Amendment No. 5

Senate Amendment to Senate Bill No. 87 (BDR 57-219)

Proposed by: Senate Committee on Commerce and Labor

Amends: Summary: No Title: No Preamble: No Joint Sponsorship: No Digest: Yes

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

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

EWR/RBL Date: 4/15/2019

S.B. No. 87—Revises provisions governing the Nevada Life and Health Insurance Guaranty Association. (BDR 57-219)

SENATE BILL NO. 87–COMMITTEE ON COMMERCE AND LABOR

(ON BEHALF OF THE DIVISION OF INSURANCE OF THE DEPARTMENT OF BUSINESS AND INDUSTRY)

PREFILED NOVEMBER 21, 2018

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions governing the Nevada Life and Health Insurance Guaranty Association. (BDR 57-219)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: 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 insurance; deeming benefits established by a long-term care rider to a life insurance policy or annuity contract to be the same type of benefits as provided in a basic policy or contract for certain purposes; clarifying the policies and contracts for which the Nevada Life and Health Insurance Guaranty Association is required to provide coverage; requiring a health maintenance organization to be a member of the Association; revising the composition of the Board of Directors of the Association; prescribing the manner in which the Association must calculate and allocate certain assessments; authorizing certain member insurers to recoup assessments; revising certain terminology; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law establishes the Nevada Life and Health Insurance Guaranty Association for the purpose of protecting owners of or certificate holders under direct, nongroup life, health and annuity policies or contracts and certain other persons against failure in the performance of contractual obligations under those policies or contracts because of the impairment or insolvency of the insurer that issued the policies or contracts. (NRS 686C.020, 686C.030, 686C.130) **Section 3** of this bill deems benefits established by a long-term care rider to a life insurance policy or annuity contract to be the same type of benefits as provided in a basic policy or contract for the purposes of provisions relating to the Association. Under existing law, such purposes include, without limitation, the determination of the date by which the Association is required to pay benefits, the calculation of limitations on the obligations of the Association and the imposition and allocation of assessments on member insurers. (NRS 686C.153, 686C.210, 686C.240)

Sections 5, 7, 9, 18, 19, 21, 24, 27-31, 35, 39 and 41 of this bill clarify that provisions relating to the Association apply equally whether coverage or benefits are established through a policy or a contract. **Section 6** of this bill clarifies that the Association is required to provide coverage for certain beneficiaries, assignees or payees of the owners of, enrollees in or certificate holders under covered policies or contracts. **Section 7** of this bill requires the

Association to cover a portion of a policy or contract that provides long-term care benefits or other health insurance benefits, regardless of whether the portion of the policy or contract would otherwise be eligible for certain exemptions. **Section 7** also provides that the Association does not cover a policy or contract for Medicaid benefits. **Sections 7, 11, 13, 15, 18, 22, 25, ~~[26,]~~ 28, 34, 36, 38, 40, 42 and 43** of this bill clarify that the provisions relating to the Association apply only to insurers that are members of the Association. **Sections 10 and 14** of this bill require a health maintenance organization that operates in this State to be a member of the Association. **Sections 13, 15, 18, 22, 24, 26, 30, 31, 35, 38, 40, 41 and 43** of this bill make conforming changes. **Sections 14 and 33** of this bill revise the names of the accounts maintained by the Association. **Section 48.5 of this bill repeals provisions requiring a nonprofit corporation for hospital, medical or dental service or health maintenance organization to take certain measures to continue coverage for insureds or enrollees if the corporation or health maintenance organization becomes insolvent, as such provisions would be unnecessary if those entities are required to participate in the Association.**

Existing law establishes the Board of Directors of the Association, which carries out the powers of the Association. (NRS 686C.130, 686C.140) **Section 15** of this bill increases the minimum and maximum number of members of the Board.

