional matters which the Commission deems necessary and appropriate to carry out the provisions of this section and which are consistent with the public policy of this State pursuant to NRS 463.0129, including that ***an interactive gaming service provider or*** a service provider ***, respectively,*** must be liable to the licensee on whose behalf the services are provided for the ***interactive gaming service provider's or*** service provider's proportionate share of the fees and taxes paid by the licensee.

~~[3.]~~ ***4.*** The Commission may not adopt regulations pursuant to this section until the Commission first determines that ***interactive gaming service***

providers or service providers ***, respectively,*** are secure and reliable, do not pose a threat to the integrity of gaming and are consistent with the public policy of this State pursuant to NRS 463.0129.

~~[4.]~~ ***5.*** Regulations adopted by the Commission pursuant to this section must provide that the premises on which ***an interactive gaming service provider and*** a service provider ***, respectively,*** conducts its operations are subject to the power and authority of the Board and Commission pursuant to NRS 463.140, as though the premises are where gaming is conducted and the ***interactive gaming service provider or*** service provider ***, respectively,*** is a gaming licensee.

~~[5.]~~ ***6.*** As used in this section:

(a) "Interactive gaming service provider" means a person who acts on behalf of an establishment licensed to operate interactive gaming and :

(1) Manages, administers or controls wagers that are initiated, received or made on an interactive gaming system;

(2) Manages, administers or controls the games with which wagers that are initiated, received or made on an interactive gaming system are associated;

(3) Maintains or operates the software or hardware of an interactive gaming system; or

(4) Provides products, services, information or assets to an establishment licensed to operate interactive gaming and receives therefor a percentage of gaming revenue from the establishment's interactive gaming system. ~~***[who assists, manages, administers or controls wagers or games or maintains or operates software or hardware of a game on behalf of the licensed person, and is authorized to share in the revenue from the games without being licensed to conduct gaming at an establishment.]***~~

(b) "Service provider" means a person who:

(1) ~~[~~Acts on behalf of another licensed person who conducts nonrestricted gaming operations, and who assists, manages, administers or controls wagers or games, or maintains or operates the software or hardware of games on behalf of such a licensed person, and is authorized to share in the revenue from games without being licensed to conduct gaming at an establishment;

(2) Is an interactive gaming service provider;

(3)~~]~~ Is a cash access and wagering instrument service provider; or

~~[~~(4)~~]~~ ***(2)*** Meets such other or additional criteria as the Commission may establish by regulation.

Sec. 6. NRS 463.750 is hereby amended to read as follows:

463.750 1. The Commission shall, with the advice and assistance of the Board, adopt regulations governing ~~[the]~~ ***:***

(a) The licensing and operation of interactive gaming ~~.~~ ***; and***

(b) The registration of service providers to perform any action described in paragraph (b) of subsection 6 of NRS 463.677.

2. The regulations adopted by the Commission pursuant to this section must:

(a) Establish the investigation fees for:

(1) A license to operate interactive gaming;

(2) A license for a manufacturer of interactive gaming systems; ~~[and]~~

(3) A license for ***an interactive gaming service provider to perform the actions described in paragraph (a) of subsection 6 of NRS 463.677; and***

(4) Registration as a service provider to perform the actions described in paragraph ~~[(a)]~~ ***(b)*** of subsection ~~[5]~~ ***6*** of NRS 463.677.

(b) Provide that:

(1) A person must hold a license for a manufacturer of interactive gaming systems to supply or provide any interactive gaming system, including, without limitation, any piece of proprietary software or hardware; ~~[and]~~

(2) A person must hold a license for ***an interactive gaming service provider to perform the actions described in paragraph (a) of subsection 6 of NRS 463.677; and***

(3) A person must be registered as a service provider to perform the actions described in paragraph ~~[(a)]~~ ***(b)*** of subsection ~~[5]~~ ***6*** of NRS 463.677.

(c) Except as otherwise provided in subsections 6 to 10, inclusive, set forth standards for the suitability of a person to be ~~[licensed]~~ ***:***

(1) Licensed as a manufacturer of interactive gaming systems ~~[or]~~ ***;***

(2) Licensed as an interactive gaming service provider as described in paragraph (a) of subsection 6 of NRS 463.677 that are as stringent as the standards for a nonrestricted license; or

(3) Registered as a service provider as described in paragraph (b) of subsection ~~[5]~~ ***6*** of NRS 463.677 that are as stringent as the standards for a nonrestricted license.

