SENATE BILL NO. 320–SENATOR O'CONNELL (BY REQUEST)

MARCH 13, 2001

Referred to Committee on Commerce and Labor

SUMMARY—Requires managed care organizations to establish system for independent review of final adverse determinations concerning allocations of health care resources and services. (BDR 57-676)

FISCAL NOTE: Effect on Local Government: Yes.
Effect on the State: Yes.

~

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

AN ACT relating to health care; making various changes relating to the rights of persons under certain policies, contracts and plans of health insurance to obtain independent review of determinations by certain health insurers that allocations of health care services and resources provided or proposed to be provided to insured persons are not medically necessary and appropriate, or are experimental or investigational; providing a penalty; 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 683A of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 9, inclusive, of this act.

Sec. 2. ***As used in sections 2 to 9, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3, 4 and 5 of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"External review" means a system in which an independent review organization provides a decision concerning whether or not an allocation of health care resources and services provided or proposed to be provided to an insured is medically necessary and appropriate, or is experimental or investigational. The term does not include responding to requests made by an insured for clarification of his coverage.***

Sec. 4. ***"Independent review organization" means an organization certified by the commissioner to accept assignments of requests for external review.***

Sec. 5. ***"Insured" means a natural person who has contracted for or participates in coverage under a policy of health insurance, a policy of group health insurance, a health benefit plan, a contract for hospital, medical or dental services, a contract with a health maintenance***

organization, a contract for limited health services, or any other program providing payment, reimbursement or indemnification for the costs of health care for himself or his dependents, or both.

Sec. 6. *1. No organization may accept an assignment to perform an external review, or offer or agree to do so, unless it has obtained a certificate as an independent review organization from the commissioner.*

2. To apply to the commissioner for certification as an independent review organization, an organization must:

(a) File an application on a form provided by the commissioner that includes or is accompanied by any information required by the commissioner; and

(b) Pay a fee of $250.

3. Certification pursuant to this section must be renewed on or before March 1 of each year by providing the information required pursuant to subsection 2 and paying a renewal fee of $250.

Sec. 7. *1. Except as otherwise provided in subsection 4, before the commissioner may certify an independent review organization, the organization must:*

(a) Demonstrate to the satisfaction of the commissioner that it is able to carry out, on a timely basis, the duties of an independent review organization as set forth in sections 2 to 9, inclusive, and 19 to 30, inclusive, of this act. This demonstration must include, without limitation, proof that the organization employs, contracts with or otherwise retains only persons who are qualified by reason of their education, training, professional licensing and experience to perform the duties assigned to them.

(b) Provide assurances acceptable to the commissioner that the organization will:

(1) Conduct its external review activities in conformity with the provisions of sections 2 to 9, inclusive, and 19 to 30, inclusive of this act;

(2) Provide its decisions in a clear, consistent, thorough and timely manner; and

(3) Avoid conflicts of interest.

2. For the purposes of this section, an independent review organization has a conflict of interest if the organization or an employee, agent or contractor of the organization who performs external review has a material professional, familial or financial interest in any person who has a substantial interest in the outcome of the review, including, without limitation:

(a) The insured;

(b) The insurer or any officer, director or management employee of the insurer;

(c) The provider of health care services provided or proposed to be provided, his partner or any other member of his medical group or practice;

(d) The hospital or other licensed health care facility at which the service or treatment subject to review has been or will be provided; or

(e) A developer, manufacturer or other person with a substantial interest in the principal procedure, equipment, drug, device or other instrumentality that is the subject of the review.

3. The commissioner shall not certify an independent review organization that is affiliated with a:

(a) Health care plan; or

(b) National, state or local trade association.

4. An independent review organization that is certified or accredited by a nationally recognized accrediting body shall be deemed to have satisfied all the conditions and qualifications required for certification pursuant to this section.

5. As used in this section, "provider of health care" means any physician or other person who is licensed, certified or otherwise authorized in this or any other state to furnish any health care service.

Sec. 8. ***An independent review organization, its employees, agents or contractors, acting in good faith, are not liable for damages arising from the performance of an external review except for damages caused by their gross negligence.***

Sec. 9. ***A person who violates any provision of sections 2 to 9, inclusive, of this act, in addition to any criminal penalty, shall be punished by an administrative fine of not more than $1,000.***

Sec. 10. NRS 683A.376 is hereby amended to read as follows:

683A.376 As used in NRS 683A.375 to 683A.379, inclusive:

1. "Agent who performs utilization review" includes any person who performs such review except a person acting on behalf of the Federal Government, but only to the extent that the person provides the service for the Federal Government or an agency thereof.