Existing law requires the Association to guarantee, assume or reinsure the policies of an impaired or insolvent insurer, cause such policies or contracts to be guaranteed, assumed or reinsured or ensure payment of the contractual obligations of the insolvent insurer. (NRS 686C.150, 686C.152) **Sections 16 and 17** of this bill additionally require the Association to reissue or cause the reissuance of such policies or contracts. **Sections 18 and 19** of this bill clarify that, if the Association issues certain alternative substitute coverage for the policies or contracts of an insolvent or impaired insurer, the alternative policy or contract must be reissued at actuarially justified rates. **Section 26** of this bill authorizes the Association to file for actuarially justified rate or premium increases for any policy for which the Association provides coverage. **Sections 19 and 20** of this bill remove a requirement that certain alternative policies or contracts or substitute coverage issued by the Association must be approved by a court in the insolvent or impaired insurer's state.

Existing law establishes limitations on the obligations of the Association to cover basic hospital, medical and surgical insurance or major medical insurance. (NRS 686C.210) **Section 25** of this bill provides that these limitations instead apply to health benefit plans, which are policies, contracts, certificates or agreements offered by a carrier to provide for, deliver payment for, arrange for the payment of, pay for or reimburse any of the costs of health care services. **Sections 1 and 44-47** of this bill standardize the definition of the term "health benefit plan" for certain purposes.

Existing law authorizes the Board to call for certain assessments, known as Class B Assessments, to the extent necessary for the Association to provide coverage for covered policies and contracts. (NRS 686C.230) **Section 32** of this bill prescribes the manner in which the Association is required to calculate the amount of a Class B Assessment for long-term care insurance written by an impaired or insolvent insurer and allocate such an assessment among the accounts of the Association.

Existing law authorizes a member insurer to offset part of the assessments paid to the Association against its liability for premium tax. (NRS 686C.280) **Section 36** of this bill authorizes a member insurer that is exempt from its liability for premium tax to recoup its assessments by imposing a surcharge on premiums. **Section 37** of this bill requires the plan of operation for the Association to include certain provisions relating to the recoupment of assessments.

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

Section 1. NRS 683A.176 is hereby amended to read as follows:

683A.176 "Third party" means:

1. An insurer, as that term is defined in NRS 679B.540;

2. A health benefit plan, as that term is defined in NRS ~~[689A.540,]~~ ***687B.470,*** for employees which provides a pharmacy benefits plan;

3. A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; or

4. Any other insurer or organization that provides health coverage or benefits or coverage of prescription drugs as part of workers' compensation insurance in accordance with state or federal law.

➥ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

Sec. 2. Chapter 686C of NRS is hereby amended by adding thereto the provisions set forth as sections 3 and 4 of this act.

Sec. 3. ***For the purposes of this chapter, benefits provided pursuant to a rider for long-term care to a life insurance policy or annuity contract shall be deemed the same type of benefits provided in the life insurance policy or annuity contract to which the rider applies.***

Sec. 4. ***"Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.***

Sec. 5. NRS 686C.020 is hereby amended to read as follows:

686C.020 The purpose of this chapter is to protect, within certain limits, the persons specified in subsections 1 and 2 of NRS 686C.030 against failure in the performance of contractual obligations under life ~~[and]~~ ***insurance,*** health insurance ***and annuity*** policies ~~[and]~~ ***or*** contracts ~~[, and annuities,]~~ specified in subsection 4 of NRS 686C.030 because of the impairment or insolvency of a member insurer issuing such policies or contracts.

Sec. 6. NRS 686C.030 is hereby amended to read as follows:

686C.030 1. This chapter provides coverage for the ***life insurance, health insurance and annuity*** policies or contracts described in subsection 4 to persons who are:

(a) Owners of ***, enrollees in*** or certificate holders under such policies or contracts, other than structured settlement annuities, and who:

(1) Are residents of this state; or

(2) Are not residents, but only if:

(I) The ***member*** insurer that issued the policies or contracts is domiciled in this state;

(II) The states in which the persons reside have associations similar to the Association created by this chapter; and

(III) The persons are not eligible for coverage by an association in another state because the ***member*** insurer was not authorized in the other state at the time specified in that state's law governing guaranty associations; and

(b) ~~[Beneficiaries,]~~ ***Regardless of where they reside, beneficiaries,*** assignees or payees of the persons covered under paragraph (a), ~~[wherever they reside,]~~ ***including, without limitation, providers of health care rendering services covered under policies or certificates of health insurance,*** except for nonresident certificate holders under group policies or contracts.

