Amendment No. 462

Assembly Amendment to Assembly Bill No. 480	(BDR 23-950)
Proposed by: Committee on Government Affairs	
Amendment Box:	
Resolves Conflicts with: N/A	
Amends: Summary: Yes Title: Yes Preamble: No Joint Sponsorship: No Digest: No	

ASSEMBLY ACTION	Initial and Date	SENATE ACTION	Initial and Date
Adopted ☐ Lost ☐		Adopted ☐ Lost ☐	
Concurred In ☐ Not ☐		Concurred In ☐ Not ☐	
Receded ☐ Not ☐		Receded ☐ Not ☐	

Amend the bill as a whole by deleting sections 1 through 24 and adding new sections designated sections 1 through 20, following the enacting clause, to read as follows:

"**Section 1.** Chapter 287 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 18, inclusive, of this act.

Sec. 2. ***As used in sections 2 to 18, inclusive, of this act, unless the context otherwise requires, the words and terms defined in sections 3 to 10, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"Beneficiary" means a person designated by a participant, or by the terms of a plan, who is or may become entitled to a benefit under the plan.***

Sec. 4. ***"District" means a county school district in a county whose population is less than 100,000.***

AM Date: 4/25/2005

A.B. No. 480—Authorizes establishment of plans of group insurance for officers and employees of certain school districts and their dependents.

Sec. 5. ***"Employee organization" means an organization of any kind having as one of its purposes improvement of the terms and conditions of employment of the employees of a district.***

Sec. 6. ***"Fiduciary" means any person who is responsible for the establishment, management, operation, control or administration of a plan or who contracts with a person to perform any such function with respect to a plan. The term includes, without limitation, any administrator, officer, trustee or custodian of a plan.***

Sec. 7. ***"Participant" means any employee or former employee of a district who is or may become eligible to receive a benefit of any type from a plan covering employees of the district, or whose beneficiaries may be eligible to receive any such benefit.***

Sec. 8. ***"Party in interest" means any fiduciary or employee of a plan or any person who provides services to the plan.***

Sec. 9. ***"Plan" means any fund or program established or maintained by a district or by an employee organization of a district, or by both, to provide for its participants or their beneficiaries, or both, through the purchase of insurance or other means, medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability or death, or any combination of these benefits. The term includes, without limitation, any such fund or program established or maintained pursuant to a collective bargaining agreement between a district and an employee organization that is recognized by the district pursuant to chapter 288 of NRS.***

Sec. 10. ***"Sponsor" means:***

1. In the case of a plan established or maintained by a single district, the district;

2. In the case of a plan established or maintained by an employee organization, the employee organization; or

3. In the case of a plan established or maintained by two or more districts, two or more employee organizations, or jointly by one or more districts and one or more employee organizations, the association, committee, board of trustees or other similar group of representatives of the parties who establish or maintain the plan.

Sec. 11. ***1. A fiduciary shall act:***

(a) Solely in the interest of the participants and beneficiaries, as a whole, of the plan;

(b) For the exclusive purpose of providing benefits to participants and beneficiaries and defraying the reasonable expenses of administering the plan;

(c) With the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a similar capacity and familiar with such matters would use in the conduct of an enterprise of a similar character and with similar purposes;

(d) To diversify the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(e) In accordance with the documents and instruments governing the plan insofar as they are not inconsistent with the provisions of sections 2 to 18, inclusive, of this act.

2. A fiduciary must not derive any benefit from the operation of the plan except as he may be entitled to receive as a participant in the plan.

3. A fiduciary shall not engage in any transaction for monetary gain with a party in interest.

4. A fiduciary who breaches any duty, trust or obligation owed to the plan or its participants or beneficiaries by virtue of his status as a fiduciary is liable to the plan and to any aggrieved participant or beneficiary for any loss caused by the breach. If a plaintiff who brings an action

against a fiduciary pursuant to this subsection is the prevailing party in the action, the fiduciary is liable to the plaintiff for the attorney's fees and costs of suit reasonably incurred by the plaintiff.

5. The provisions of this section do not prohibit the payment of reasonable compensation to a fiduciary for services rendered by the fiduciary to the plan.