2. "Insured" means a natural person who has contracted for or participates in coverage under a policy of insurance, a contract with a health maintenance organization, a plan for hospital, medical or dental services ***,*** or any other program providing payment, reimbursement or indemnification for the costs of health care for himself, his dependents ~~[,]~~ or both.

3. "Utilization review" means a system that provides, at a minimum, for review of the ***medical*** necessity and appropriateness of the allocation of health care resources and services provided or proposed to be provided to an insured. The term does not include responding to requests made by an insured for clarification of his coverage.

Sec. 11. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

No policy of health insurance that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care may be delivered or issued for delivery in this state unless it provides a system for resolving complaints of an insured concerning such services that complies with the provisions of NRS 695G.200 to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act.

Sec. 12. NRS 689B.0285 is hereby amended to read as follows:

689B.0285 1. Each insurer that issues a policy of group health insurance in this state shall establish a system for resolving ~~[any]~~

complaints of an insured concerning health care services covered under the policy. The system must be approved by the commissioner in consultation with the state board of health.

2. A system for resolving complaints pursuant to subsection 1 must include an initial investigation, a review of the complaint by a review board and a procedure for appealing a determination regarding the complaint. The majority of the members on a review board must be insureds who receive health care services pursuant to a policy of group health insurance issued by the insurer.

3. The commissioner or the state board of health may examine the system for resolving complaints established pursuant to this section at such times as either deems necessary or appropriate.

4. Each insurer that issues a policy of group health insurance in this state that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care must provide a system for resolving complaints of an insured concerning such services that complies with the provisions of NRS 695G.200 to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act.

Sec. 13. NRS 689C.156 is hereby amended to read as follows:

689C.156 1. As a condition of transacting business in this state with small employers, a carrier shall actively market to a small employer each health benefit plan which is actively marketed in this state by the carrier to any small employer in this state. The health insurance plans marketed pursuant to this section by the carrier must include, without limitation, a basic health benefit plan and a standard health benefit plan. A carrier shall be deemed to be actively marketing a health benefit plan when it makes available any of its plans to a small employer that is not currently receiving coverage under a health benefit plan issued by that carrier.

2. ***If a health benefit plan marketed pursuant to this section provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care, it must provide a system for resolving complaints of an insured concerning such services that complies with the provisions of NRS 695G.200 to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act.***

3. A carrier shall issue to a small employer any health benefit plan marketed in accordance with this section if the eligible small employer applies for the plan and agrees to make the required premium payments and satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with NRS 689C.015 to 689C.355, inclusive, and 689C.610 to 689C.980, inclusive, except that a carrier is not required to issue a health benefit plan to a self-employed person who is covered by, or is eligible for coverage under, a health benefit plan offered by another employer.

Sec. 14. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

Each contract that is authorized pursuant to this chapter must, if it provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care, provide a system for resolving complaints of an insured concerning such services that complies with the

provisions of NRS 695G.200 to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act.

Sec. 15. NRS 695B.181 is hereby amended to read as follows:

695B.181 1. Except as otherwise provided in NRS 695B.182 ***and section 14 of this act*** and subject to the approval of the commissioner, any contract which is authorized pursuant to this chapter may include a provision which requires the parties to the contract to submit for binding arbitration any dispute between the parties concerning any matter directly or indirectly related to, or associated with, the contract. If such a provision is included in the contract:

(a) A person who elects to be covered by the contract must be given the opportunity to decline to participate in binding arbitration at the time he elects to be covered by the contract.

(b) It must clearly state that the parties to the contract who have not declined to participate in binding arbitration agree to forego their right to resolve any such dispute in a court of law or equity.

2. Except as otherwise provided in subsection 3, the arbitration must be conducted pursuant to the rules for commercial arbitration established by the American Arbitration Association. The insurer is responsible for any administrative fees and expenses relating to the arbitration, except that the insurer is not responsible for attorney's fees and fees for expert witnesses unless those fees are awarded by the arbitrator.

3. If a dispute required to be submitted to binding arbitration requires an immediate resolution to protect the physical health of a person insured under the contract, any party to the dispute may waive arbitration and seek declaratory relief in a court of competent jurisdiction.

4. If a provision described in subsection 1 is included in a contract, the provision shall not be deemed unenforceable as an unreasonable contract of adhesion if the provision is included in compliance with the provisions of subsection 1.