(d) Set forth provisions governing:

(1) The initial fee for a license for ***an interactive gaming service provider as described in paragraph (a) of subsection 6 of NRS 463.677.***

(2) The initial fee for registration as a service provider as described in paragraph (b) of subsection ~~[5]~~ ***6*** of NRS 463.677.

~~[(2)]~~ ***(3)*** The fee for the renewal of such a license for such ***an interactive gaming service provider or registration as*** a service provider ***, as applicable,*** and any renewal requirements for such a license ~~[.]~~ ***or registration, as applicable.***

~~[(3)]~~ ***(4)*** Any portion of the license fee paid by a person licensed to operate interactive gaming, pursuant to subsection 1 of NRS 463.770, for which ~~[a]~~ ***an interactive gaming*** service provider may be liable to the person licensed to operate interactive gaming.

(e) Provide that gross revenue received by an establishment from the operation of interactive gaming is subject to the same license fee provisions of NRS 463.370 as the games and gaming devices of the establishment, unless federal law otherwise provides for a similar fee or tax.

(f) Set forth standards for the location and security of the computer system and for approval of hardware and software used in connection with interactive gaming.

(g) Define "interactive gaming system," "manufacturer of interactive gaming systems," "operate interactive gaming" and "proprietary hardware and software" as the terms are used in this chapter.

3. Except as otherwise provided in subsections 4 and 5, the Commission shall not approve a license for an establishment to operate interactive gaming unless:

(a) In a county whose population is 700,000 or more, the establishment is a resort hotel that holds a nonrestricted license to operate games and gaming devices.

(b) In a county whose population is 45,000 or more but less than 700,000, the establishment is a resort hotel that holds a nonrestricted license to operate games and gaming devices or the establishment:

(1) Holds a nonrestricted license for the operation of games and gaming devices;

(2) Has more than 120 rooms available for sleeping accommodations in the same county;

(3) Has at least one bar with permanent seating capacity for more than 30 patrons that serves alcoholic beverages sold by the drink for consumption on the premises;

(4) Has at least one restaurant with permanent seating capacity for more than 60 patrons that is open to the public 24 hours each day and 7 days each week; and

(5) Has a gaming area that is at least 18,000 square feet in area with at least 1,600 slot machines, 40 table games, and a sports book and race pool.

(c) In all other counties, the establishment is a resort hotel that holds a nonrestricted license to operate games and gaming devices or the establishment:

(1) Has held a nonrestricted license for the operation of games and gaming devices for at least 5 years before the date of its application for a license to operate interactive gaming;

(2) Meets the definition of group 1 licensee as set forth in the regulations of the Commission on the date of its application for a license to operate interactive gaming; and

(3) Operates either:

(I) More than 50 rooms for sleeping accommodations in connection therewith; or

(II) More than 50 gaming devices in connection therewith.

4. The Commission may:

(a) Issue a license to operate interactive gaming to an affiliate of an establishment if:

(1) The establishment satisfies the applicable requirements set forth in subsection 3;

(2) The affiliate is located in the same county as the establishment; and

(3) The establishment has held a nonrestricted license for at least 5 years before the date on which the application is filed; and

(b) Require an affiliate that receives a license pursuant to this subsection to comply with any applicable provision of this chapter.

5. The Commission may issue a license to operate interactive gaming to an applicant that meets any qualifications established by federal law regulating the licensure of interactive gaming.

6. Except as otherwise provided in subsections 7, 8 and 9:

(a) A covered person may not be found suitable for licensure under this section within 5 years after February 21, 2013;

(b) A covered person may not be found suitable for licensure under this section unless such covered person expressly submits to the jurisdiction of the United States and of each state in which patrons of interactive gaming operated by such covered person after December 31, 2006, were located, and agrees to waive any statutes of limitation, equitable remedies or laches that otherwise would preclude prosecution for a violation of any provision of federal law or the law of any state in connection with such operation of interactive gaming after that date;

(c) A person may not be found suitable for licensure under this section within 5 years after February 21, 2013, if such person uses a covered asset for the operation of interactive gaming; and

(d) Use of a covered asset is grounds for revocation of an interactive gaming license, or a finding of suitability, issued under this section.