Sec. 12. ***1. Except as otherwise provided in subsection 2, a fiduciary may purchase services or insurance from any person or entity that the fiduciary determines to have the financial resources to meet all the obligations of the plan.***

2. A fiduciary may purchase coverage for the plan from an insurance company or health maintenance organization if the insurance company or health maintenance organization:

(a) Has and maintains a rating of:

(1) "B++" or better by A.M. Best Company, Inc.;

(2) "Aa3" or better by Moody's Investors Service, Inc.;

(3) "AA-" or better by Standard & Poor's Ratings Services; or

(4) "B+" or better by Weiss Ratings, Inc.; or

(b) Is a domestic insurer licensed by the Commissioner of Insurance.

Sec. 13. ***1. Within 120 days after a plan is established, and within 120 days after any material modification of the plan, the sponsor of the plan shall send a description of the plan to each participant and to the Commissioner of Insurance. The description must include, without limitation:***

(a) An explanation of:

(1) The benefits provided by the plan;

(2) The method used to provide the benefits of the plan, including, without limitation, insurance or self-insurance;

(3) The eligibility requirements to receive benefits provided by the plan;

(4) The manner in which claims are processed; and

(5) The procedure for appealing denials of claims; and

(b) The name, business address and business telephone number of:

(1) The administrator of the plan;

(2) Each fiduciary of the plan; and

(3) Each entity which provides benefits under the plan.

2. The description of the plan must be written in plain English.

3. A description of a plan submitted to the Commissioner of Insurance pursuant to this section is a public record for purposes of NRS 239.010.

Sec. 14. ***1. Within 90 days after the end of each fiscal year in which the plan is in operation, the sponsor of the plan shall send to each participant and to the Commissioner of Insurance a summary of the financial condition of the plan as of the end of that fiscal year. The summary must include, without limitation:***

(a) The number of participants in the plan;

(b) The revenue, expenses, assets and liabilities of the plan; and

(c) If the plan is self-funded in whole or in part, a statement from a qualified actuary as to the adequacy of any reserves maintained by the plan.

2. A summary submitted to the Commissioner of Insurance pursuant to this section is a public record for purposes of NRS 239.010.

Sec. 15. ***1. Within 90 days after the end of each fiscal year in which the plan is in operation, the sponsor shall provide to the Commissioner of Insurance a report of the plan, as of the end of that fiscal year. The report must be in a form prescribed by the Commissioner and must include, without limitation:***

(a) The number of active and retired employees participating in the plan;

(b) The name, business address and business telephone number of:

(1) Each fiduciary of the plan;

(2) Each entity which provides insurance or benefits under the plan; and

(3) Each accountant, insurer, actuary, administrator, investment manager or custodian of the plan and, if applicable, a statement explaining why any business relationship between the plan and such person was terminated;

(c) If the plan provides at least some benefits through the purchase of insurance:

(1) The rate of the premium for each category of insurance in the plan;

(2) The average number of participants covered under each category of insurance in the plan during each month of the applicable fiscal year;

(3) The dividends, retroactive adjustments of rates, commissions and fees for administrative services, if any, paid by the provider of insurance;

(4) The total amount of the claims paid during the applicable fiscal year if the plan has rates based on other than a fully pooled basis; and

(5) The name and business address of any person who received a commission from the plan during the applicable fiscal year, the amount paid to that person and the service provided for payment; and

(d) If the plan provides at least some benefits through self-funding:

(1) A financial statement prepared in accordance with generally accepted accounting principles;

(2) A statement of accounts from a certified public accountant attesting that he has examined:

(I) The financial statement of the plan and found the financial statement to be prepared in accordance with generally accepted accounting principles; and

(II) The financial records of the plan and found the financial records to be maintained in conformity with generally accepted accounting principles;

(3) A description of the plan, including, without limitation, any significant changes to the plan made during the fiscal year and the effect of such changes on the benefits provided by the plan;

(4) A description of any material lease commitments, other contingent liabilities and other similar commitments or liabilities;

(5) A description of any agreements or transactions made by or on behalf of the plan with any parties in interest;

(6) A statement from a qualified actuary as to the adequacy of reserves established for contingencies and claims incurred and outstanding but not reported; and

(7) A financial statement, in a form prescribed by the Commissioner of Insurance, setting forth:

(I) The number of participants enrolled in each category of insurance in the plan during each month;

(II) The contributions paid to the plan each month by any participants in the plan and any employers for the coverage of participants and beneficiaries in the plan;

(III) The amount paid, each month, to any person who received financial compensation from the plan for any service rendered to the plan or its participants;

(IV) The amount paid, each month, for stop-loss insurance and medical management services, and any access fees paid to preferred-provider organizations, prescription benefit managers or similar services;

(V) The total assets and liabilities of the plan for each month;

(VI) A schedule of all investments of the plan for each month; and

(VII) A schedule of all loans made by or to the plan for each month.