2. For structured settlement annuities, except as otherwise provided in subsection 3, this chapter provides coverage to a payee under the annuity, or beneficiary of a payee if the payee is deceased, if the payee or beneficiary:

(a) Is a resident of this state, regardless of the residence of the owner of the annuity; or

(b) Is not a resident of this state, but:

(1) The owner of the annuity is a resident of this state, or the issuer of the annuity is domiciled in this state and the state in which the owner resides has an association similar to the Association created by this chapter; and

(2) Neither the payee or beneficiary nor the owner of the annuity is eligible for coverage by the association of the state in which the payee, beneficiary or owner resides.

3. This chapter does not provide coverage for a payee or beneficiary of a structured settlement annuity if the owner of the annuity is a resident of this state and the payee or beneficiary is afforded any coverage by the association of another state. In determining the application of the provisions of this chapter to a situation where a person could be covered by the association of more than one state, this chapter must be construed in conjunction with the laws of other states to result in coverage by only one association.

4. This chapter provides coverage to the persons described in subsections 1 and 2 for ***policies or contracts of*** direct, nongroup life ~~[,]~~ ***insurance,*** health ***insurance*** and ~~[annuity policies or contracts,]~~ ***annuities,*** for certificates under direct group policies and contracts, and for supplemental contracts to any of these, in each case issued by member insurers, except as limited by this chapter.

Sec. 7. NRS 686C.035 is hereby amended to read as follows:

686C.035 1. This chapter does not provide coverage for:

(a) A portion of a policy or contract not guaranteed by the ***member*** insurer, or under which the risk is borne by the owner of the policy or contract.

(b) A policy or contract of reinsurance unless assumption certificates have been issued pursuant to that policy or contract.

(c) A portion of a policy or contract ***, other than a portion of a policy or contract of health insurance or that provides benefits for long-term care, including, without limitation, a rider that provides such benefits,*** to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by the use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(1) Averaged over the period of 4 years before the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting 2 percentage points from Moody's Corporate Bond Yield Average averaged for the same period, or for the period between the date of issuance of the policy or contract and the date the association became obligated, whichever period is less; and

(2) On or after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting 3 percentage points from Moody's Corporate Bond Yield Average as most recently available.

(d) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or other persons to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or other person under:

(1) A multiple employer welfare arrangement described in 29 U.S.C. § 1002(40);

(2) A minimum-premium group insurance plan;

(3) A stop-loss group insurance plan; or

(4) A contract for administrative services only.

(e) A portion of a policy or contract to the extent that it provides for dividends, credits for experience, voting rights or the payment of any fee or allowance to any

person, including the owner of a policy or contract, for services or administration connected with the policy or contract.

(f) A policy or contract issued in this state by a member insurer at a time when the member insurer was not authorized to issue the policy or contract in this state.

(g) A portion of a policy or contract to the extent that the assessments required by NRS 686C.230 with respect to the policy or contract are preempted by federal law.

(h) An obligation that does not arise under the express written terms of the policy or contract issued by the ***member*** insurer, including:

(1) Claims based on marketing materials;

(2) Claims based on side letters or other documents that were issued by the ***member*** insurer without satisfying applicable requirements for filing or approval of policy ***or contract*** forms;

(3) Misrepresentations of or regarding policy ***or contract*** benefits;

(4) Extra-contractual claims; or

(5) A claim for penalties or consequential or incidental damages.

(i) A contractual agreement that establishes the member insurer's obligation to provide a guarantee based on accounting at book value for participants in a defined-contribution benefit plan by reference to a portfolio of assets owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer.

(j) A portion of a policy or contract to the extent that it provides for interest or other changes in value which are determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the rights of the owner of the policy or contract are subject to forfeiture, determined on the date the member insurer becomes an impaired or insolvent insurer, whichever occurs first. If the interest or changes in value of a policy or contract are credited less frequently than annually, for the purpose of determining the values that have been credited and are not subject to forfeiture, the interest or change in value determined by using procedures stated in the policy or contract must be credited as if the contractual date for crediting interest or changing values was the date of the impairment or insolvency of the insured member, whichever occurs first and is not subject to forfeiture.