Sec. 16. NRS 695C.260 is hereby amended to read as follows:

695C.260 Every health maintenance organization shall establish a complaint system which complies with the provisions of NRS 695G.200 to 695G.230, inclusive ~~.~~ ***, and sections 19 to 30, inclusive, of this act.***

Sec. 17. NRS 695F.230 is hereby amended to read as follows:

695F.230 1. Each prepaid limited health service organization shall establish a system for the resolution of written complaints submitted by enrollees and providers.

2. The provisions of subsection 1 do not prohibit an enrollee or provider from filing a complaint with the commissioner or limit the commissioner's authority to investigate such a complaint.

3. Each prepaid limited health service organization that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care shall provide a system for resolving complaints of an insured concerning such services that complies with the provisions of NRS 695G.200 to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act.

Sec. 18. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 19 to 30, inclusive, of this act.

Sec. 19. *As used in NRS 695G.200 to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 20, 21 and 22 of this act have the meanings ascribed to them in those sections.*

Sec. 20. *"Adverse determination" means the decision of a managed care organization that an allocation of health care resources and services which is provided or proposed to be provided to an insured is not medically necessary and appropriate, or is experimental or investigational. The term does not include the decision of a managed care organization that such an allocation is not a covered benefit.*

Sec. 21. *"External review" has the meaning ascribed to it in section 3 of this act.*

Sec. 22. *"Independent review organization" has the meaning ascribed to it in section 4 of this act.*

Sec. 23. *1. For the purposes of NRS 695G.200 to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act, an adverse determination is final if the insured has exhausted all procedures provided in the health care plan for reviewing the determination within the managed care organization.*

2. A final adverse determination shall be deemed to exist for the purpose of assigning it to an independent review organization for external review if:

(a) An insured has exhausted all procedures provided in the health care plan for reviewing a determination within a managed care organization, but the managed care organization has failed to render a decision within the time allotted by the plan for it to do so; or

(b) A managed care organization assigns a matter concerning an insured to an independent review organization for external review without requiring the insured to exhaust all procedures provided in the health care plan for reviewing the determination within the managed care organization.

Sec. 24. *1. For the purposes of NRS 695G.200 to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act, an allocation of health care resources and services that is provided or proposed to be provided to an insured is medically necessary and appropriate if it is:*

(a) Consistent with the diagnosis and treatment of an insured's illness or injury according to generally accepted standards of medical practice;

(b) Needed to improve a specific health condition of an insured or preserve his existing state of health;

(c) Clinically appropriate with regard to the type, frequency, extent, location and duration of care;

(d) Not solely for the convenience of the insured, his provider of health care, or the hospital or other licensed health care facility at which the care takes place; and

(e) The most clinically appropriate level of health care that can be safely provided to the insured.

2. An allocation of health care resources and services that is provided or proposed to be provided to an insured is not medically necessary and appropriate solely because it is prescribed by a provider of health care.

Sec. 24.5. *1. A managed care organization shall develop standards for selecting independent review organizations for the performance of external reviews.*

2. Except as otherwise provided in subsection 3, a managed care organization shall, before it enters into a contract with an independent review organization for the performance of external reviews, obtain the approval of the commissioner of the standards used by the managed care organization to select independent review organizations. The standards must include, without limitation:

(a) Standards to ensure the independence of the independent review organizations; and

(b) Standards to ensure the independence of each employee, agent or contractor of the independent review organizations who performs external review.

3. The commissioner shall approve or object to the standards within 30 days after receiving a copy of the standards from the managed care organization. If the commissioner fails to approve or object to the standards within 30 days, the standards shall be deemed to be approved.

Sec. 25. *A managed care organization shall:*

1. Enter into contracts for the performance of external reviews with four or more independent review organizations.

2. File with the commissioner a copy of each contract the managed care organization enters into with an independent review organization for the performance of external reviews.

3. Assign requests for external review on a rotating basis among the independent review organizations with which it has contracts for the performance of external reviews.

Sec. 26. *1. A managed care organization shall grant a request for external review of a final adverse determination if:*

(a) The insured or an authorized representative of the insured serves a request for external review, in writing, on the managed care organization not more than 60 days after the insured receives actual notice of the final adverse determination; and

(b) Providing the health care service is likely to involve a cost to the managed care organization greater than $500.

2. A managed care organization may request an external review.

Sec. 27. *1. Except as otherwise provided in section 28 of this act, if a managed care organization grants a request for external review of a final adverse determination, it shall:*

(a) Assign the request to an independent review organization not later than 5 working days thereafter; and

(b) Provide that independent review organization with all relevant documents in its possession not later than 5 working days after the date of the assignment.

2. An independent review organization that accepts a request for external review shall:

(a) Demand any additional documents or other evidence not later than 5 working days after it receives the documents submitted by the managed care organization pursuant to subsection 1;

(b) Complete its external review not later than 15 days after it receives all documents and other evidence provided or demanded pursuant to this section unless the insured and the managed care organization consent to a longer period of time;

(c) Provide notification of its decision to the insured, his provider of health care and the managed care organization not later than 5 working days after the external review is completed; and

(d) Provide its decision in writing to the insured, his provider of health care and the managed care organization not later than 5 working days after the notification is given.

Sec. 28. *1. A managed care organization shall grant a request for external review of a final adverse determination on an expedited basis if:*

(a) Requested by an insured or an insured's provider of health care; and

(b) The insured's provider of health care substantiates that failure to proceed on an expedited basis could jeopardize the life or health of the insured.

2. A managed care organization shall grant or deny a request for external review on an expedited basis not later than 72 hours after it receives substantiation from the insured's provider of health care that failure to proceed on an expedited basis could jeopardize the life or health of the insured.

3. If a managed care organization grants a request for external review on an expedited basis, it shall:

(a) Assign the request to an independent review organization not later than 1 working day thereafter; and

(b) Provide that independent review organization with all relevant documents in its possession at the time it assigns the request.

4. An independent review organization that accepts an assignment for external review on an expedited basis shall:

(a) Complete its external review not later than 2 working days after the independent review organization receives the assignment unless the insured and the managed care organization consent to a longer period of time;

(b) Provide notification of its decision by telephone to the insured, his provider of health care and the managed care organization not later than 1 working day after the external review is completed; and

(c) Provide its decision in writing to the insured, his provider of health care and the managed care organization not later than 5 working days after the external review is completed.

Sec. 29. *The decision of an independent review organization on a request for external review must be based on:*

1. Documentary evidence provided by the parties pursuant to section 27 or 28 of this act.

2. Medical evidence, including, without limitation:

(a) The likelihood that the health care service, if provided, would produce a significant positive outcome;

(b) Professional standards of safety and effectiveness for diagnosis, care and treatment that are generally recognized in the United States;

(c) Reports in peer-reviewed literature;

(d) Evidence based medicine, including, without limitation, reports and guidelines published by nationally recognized professional organizations that include supporting scientific data; and

(e) Opinions of independent physicians who are experts in the health specialty involved to the extent that the opinions are based on the consensus of physicians who practice in that specialty.

3. The terms and conditions regarding benefits set forth in the evidence of coverage issued by the managed care organization to the insured.

Sec. 30. ***If the decision of an independent review organization on a request for external review is in favor of the insured, the decision is final, conclusive and binding upon the managed care organization.***

Sec. 31. NRS 695G.080 is hereby amended to read as follows:

695G.080 ***1.*** "Utilization review" means the various methods that may be used by a managed care organization to review the amount and appropriateness of the provision of a specific health care service to an insured.

2. The term does not include an external review conducted pursuant to NRS 695G.200 to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act.

Sec. 32. NRS 695G.200 is hereby amended to read as follows:

695G.200 1. Each managed care organization shall establish a system for resolving complaints of an insured concerning:

(a) Payment or reimbursement for covered health care services;

(b) Availability, delivery or quality of covered health care services, including, without limitation, an adverse determination made pursuant to utilization review ~~[;]~~ ***or a final adverse determination;*** or

(c) The terms and conditions of a health care plan.

The system must be approved by the commissioner in consultation with the state board of health.

2. If an insured makes an oral complaint, a managed care organization shall inform the insured that if he is not satisfied with the resolution of the complaint, he must file the complaint in writing to receive further review of the complaint.

3. Each managed care organization shall:

(a) Upon request, assign an employee of the managed care organization to assist an insured or other person in filing a complaint ***,*** ~~[or]~~ appealing a decision of the review board ~~[;]~~ ***or requesting an external review;***

(b) Authorize an insured who appeals a decision of the review board to appear before the review board to present testimony at a hearing concerning the appeal; and

(c) Authorize an insured to introduce any documentation into evidence at a hearing of a review board and require an insured to provide the

documentation required by his health care plan to the review board not later than 5 ~~[business]~~ ***working*** days before a hearing of the review board.

4. The commissioner or the state board of health may examine the system for resolving complaints established pursuant to this section at such times as either deems necessary or appropriate.

Sec. 33. NRS 695G.210 is hereby amended to read as follows:

695G.210 1. A system for resolving complaints created pursuant to NRS 695G.200 ***to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act*** must include, without limitation, an initial investigation, a review of the complaint by a review board ***,*** ~~[and]~~ a procedure for appealing a ***decision of a review board and procedures for obtaining an external review of a final adverse*** determination ***.*** ~~[regarding the complaint.]~~ The majority of the members of ~~[the]~~ ***each*** review board must be insureds who receive health care services from the managed care organization.