7. The Commission, upon recommendation of the Board, may waive the requirements of subsection 6 if the Commission determines that:

(a) In the case of a covered person described in paragraphs (a) and (b) of subsection 1 of NRS 463.014645:

(1) The covered person did not violate, directly or indirectly, any provision of federal law or the law of any state in connection with the ownership and operation of, or provision of services to, an interactive gaming facility that, after December 31, 2006, operated interactive gaming involving patrons located in the United States; and

(2) The assets to be used or that are being used by such person were not used after that date in violation of any provision of federal law or the law of any state;

(b) In the case of a covered person described in paragraph (c) of subsection 1 of NRS 463.014645, the assets that the person will use in connection with interactive gaming for which the covered person applies for a finding of suitability were not used after December 31, 2006, in violation of any provision of federal law or the law of any state; and

(c) In the case of a covered asset, the asset was not used after December 31, 2006, in violation of any provision of federal law or the law of any state, and the interactive gaming facility in connection with which the asset was used was not used after that date in violation of any provision of federal law or the law of any state.

8. With respect to a person applying for a waiver pursuant to subsection 7, the Commission shall afford the person an opportunity to be heard and present

relevant evidence. The Commission shall act as finder of fact and is entitled to evaluate the credibility of witnesses and persuasiveness of the evidence. The affirmative votes of a majority of the whole Commission are required to grant or deny such waiver. The Board shall make appropriate investigations to determine any facts or recommendations that it deems necessary or proper to aid the Commission in making determinations pursuant to this subsection and subsection 7.

9. The Commission shall make a determination pursuant to subsections 7 and 8 with respect to a covered person or covered asset without regard to whether the conduct of the covered person or the use of the covered asset was ever the subject of a criminal proceeding for a violation of any provision of federal law or the law of any state, or whether the person has been prosecuted and the prosecution terminated in a manner other than with a conviction.

10. It is unlawful for any person, either as owner, lessee or employee, whether for hire or not, either solely or in conjunction with others, to operate interactive gaming:

(a) Until the Commission adopts regulations pursuant to this section; and

(b) Unless the person first procures, and thereafter maintains in effect, all appropriate licenses as required by the regulations adopted by the Commission pursuant to this section.

11. A person who violates subsection 10 is guilty of a category B felony and shall be punished by imprisonment in the state prison for a minimum term of not less than 1 year and a maximum term of not more than 10 years or by a fine of not more than $50,000, or both.

Sec. 7. NRS 463.767 is hereby amended to read as follows:

463.767 1. The Commission may, with the advice and assistance of the Board, adopt a seal for its use to identify:

(a) A license to operate interactive gaming;

(b) A license for a manufacturer of interactive gaming systems; ~~[and]~~

(c) A license for ***an interactive gaming service provider to perform the actions described in paragraph (a) of subsection 6 of NRS 463.677; and***

(d) Registration as a service provider to perform the actions described in paragraph ~~[(a)]~~ ***(b)*** of subsection ~~[5]~~ ***6*** of NRS 463.677.

2. The Chair of the Commission has the care and custody of the seal.

3. The seal must have imprinted thereon the words "Nevada Gaming Commission."

4. A person shall not use, copy or reproduce the seal in any way not authorized by this chapter or the regulations of the Commission. Except under circumstances where a greater penalty is provided in NRS 205.175, a person who violates this subsection is guilty of a gross misdemeanor.

5. A person convicted of violating subsection 4 is, in addition to any criminal penalty imposed, liable for a civil penalty upon each such conviction. A court before whom a defendant is convicted of a violation of subsection 4

shall, for each violation, order the defendant to pay a civil penalty of $5,000. The money so collected:

(a) Must not be deducted from any penal fine imposed by the court;

(b) Must be stated separately on the court's docket; and

(c) Must be remitted forthwith to the Commission.

Sec. 8. NRS 179.460 is hereby amended to read as follows:

179.460 1. The Attorney General or the district attorney of any county may apply to a Supreme Court justice or to a district judge in the county where the interception is to take place for an order authorizing the interception of wire, electronic or oral communications, and the judge may, in accordance with NRS 179.470 to 179.515, inclusive, grant an order authorizing the interception of wire, electronic or oral communications by investigative or law enforcement officers having responsibility for the investigation of the offense as to which the application is made, when the interception may provide evidence of the commission of murder, kidnapping, robbery, extortion, bribery, escape of an offender in the custody of the Department of Corrections, destruction of public property by explosives, a sexual offense against a child, sex trafficking, a violation of NRS 200.463, 200.464 or 200.465, trafficking in persons in violation of NRS 200.467 or 200.468 ***,*** ~~[or]~~ the commission of any offense which is made a felony by the provisions of chapter 453 or 454 of NRS ~~[.]~~ ***or a violation of NRS 463.160 or 465.086.***

2. A provider of electronic communication service or a public utility, an officer, employee or agent thereof or another person associated with the provider of electronic communication service or public utility who, pursuant to an order issued pursuant to subsection 1, provides information or otherwise assists an investigative or law enforcement officer in the interception of a wire, electronic or oral communication is immune from any liability relating to any interception made pursuant to the order.

3. As used in this section, "sexual offense against a child" includes any act upon a child constituting:

(a) Incest pursuant to NRS 201.180;

(b) Lewdness with a child pursuant to NRS 201.230;

(c) Sado-masochistic abuse pursuant to NRS 201.262;

(d) Sexual assault pursuant to NRS 200.366;

(e) Statutory sexual seduction pursuant to NRS 200.368;

(f) Open or gross lewdness pursuant to NRS 201.210; or

(g) Luring a child or a person with mental illness pursuant to NRS 201.560, if punished as a felony.

Sec. 9. This act becomes effective:

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

2. On July 1, 2019, for all other purposes.

Assemblyman Yeager moved the adoption of the amendment.
Remarks by Assemblyman Yeager.
Amendment adopted.
Bill ordered reprinted, reengrossed and to third reading.

Senate Bill No. 55.
Bill read second time and ordered to third reading.

Senate Bill No. 77.
Bill read second time and ordered to third reading.

Senate Bill No. 85.
Bill read second time and ordered to third reading.

Senate Bill No. 92.
Bill read second time and ordered to third reading.

Senate Bill No. 184.
Bill read second time and ordered to third reading.

Senate Bill No. 232.
Bill read second time and ordered to third reading.

Senate Bill No. 284.
Bill read second time and ordered to third reading.

Senate Bill No. 454.
Bill read second time and ordered to third reading.

GENERAL FILE AND THIRD READING

Assembly Bill No. 151.
Bill read third time.
Remarks by Assemblywoman Carlton.

ASSEMBLYWOMAN CARLTON:

Assembly Bill 151 requires that any person who is currently required to report the abuse or neglect of a child is to report suspected commercial sexual exploitation of a child to a child welfare agency as soon as reasonably practicable, but not later than 24 hours after becoming aware of the possible exploitation. In addition, the reporting party is required to immediately contact a law enforcement agency if an alleged perpetrator is present or believed to be with the child or the child is otherwise in imminent danger. Any person who knowingly and willfully violates reporting requirements is guilty of a misdemeanor for the first violation and a gross misdemeanor for each subsequent violation.

The bill requires a child welfare agency that receives such a report to conduct an initial screening and report the commercial sexual exploitation to the appropriate law enforcement agency. Additionally, if the child is not in the agency's jurisdiction, the agency is authorized to contact child welfare in another jurisdiction.

The measure requires the adoption of rules, policies, and regulations regarding the release of certain confidential information by child welfare agencies and provides for a penalty that may be assessed for the improper release or dissemination of confidential information.

The bill is effective on October 1, 2019.

Roll call on Assembly Bill No. 151:

YEAS—40.

NAYS—None.

EXCUSED—Hambrick.

VACANT—1.

Assembly Bill No. 151 having received a two-thirds majority, Mr. Speaker declared it passed.

Bill ordered transmitted to the Senate.

Assembly Bill No. 298.

Bill read third time.

Remarks by Assemblywoman Carlton.

ASSEMBLYWOMAN CARLTON:

Assembly Bill 298, as amended, requires a child welfare agency to adopt, publish, and update annually a plan for the recruitment and retention of foster homes. The report shall include a determination of, and goals related to, the number of foster homes needed by area, necessary corrective actions, efforts to keep a child in his/her community, foster home recruitment strategies, and identification of resources for foster families.

The measure, as amended, requires an agency which provides child welfare services to appoint one or more employees to develop, carry out, and evaluate the implementation of the plan and certain other issues related to the ability of existing foster homes to meet the needs of children.

Roll call on Assembly Bill No. 298:

YEAS—40.

NAYS—None.

EXCUSED—Hambrick.

VACANT—1.

Assembly Bill No. 298 having received a constitutional majority, Mr. Speaker declared it passed, as amended.

Bill ordered transmitted to the Senate.

Assembly Bill No. 496.

Bill read third time.

Remarks by Assemblywoman Carlton.

ASSEMBLYWOMAN CARLTON:

Under existing law, the Executive Director of the Silver State Health Insurance Exchange is authorized to appoint employees in the unclassified service. Assembly Bill 496 authorizes the Executive Director to also appoint employees in the classified service.

Roll call on Assembly Bill No. 496:

YEAS—40.

NAYS—None.

EXCUSED—Hambrick.

VACANT—1.

Assembly Bill No. 496 having received a constitutional majority, Mr. Speaker declared it passed.

Bill ordered transmitted to the Senate.

Assembly Bill No. 510.

Bill read third time.

Remarks by Assemblywoman Jauregui.

ASSEMBLYWOMAN JAUREGUI:

Assembly Bill 510 appropriates $87,000 from the State General Fund to the Department of Motor Vehicles for the costs of implementing the Automatic Voter Registration Initiative, or Ballot Question Number 5, passed by the voters at the 2018 General Election.

Roll call on Assembly Bill No. 510:

YEAS—40.

NAYS—None.

EXCUSED—Hambrick.

VACANT—1.

Assembly Bill No. 510 having received a constitutional majority, Mr. Speaker declared it passed.

Bill ordered transmitted to the Senate.

UNFINISHED BUSINESS

SIGNING OF BILLS AND RESOLUTIONS

There being no objections, the Speaker and Chief Clerk signed Assembly Bills Nos. 11 and 147.

CONSIDERATION OF SENATE AMENDMENTS

Assembly Bill No. 170.

The following Senate amendment was read:

Amendment No. 655.

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

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

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

Legislative Counsel's Digest:

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

bill requires the Advocate to assist consumers with accessing a navigator, case manager or facilitator to help the consumer obtain health care services. **Section 30.5** also requires the Advocate to assist consumers with: (1) scheduling an appointment with an in-network provider of health care; and (2) filing complaints against health carriers.

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

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

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

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

conformance with federal law and **sections 12 and 31** of this bill. **Section 31.5** of this bill authorizes such an insurance plan for only retired officers and employees to exclude claims for preexisting conditions under the same conditions as previously authorized for grandfathered plans. **Sections 11, 14, 22 and 35** of this bill remove other provisions of existing law that reference exclusions based on a preexisting condition. **Sections 8 and 28** of this bill make other conforming changes.

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

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

Sec. 2. (Deleted by amendment.)

Sec. 3. (Deleted by amendment.)

Sec. 4. (Deleted by amendment.)

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

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

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

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

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

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

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

2. As used in this section:

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

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

Sec. 5. (Deleted by amendment.)

Sec. 6. (Deleted by amendment.)

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

687B.600 As used in NRS 687B.600 to 687B.850, inclusive, ***and section 4.5 of this act,*** unless the context otherwise requires, the words and terms

defined in NRS 687B.605 to 687B.665, inclusive, have the meanings ascribed to them in those sections.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

Sec. 8. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~[.]~~ ***, and section 7 of this act.***

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

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

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

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

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

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

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

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

3. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

3. As used in this section:

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

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

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

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

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

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

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

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

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

(d) Provisions relating to renewability; ***and***

(e) ~~[~~Provisions relating to preexisting conditions; and

~~— (f)~~] Other information that the Commissioner finds necessary for full and fair disclosure of the provisions of the policy.

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

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

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

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

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

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

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

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

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

(c) Genetic information relating to the insured; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Health status.

(b) Medical condition, including physical and mental illnesses, or both.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions which arise out of acts of domestic violence.

(h) Disability.

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

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

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

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

~~5.]~~ This section does not:

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

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

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

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

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

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

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

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

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

(c) Genetic information relating to the insured; and

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

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

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

(b) Require an insured, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance

charged to a similarly situated insured who does not have such a health status.

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

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

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

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

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

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

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

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

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

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

(a) Health status.

(b) Medical condition, including physical and mental illnesses, or both.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions which arise out of acts of domestic violence.

(h) Disability.

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

4. ~~[As a condition of enrollment or continued enrollment under a health benefit plan, a carrier shall not require any person to pay a premium or contribution that is greater than the premium or contribution for a similarly situated person covered by similar coverage on the basis of any factor described in subsection 2 in relation to the person or a dependent of the person. — 5.]~~ Nothing in this section:

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

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

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

~~[6.]~~ ***5.*** As used in this section:

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

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

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

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

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

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

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

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

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

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

3. As used in this section:

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

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

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

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

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

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

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

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 21. NRS 695B.193 is hereby amended to read as follows:

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

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

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

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

➥ The contracts must provide the coverage specified in subsection 3, and must not exclude premature births.

2. The contract may require that notification of:

(a) The birth of a newly born child;

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

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

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

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

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

~~5.]~~ For covered services provided to the child, the corporation shall reimburse noncontracted providers of health care to an amount equal to the average amount of payment for which the organization has agreements, contracts or arrangements for those covered services.

Sec. 22. NRS 695B.2555 is hereby amended to read as follows:

695B.2555 A converted contract ~~[must not exclude a preexisting condition not excluded by the group contract, but a converted contract]~~ may provide that

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

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

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

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

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

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

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

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

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

3. As used in this section:

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

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

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

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

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

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, 695C.1751, 695C.1755, 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

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

Sec. 26. NRS 695C.173 is hereby amended to read as follows:

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

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

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

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

➥ The plans must provide the coverage specified in subsection 3, and must not exclude premature births.

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

(a) The birth of a newly born child;

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

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

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

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

4. ~~[A health maintenance organization shall not restrict the coverage of a dependent child adopted or placed for adoption solely because of a preexisting condition the child has at the time the child would otherwise become eligible for coverage pursuant to that plan. Any provision relating to an exclusion for a preexisting condition must comply with NRS 689B.500 or 689C.190, as appropriate.~~

~~5.]~~ For covered services provided to the child, the health maintenance organization shall reimburse noncontracted providers of health care to an amount equal to the average amount of payment for which the organization has agreements, contracts or arrangements for those covered services.

Sec. 27. NRS 695C.207 is hereby amended to read as follows:

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

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

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

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

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

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

2. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Genetic information relating to the person; and

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

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

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

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

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

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

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

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

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

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

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

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

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

232.459 1. The Advocate shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. As used in this section:

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

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

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

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

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

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

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

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

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

exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.

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

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

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

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

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

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

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

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

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

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

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

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

(b) Under the Public Employees' Benefits Program, if the last public employer of the retired officer or employee participates in the Public

Employees' Benefits Program pursuant to paragraph (a) of subsection 1 of NRS 287.025.

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

(a) Giving written notice of the intent of the public officer or employee or surviving spouse to reinstate the insurance to the last public employer of the public officer or employee not later than January 31 of an even-numbered year;

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

(c) Except as otherwise provided in paragraph (b) of subsection 4 of NRS 287.023, paying any portion of the premiums or contributions of the public employer's program or plan of insurance, in the manner set forth in NRS 1A.470 or 286.615, which is due from the date of reinstatement and not paid by the public employer.

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

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

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

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

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

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 687B.409, 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and***

section 30 of this act in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

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

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

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

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

Sec. 34. The provisions of sections 7, 12, 15, 19, 20, 24, 29 and 30 of this act apply to any contract, agreement, network plan, policy of health insurance, policy of group health insurance, health benefit plan, benefit contract, contract for hospital or medical service and health care plan that is delivered, issued for delivery or renewed on or after January 1, 2020.

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

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

Sec. 36. ***This act becomes effective:***

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

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

LEADLINES OF REPEALED SECTIONS

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

689A.585 "Preexisting condition" defined.

689B.450 "Preexisting condition" defined.

689C.082 "Preexisting condition" defined.