(k) An unallocated annuity contract other than an annuity owned by a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code, 26 U.S.C. §§ 401, 403(b) and 457, respectively, or the trustees of such a plan.

(l) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to 42 U.S.C. §§ 1395w-21 et seq. and 1395w-101 et seq. ~~[.]~~ ***or 42 U.S.C. §§ 1396 et seq.,*** and any regulations adopted pursuant thereto.

2. As used in this section, "Moody's Corporate Bond Yield Average" means the monthly average for corporate bonds published by Moody's Investors Service, Inc., or any successor average.

Sec. 8. NRS 686C.040 is hereby amended to read as follows:

686C.040 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 686C.045 to 686C.127, inclusive, ***and section 4 of this act*** have the meanings ascribed to them in those sections.

Sec. 9. NRS 686C.080 is hereby amended to read as follows:

686C.080 "Covered policy ~~[".]~~ ***or contract"*** means any policy or contract included within the scope of this chapter, as expressed in NRS 686C.030 and 686C.035.

Sec. 10. NRS 686C.100 is hereby amended to read as follows:

686C.100 "Member insurer" means an insurer which is licensed or holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided in this chapter ~~[and]~~ ***or a health maintenance organization which holds a certificate of authority to operate in this State. The term*** includes an insurer ***or health maintenance organization*** whose license or certificate of authority in this state has been suspended, revoked, not renewed or voluntarily withdrawn. The term does not include:

1. ~~[A hospital or medical organization, whether or not for profit;~~

~~2. A health maintenance organization;~~

~~3.]~~ A fraternal benefit society;

~~[4.]~~ ***2.*** A mandatory state pooling plan;

~~[5.]~~ ***3.*** A mutual assessment company or other person that operates on the basis of assessments;

~~[6.]~~ ***4.*** An insurance exchange;

~~[7.]~~ ***5.*** An organization that is authorized only to issue charitable gift annuities under NRS 688A.281 to 688A.285, inclusive; ~~[or~~

~~8.]~~ ***6. A reinsurance program operated by the State Government; or***

7. An organization similar to any of those listed in subsections 1 to ~~[7,]~~ ***6,*** inclusive.

Sec. 11. NRS 686C.120 is hereby amended to read as follows:

686C.120 "Resident" means any person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be impaired or insolvent. A person may be a resident of but one state, which in the case of a person other than a natural person is its principal place of business. A citizen of the United States who is a resident of a foreign country or of a territory or insular possession subject to the jurisdiction of the United States which does not have an association similar to the Association created by this chapter shall be deemed to be a resident of the state of domicile of the ***member*** insurer that issued the policy or contract.

Sec. 12. NRS 686C.125 is hereby amended to read as follows:

686C.125 "Supplemental contract" means a written agreement for the distribution of proceeds from a life or health insurance policy ***or contract*** or an annuity.

Sec. 13. NRS 686C.128 is hereby amended to read as follows:

686C.128 1. The Association shall prepare, and submit to the Commissioner for approval, a summary document describing the general purposes and current limitations of this chapter. After the expiration of 60 days after the approval of the summary document by the Commissioner, ~~[an]~~ ***a member*** insurer may not deliver a policy or contract to the ~~[owner of the]~~ policy or contract ***owner, certificate holder or enrollee*** unless the summary document is delivered to the ***policy or contract*** owner ***, certificate holder or enrollee*** at the time of delivery of the policy or contract. The document must also be available upon request by the ***policy or contract*** owner ~~[of a policy.]~~ ***, certificate holder or enrollee.*** The distribution, delivery, contents or interpretation of this document does not guarantee that the policy or ~~[the]~~ contract or ~~[its]~~ ***the policy or contract*** owner ***, certificate holder or enrollee*** is covered in the event of the impairment or insolvency of a member insurer. The descriptive document must be revised by the Association as amendments to this chapter may require. Failure to receive this document does not give the ~~[owner of a]~~ policy or contract ~~[, or an insured,]~~ ***owner, certificate holder or enrollee*** any greater rights than those stated in this chapter.