2. Except as otherwise provided in subsection 3, a review board shall complete its review regarding a complaint or appeal and notify the insured of its determination not later than 30 days after the complaint or appeal is filed, unless the insured and the review board have agreed to a longer period of time.

3. If a complaint involves an imminent and serious threat to the health of the insured, the managed care organization shall inform the insured immediately of his right to an expedited review of his complaint ~~[.]~~ ***by a review board.*** If an expedited review is required, the review board shall notify the insured in writing of its determination within 72 hours after the complaint is filed.

4. Notice provided to an insured by a review board regarding a complaint must include, without limitation, an explanation of any further rights of the insured regarding the complaint that are available under his health care plan.

Sec. 34. NRS 695G.220 is hereby amended to read as follows:

695G.220 1. Each managed care organization shall submit to the commissioner and the state board of health an annual report regarding its system for resolving complaints established pursuant to NRS 695G.200 ***to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act. The report must be*** on a form prescribed by the commissioner in consultation with the state board of health which includes, without limitation:

(a) A description of the procedures used for resolving complaints of an insured;

(b) The total number of complaints ***,*** ~~[and]~~ appeals ***and requests for external review*** handled through the system for resolving complaints since the last report and a compilation of the causes underlying the complaints filed;

(c) The current status of each complaint ***,*** ~~[and]~~ appeal ***and request for external review*** filed; and

(d) The average amount of time that was needed to resolve a complaint ***.*** ~~[and an appeal, if any.]~~

2. Each managed care organization shall maintain records of complaints filed with it which concern something other than health care services and shall submit to the commissioner a report summarizing such

complaints at such times and in such format as the commissioner may require.

Sec. 35. NRS 695G.230 is hereby amended to read as follows:

695G.230 1. Following approval by the commissioner, each managed care organization shall provide written notice to an insured, in clear and comprehensible language that is understandable to an ordinary layperson, explaining the ~~[right]~~ ***rights*** of the insured ~~[to file a written complaint and to obtain an expedited review pursuant to NRS 695G.210.]~~ ***under the system for resolving complaints established pursuant to NRS 695G.200 to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act.*** Such notice must be provided to an insured:

(a) At the time he receives his certificate of coverage or evidence of coverage;

(b) Any time that the managed care organization denies coverage of a health care service or limits coverage of a health care service to an insured; and

(c) Any other time deemed necessary by the commissioner.

2. Any time that a managed care organization denies coverage of a health care service to an insured, including, without limitation, a health maintenance organization that denies a claim related to a health care plan pursuant to NRS 695C.185, it shall notify the insured in writing within 10 working days after it denies coverage of the health care service of:

(a) The reason for denying coverage of the service;

(b) The criteria by which the managed care organization or insurer determines whether to authorize or deny coverage of the health care service; and

(c) His ~~[right to file a written complaint and the procedure for filing such a complaint.]~~ ***rights under the system for resolving complaints established pursuant to NRS 695G.200 to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act and the procedures for exercising those rights.***

3. A written notice which is approved by the commissioner shall be deemed to be in clear and comprehensible language that is understandable to an ordinary layperson.

Sec. 36. Chapter 287 of NRS is hereby amended by adding thereto a new section to read as follows:

A health insurance program offered by the board that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care must provide a system for resolving complaints of an insured concerning such services that complies with the provisions of NRS 695G.200 to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act.

Sec. 37. 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 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 689B.030 to 689B.050, inclusive, apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0359 do not apply to such coverage.

(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.

3. All group insurance offered pursuant to this section that provides, delivers, arranges for, pays for or reimburses any cost of health care services through managed care must provide a system for resolving complaints of an insured concerning such services that complies with the provisions of NRS 695G.200 to 695G.230, inclusive, and sections 19 to 30, inclusive, of this act.

Sec. 38. NRS 287.0402 is hereby amended to read as follows:

287.0402 As used in NRS 287.0402 to 287.049, inclusive, ***and section 36 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 287.0404 and 287.0406 have the meanings ascribed to them in those sections.

Sec. 39. The amendatory provisions of this act apply to all policies, contracts and plans for health insurance, managed care or the provision of health care services entered into or renewed on or after July 1, 2002.

Sec. 40. The amendatory provisions of this act do not apply to offenses committed before July 1, 2002.

Sec. 41. This act becomes effective on July 1, 2002.

㉚