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

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

Assemblywoman Spiegel moved that the Assembly concur in the Senate Amendment No. 655 to Assembly Bill No. 170.

Remarks by Assemblywoman Spiegel.

ASSEMBLYWOMAN SPIEGEL:

Senate Amendment No. 655 to Assembly Bill 170 adds additional sponsors.

Motion carried by a constitutional majority.

Bill ordered to enrollment.

Assembly Bill No. 377.

The following Senate amendment was read:

Amendment No. 650.

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

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

Legislative Counsel's Digest:

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

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

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

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

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

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

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

3. This section does not apply to:

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

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

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

4. As used in this section:

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

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

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

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

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

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

4. The Department of Transportation, by regulation, shall provide for the operation of combinations of vehicles in excess of 70 feet in length. The

regulations must establish standards for the operation of such vehicles which must be consistent with their safe operation upon the public highways and with the provisions of 23 C.F.R. § 658.23. Such standards must include:

(a) Types and number of vehicles to be permitted in combination;

(b) Horsepower of a motortruck;

(c) Operating speeds;

(d) Braking ability; and

(e) Driver qualifications.

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

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

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

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

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

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

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

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

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

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

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

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

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

9. This section does not apply to:

(a) Vehicles used by a public utility for the transportation of poles;

(b) A combination of vehicles consisting of a truck-tractor drawing a semitrailer that does not exceed 53 feet in length;

(c) A combination of vehicles consisting of a truck-tractor drawing a semitrailer and a trailer, neither of which exceeds 28 1/2 feet in length; ~~[or]~~

(d) A driveaway saddle mount with full mount vehicle transporter combination that does not exceed 97 feet in length ~~[.]~~ ***; or***

(e) A towaway trailer transporter combination that does not exceed:

(1) Eighty-two feet in length; and

(2) Twenty-six thousand pounds in weight.

10. As used in this section:

(a) "Driveaway saddle mount with full mount vehicle transporter combination" means a vehicle combination designed and specifically used to tow up to three trucks or truck-tractors, each connected by a saddle to the frame or fifth wheel of the forward vehicle of the truck-tractor in front of it.

(b) "Motortruck" has the meaning ascribed to it in NRS 482.073.

(c) "Towaway trailer transporter combination" has the meaning ascribed to it in 49 U.S.C. § 31111.

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

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

(a) The maximum weight on any single axle does not exceed 20,000 pounds.

(b) The maximum weight on any tandem axle does not exceed 34,000 pounds.

(c) The maximum weight per tire, measured by pounds per inch of tire width, does not exceed 600 pounds per inch for a steering axle and 500 pounds per inch for all other axles.

(d) Except for a steering axle and axles that weigh less than 10,000 pounds, each axle has at least four tires if the tire width of each tire on the axle is less than or equal to 14 inches. If the maximum weight per tire does not exceed 500 pounds per inch of tire width, an axle may be equipped with tires that have a width of more than 14 inches.

(e) Except as otherwise provided in subsection 2, the maximum overall gross weight on any group of two or more consecutive axles does not exceed

the values set forth in the following formula: W=500 [LN/(N-1) + 12N + 36] wherein:

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

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

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

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

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

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

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

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

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

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

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

Assemblywoman Monroe-Moreno moved that the Assembly concur in the Senate Amendment No. 650 to Assembly Bill No. 377.

Remarks by Assemblywoman Monroe-Moreno.

ASSEMBLYWOMAN MONROE-MORENO:
The amendment adds the word "length" to the limits of exempted vehicles in the bill.

Motion carried by a constitutional majority.

Bill ordered to enrollment.

GUESTS EXTENDED PRIVILEGE OF ASSEMBLY FLOOR

On request of Assemblyman Assefa, the privilege of the floor of the Assembly Chamber for this day was extended to Margie Gonzales.

On request of Assemblywoman Backus, the privilege of the floor of the Assembly Chamber for this day was extended to Sonny Vinuya.

On request of Assemblywoman Bilbray-Axelrod, the privilege of the floor of the Assembly Chamber for this day was extended to Fayyaz Raja.

On request of Assemblyman Carrillo, the privilege of the floor of the Assembly Chamber for this day was extended to Ash Mirchandani.