2. The document prepared pursuant to subsection 1 must contain a clear and conspicuous disclaimer on its face. The Commissioner shall establish the form and content of the disclaimer. The disclaimer must:

(a) State the name and address of the Association and of the Division;

(b) Prominently warn the ~~[owner of the]~~ policy or contract ***owner, certificate holder or enrollee*** that the Association may not cover the policy ***or contract*** or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this State;

(c) State the types of policies ***and contracts*** for which guaranty funds will provide coverage;

(d) State that the ***member*** insurer and its agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance ~~[;]~~ ***or coverage offered by a health maintenance organization;***

(e) State that the ~~[owner of a]~~ policy or contract ***owner, certificate holder or enrollee*** should not rely on coverage under the Association when selecting an insurer;

(f) Explain the rights and procedures for filing a complaint to allege a violation of any provision of this chapter; and

(g) Provide other information as directed by the Commissioner, including sources of information about the financial condition of insurers, if the information is not proprietary and is subject to disclosure under the law of the state in which the ***member*** insurer is domiciled.

3. A member insurer shall retain evidence of compliance with subsection 1 while the policy or contract for which the notice is given remains in effect.

Sec. 14. NRS 686C.130 is hereby amended to read as follows:

686C.130 1. There is hereby created a nonprofit legal entity to be known as the Nevada Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance ***or operate a health maintenance organization, as applicable,*** in this state. The Association shall perform its functions under the plan of operation established and approved pursuant to NRS 686C.290 and shall exercise its powers through a Board of Directors established pursuant to NRS 686C.140.

2. For purposes of administration and assessment, the Association shall maintain two accounts:

(a) The ***Health*** Account ***;*** ~~[for Health Insurance;]~~ and

(b) The ***Life and Annuity*** Account ***,*** ~~[for Life Insurance and Annuities,]~~ which consists of:

(1) The Subaccount for Life Insurance; and

(2) The Subaccount for Annuities, including annuities owned by a governmental retirement plan, or its trustees, established under section 401, 403(b) or 457 of the Internal Revenue Code, 26 U.S.C. §§ 401, 403(b) and 457.

3. The Association is under the immediate supervision of the Commissioner and is subject to the applicable provisions of the Nevada Insurance Code. Meetings or records of the Association may be opened to the public by majority vote of the Board of Directors.

Sec. 15. NRS 686C.140 is hereby amended to read as follows:

686C.140 1. The Board of Directors of the Association consists of not less than ~~[five]~~ ***7*** nor more than ~~[nine]~~ ***11*** members, serving terms as established in the plan of operation.

2. The members of the Board who represent ***member*** insurers must be selected by member insurers subject to the approval of the Commissioner. If

practicable, one of the members of the Board must be an officer of a domestic ***member*** insurer.

3. Two public representatives must be appointed to the Board by the Commissioner. A public representative may not be an officer, director or employee of ~~[an]~~ ***a member*** insurer ***,*** ~~[or]~~ engaged in the business of insurance ~~[.]~~ ***or a health maintenance organization.***

4. Vacancies on the Board must be filled for the remaining period of the term by majority vote of the members of the Board, subject to the approval of the Commissioner, for members who represent ***member*** insurers, and by the Commissioner for public representatives.

5. To select the initial Board of Directors, and initially organize the Association, the Commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member insurer is entitled to one vote in person or by proxy. If the Board of Directors is not selected within 60 days after notice of the organizational meeting, the Commissioner may appoint the initial members to represent ***member*** insurers in addition to the public representatives.

6. In approving selections or in appointing members to the Board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

7. Members of the Board may be reimbursed from the assets of the Association for expenses incurred by them as members of the Board of Directors, but members of the Board may not otherwise be compensated by the Association for their services.

Sec. 16. NRS 686C.150 is hereby amended to read as follows:

686C.150 If a member insurer is an impaired insurer, the Association may, subject to any conditions it may impose which do not impair the contractual obligations of the impaired insurer and which are approved by the Commissioner:

1. Guarantee, assume ***, reissue*** or reinsure, or cause to be guaranteed, assumed ***, reissued*** or reinsured, any or all of the covered policies or contracts of the impaired insurer.

2. