ASSEMBLY BILL NO. 60–ASSEMBLYWOMAN GIUNCHIGLIANI

PREFILED JANUARY 27, 1999

Referred to Committee on Commerce and Labor

SUMMARY—Makes various changes concerning health care services related to contraceptives and hormone replacement therapy. (BDR 57-181)

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

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

AN ACT relating to health care; requiring health insurers to include in certain policies of health insurance coverage for services and prescription drugs and devices related to contraceptives and hormone replacement therapy; providing a religious exemption for certain insurers; prohibiting certain health insurers from committing certain acts concerning coverage for services related to contraceptives and hormone replacement therapy; 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. Chapter 689A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. ***1. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of health insurance which provides coverage for prescription drugs or devices shall include in the policy coverage for:***

(a) Any type of drug or device for contraception; and

(b) Any type of hormone replacement therapy,

which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

2. An insurer that offers or issues a policy of health insurance that provides coverage for prescription drugs shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for a prescription for a contraceptive or hormone replacement

therapy than is required for other prescription drugs covered by the policy;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use in the future any of the services listed in subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing any of the services listed in subsection 1;

(d) Penalize a provider of health care who provides any of the services listed in subsection 1 to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay any of the services listed in subsection 1 to an insured.

3. Except as otherwise provided in subsection 5, a policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

4. The provisions of this section do not:

(a) Require an insurer to provide coverage for fertility drugs.

(b) Prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by paragraphs (a) and (b) of subsection 1 that is the same as the insured is required to pay for other prescription drugs covered by the policy.

5. An insurer which offers or issues a policy of health insurance and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of health insurance and before the renewal of such a policy, provide to the prospective insured, written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

6. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 3. *1. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of health insurance which provides coverage for outpatient care shall include in the policy coverage for any health care service related to contraceptives or hormone replacement therapy.*

2. An insurer that offers or issues a policy of health insurance that provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for

coverage for outpatient care related to contraceptives or hormone replacement therapy than is required for other outpatient care covered by the policy;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use in the future any of the services listed in subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing any of the services listed in subsection 1;

(d) Penalize a provider of health care who provides any of the services listed in subsection 1 to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay any of the services listed in subsection 1 to an insured.

3. Except as otherwise provided in subsection 5, a policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

4. The provisions of this section do not prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by subsection 1 that is the same as the insured is required to pay for other outpatient care covered by the policy.

5. An insurer which offers or issues such a policy of health insurance and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of health insurance and before the renewal of such a policy, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

6. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 4. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the commissioner that the policy is not subject to approval or disapproval by that officer, the commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~[.]~~ ***, and sections 2 and 3 of this act.***

Sec. 5. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 6 and 7 of this act.

Sec. 6. *1. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of group health insurance which provides coverage for prescription drugs or devices shall include in the policy coverage for:*

(a) Any type of drug or device for contraception; and

(b) Any type of hormone replacement therapy,

which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

2. An insurer that offers or issues a policy of group health insurance that provides coverage for prescription drugs shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for a prescription for a contraceptive or hormone replacement therapy than is required for other prescription drugs covered by the policy;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use in the future any of the services listed in subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing any of the services listed in subsection 1;

(d) Penalize a provider of health care who provides any of the services listed in subsection 1 to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay any of the services listed in subsection 1 to an insured.

3. Except as otherwise provided in subsection 5, a policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

4. The provisions of this section do not:

(a) Require an insurer to provide coverage for fertility drugs.

(b) Prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by paragraphs (a) and (b) of subsection 1 that is the same as the insured is required to pay for other prescription drugs covered by the policy.

5. An insurer which offers or issues a policy of group health insurance and which is affiliated with a religious organization is not

required to provide the coverage required by paragraph (a) of subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of group health insurance and before the renewal of such a policy, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall provide notice to each insured, at the time the insured receives his certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.

6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for his employees.

7. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 7. *1. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of group health insurance which provides coverage for outpatient care shall include in the policy coverage for any health care service related to contraceptives or hormone replacement therapy.*

2. An insurer that offers or issues a policy of group health insurance that provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to contraceptives or hormone replacement therapy than is required for other outpatient care covered by the policy;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use in the future any of the services listed in subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing any of the services listed in subsection 1;

(d) Penalize a provider of health care who provides any of the services listed in subsection 1 to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay any of the services listed in subsection 1 to an insured.

3. Except as otherwise provided in subsection 5, a policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the

coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

4. The provisions of this section do not prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by subsection 1 that is the same as the insured is required to pay for other outpatient care covered by the policy.

5. An insurer which offers or issues a policy of group health insurance and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of group health insurance and before the renewal of such a policy, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall provide notice to each insured, at the time the insured receives his certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.

6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for his employees.

7. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 8. Chapter 695B of NRS is hereby amended by adding thereto the provisions set forth as sections 9 and 10 of this act.

Sec. 9. ***1. Except as otherwise provided in subsection 5, an insurer that offers or issues a contract for hospital or medical service which provides coverage for prescription drugs or devices shall include in the contract coverage for:***

(a) Any type of drug or device for contraception; and

(b) Any type of hormone replacement therapy,

which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

2. An insurer that offers or issues a contract for hospital or medical service that provides coverage for prescription drugs shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for a prescription for a contraceptive or hormone replacement therapy than is required for other prescription drugs covered by the contract;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use in the future any of the services listed in subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing any of the services listed in subsection 1;

(d) Penalize a provider of health care who provides any of the services listed in subsection 1 to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay any of the services listed in subsection 1 to an insured.

3. Except as otherwise provided in subsection 5, a contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

4. The provisions of this section do not:

(a) Require an insurer to provide coverage for fertility drugs.

(b) Prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by paragraphs (a) and (b) of subsection 1 that is the same as the insured is required to pay for other prescription drugs covered by the contract.

5. An insurer which offers or issues a contract for hospital or medical service and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a contract for hospital or medical service and before the renewal of such a contract, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall provide notice to each insured, at the time the insured receives his certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.

6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for his employees.

7. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 10. *1. Except as otherwise provided in subsection 5, an insurer that offers or issues a contract for hospital or medical service which provides coverage for outpatient care shall include in the contract coverage for any health care service related to contraceptives or hormone replacement therapy.*

2. An insurer that offers or issues a contract for hospital or medical service that provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to contraceptives or hormone replacement therapy than is required for other outpatient care covered by the contract;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use in the future any of the services listed in subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing any of the services listed in subsection 1;

(d) Penalize a provider of health care who provides any of the services listed in subsection 1 to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay any of the services listed in subsection 1 to an insured.

3. Except as otherwise provided in subsection 5, a contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

4. The provisions of this section do not prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by subsection 1 that is the same as the insured is required to pay for other outpatient care covered by the contract.

5. An insurer which offers or issues a contract for hospital or medical service and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a contract for hospital or medical service and before the renewal of such a contract, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall provide notice to each insured, at the time the insured receives his certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.

6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for his employees.

7. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 11. Chapter 695C of NRS is hereby amended by adding thereto the provisions set forth as sections 12 and 13 of this act.

Sec. 12. ***1. Except as otherwise provided in subsection 5, a health maintenance organization which offers or issues a health care plan that provides coverage for prescription drugs or devices shall include in the plan coverage for:***

(a) Any type of drug or device for contraception; and

(b) Any type of hormone replacement therapy,

which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

2. A health maintenance organization that offers or issues a health care plan that provides coverage for prescription drugs shall not:

(a) Require an enrollee to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for a prescription for a contraceptive or hormone replacement therapy than is required for other prescription drugs covered by the plan;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use in the future any of the services listed in subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from accessing any of the services listed in subsection 1;

(d) Penalize a provider of health care who provides any of the services listed in subsection 1 to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay any of the services listed in subsection 1 to an enrollee.

3. Except as otherwise provided in subsection 5, evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

4. The provisions of this section do not:

(a) Require a health maintenance organization to provide coverage for fertility drugs.

(b) Prohibit a health maintenance organization from requiring an enrollee to pay a deductible, copayment or coinsurance for the coverage required by paragraphs (a) and (b) of subsection 1 that is the same as the

enrollee is required to pay for other prescription drugs covered by the plan.

5. A health maintenance organization which offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of subsection 1 if the health maintenance organization objects on religious grounds. The health maintenance organization shall, before the issuance of a health care plan and before renewal of enrollment in such a plan, provide to the group policyholder or prospective enrollee, as applicable, written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection. The health maintenance organization shall provide notice to each enrollee, at the time the enrollee receives his evidence of coverage, that the health maintenance organization refused to provide coverage pursuant to this subsection.

6. If a health maintenance organization refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for his employees.

7. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 13. *1. Except as otherwise provided in subsection 5, a health maintenance organization that offers or issues a health care plan which provides coverage for outpatient care shall include in the plan coverage for any health care service related to contraceptives or hormone replacement therapy.*

2. A health maintenance organization that offers or issues a health care plan that provides coverage for outpatient care shall not:

(a) Require an enrollee to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to contraceptives or hormone replacement therapy than is required for other outpatient care covered by the plan;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use in the future any of the services listed in subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from accessing any of the services listed in subsection 1;

(d) Penalize a provider of health care who provides any of the services listed in subsection 1 to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay any of the services listed in subsection 1 to an enrollee.

3. Except as otherwise provided in subsection 5, evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

4. The provisions of this section do not prohibit a health maintenance organization from requiring an enrollee to pay a deductible, copayment or coinsurance for the coverage required by subsection 1 that is the same as the enrollee is required to pay for other outpatient care covered by the plan.

5. A health maintenance organization which offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the health maintenance organization objects on religious grounds. The health maintenance organization shall, before the issuance of a health care plan and before renewal of enrollment in such a plan, provide to the group policyholder or prospective enrollee, as applicable, written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection. The health maintenance organization shall provide notice to each enrollee, at the time the enrollee receives his evidence of coverage, that the health maintenance organization refused to provide coverage pursuant to this subsection.

6. If a health maintenance organization refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for his employees.

7. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 14. 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.170 to 695C.200, inclusive, 695C.250 and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid ~~[pursuant to a contract with the welfare division of the department of human resources.]~~ ***under the state plan for Medicaid.*** 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 sections 12 and 13 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. 15. 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 he 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.170 to 695C.200, inclusive, or 695C.207 ~~[,]~~ ***or section 12 or 13 of this act;***

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

(d) The state board of health certifies to the commissioner that:

(1) The health maintenance organization does not meet the requirements of subsection 2 of NRS 695C.080; or

(2) The health maintenance organization 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 for complaints required by NRS 695C.260 in a manner reasonably to dispose of valid complaints;

(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

(j) 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 he 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. 16. 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 public 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 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 689B.030 to 689B.050, inclusive, ***and sections 6 and 7 of this act*** apply to coverage provided pursuant to this paragraph.

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

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