2. A report submitted to the Commissioner of Insurance pursuant to this section is a public record for the purposes of NRS 239.010.

Sec. 16. ***1. The Commissioner of Insurance shall review the report described in section 15 of this act and evaluate the financial condition of the plan in accordance with the standards and procedures applicable to insurers licensed to transact the business of insurance in this State. If the Commissioner determines that the plan is in hazardous financial condition, the Commissioner shall inform the sponsor of the plan of that determination.***

2. If the sponsor of a plan is informed by the Commissioner of Insurance of a determination of hazardous financial condition, as described in subsection 1, the sponsor shall:

(a) Immediately give written notice of the determination to the participants in the plan; and

(b) Within a reasonable time determined by the Commissioner of Insurance, deliver to the Commissioner a written proposal to protect the interests of the participants and beneficiaries of

the plan and to cure the hazardous financial condition of the plan. The proposal must be approved by the Commissioner. If the Commissioner determines that the plan is not satisfactory, the Commissioner may order the plan to be terminated.

3. A proposal to restore the solvency of a plan submitted to the Commissioner of Insurance pursuant to this section is a public record for the purposes of NRS 239.010.

4. As used in this section, "hazardous financial condition" means a condition that, based on current or reasonably anticipated financial circumstances, while not yet qualifying as financial impairment or insolvency, is unlikely to allow:

(a) Obligations to participants, with respect to known claims and reasonably anticipated claims, to be met; or

(b) Other obligations in the normal course of business to be paid.

Sec. 17. ***1. If a plan is self-funded and has 2,000 or fewer participants, the plan must obtain a contract of stop-loss insurance to provide coverage in the event that a claim relating to any one person, during a plan year, exceeds the individual threshold per participant for the types of plans, categorized by number of participants and amount of surplus, described below:***

Number of participants	***Free surplus***	***Individual threshold per participant***
500 or less	***Less than $100,000***	***$25,000***
500 or less	***$100,000 or more***	***$50,000***
501 to 2,000	***Less than $250,000***	***$50,000***
501 to 2,000	***$250,000 or more***	***$100,000***

2. Any contract for stop-loss insurance as described in this section must:

(a) Provide that if the contract is terminated, a claim will remain eligible for payment if:

(1) The claim is incurred during the period in which the contract for stop-loss insurance was in effect; and

(2) The claim is submitted for payment not later than 90 days after the date that the contract is terminated; or

(b) Be supplemented by another contract of insurance which pays a claim if:

(1) The claim is incurred during the period in which the contract for stop-loss insurance was in effect; and

(2) The claim is submitted for payment not later than 90 days after the date that the contract is terminated.

3. As used in this section, "free surplus" means the amount by which the total of the cash and investments of a plan exceeds the total of its reported claims and its reserves for incurred but unreported claims and expenses.

Sec. 18. ***The Commissioner of Insurance shall adopt regulations to carry out the provisions of sections 2 to 18, inclusive, of this act.***

Sec. 19. If a plan is in existence on July 1, 2005, the sponsor of the plan, as those terms are defined in sections 9 and 10 of this act, shall, on or before October 1, 2005, send to each participant in the plan a description of the plan, as described in section 13 of this act.

Sec. 20. 1. This section and section 18 of this act become effective upon passage and approval.

2. Sections 1 through 17, inclusive, and 19 of this act become effective on July 1, 2005.".

Amend the title of the bill to read as follows:

"AN ACT relating to programs for public employees; establishing requirements for certain plans of group insurance for employees of certain school districts; and providing other matters properly relating thereto.".

Amend the summary of the bill to read as follows:

"SUMMARY—Establishes requirements for certain plans of group insurance for employees of certain school districts. (BDR 23-950)".