On request of Assemblywoman Cohen, the privilege of the floor of the Assembly Chamber for this day was extended to Connie Chiang.

On request of Assemblyman Daly, the privilege of the floor of the Assembly Chamber for this day was extended to Christopher Luke, Kawaiola Deguilmo, and Mohalapua Banner.

On request of Assemblywoman Duran, the privilege of the floor of the Assembly Chamber for this day was extended to Emelita Tugas.

On request of Assemblyman Flores, the privilege of the floor of the Assembly Chamber for this day was extended to Jennie Kim.

On request of Assemblyman Fumo, the privilege of the floor of the Assembly Chamber for this day was extended to Evan Louie, Cevan Louie, and Joe Tinio Jr.

On request of Assemblywoman Gorelow, the privilege of the floor of the Assembly Chamber for this day was extended to Ana Wood.

On request of Assemblywoman Jauregui, the privilege of the floor of the Assembly Chamber for this day was extended to Dorothy Domingo.

On request of Assemblywoman Krasner, the privilege of the floor of the Assembly Chamber for this day was extended to Sigal Chattah and Lenna Hovanessian.

On request of Assemblyman Leavitt, the privilege of the floor of the Assembly Chamber for this day was extended to Consul General Wan-Joong Kim and Leah Elmquist.

On request of Assemblywoman Martinez, the privilege of the floor of the Assembly Chamber for this day was extended to Ginalyn Baltazar-Sumbang.

On request of Assemblyman McCurdy, the privilege of the floor of the Assembly Chamber for this day was extended to Vida Lin and Rita Vaswani.

On request of Assemblywoman Miller, the privilege of the floor of the Assembly Chamber for this day was extended to Hieu Le.

On request of Assemblywoman Monroe-Moreno, the privilege of the floor of the Assembly Chamber for this day was extended to Nia Wong and the following students, teachers, and chaperones from Liberty Home School Co-op: Jeffery Neal Berkey Jr., Charity Berkey, Jeffery Neal Berkey III, Cherish Berkey, Lincoln Berkey, Felicity Berkey, Bryce Miano, Luke Vogal, Rachel Loya, Gabriel Loya, Lilly Loya, Noel Loya, Delilah Loya, Johnny Loya, Westly Loya, Janette Whellems, Abigail Whellems, Emma Whellems, Jeanetta Campbell, Joseph Campbell, Nichole Smith, Emma Smith, Aubrey Smith, Hannah Smith, Sadie Smith, Becca Smith, and Gunner Smith.

On request of Assemblywoman Munk, the privilege of the floor of the Assembly Chamber for this day was extended to Sharifa Wahab and Gaity Wahab.

On request of Assemblywoman Nguyen, the privilege of the floor of the Assembly Chamber for this day was extended to Grace T. Vergara-Mactal and Brigadier General William Burks.

On request of Assemblywoman Peters, the privilege of the floor of the Assembly Chamber for this day was extended to Perly Espina and Lindy Frey.

On request of Assemblyman Smith, the privilege of the floor of the Assembly Chamber for this day was extended to Leilani Pimentel and Marietta Hunter.

On request of Assemblywoman Spiegel, the privilege of the floor of the Assembly Chamber for this day was extended to Zhan Okuda-lim and Carolene Layugan.

On request of Assemblywoman Swank, the privilege of the floor of the Assembly Chamber for this day was extended to Brenda Marzan.

On request of Assemblywoman Tolles, the privilege of the floor of the Assembly Chamber for this day was extended to Derek Furukawa, Loe Molino, and Vangie Molino.

On request of Assemblywoman Torres, the privilege of the floor of the Assembly Chamber for this day was extended to Ryan Tsui.

On request of Assemblyman Watts, the privilege of the floor of the Assembly Chamber for this day was extended to Ronald Sumbang.

On request of Assemblyman Yeager, the privilege of the floor of the Assembly Chamber for this day was extended to Tim Mullin and Emily Ku.

Assemblywoman Benitez-Thompson moved that the Assembly adjourn until Thursday, May 9, 2019, at 11:30 a.m.

Motion carried.

Assembly adjourned at 12:20 p.m.

Approved: JASON FRIERSON
Speaker of the Assembly

Attest: SUSAN FURLONG
Chief Clerk of the Assembly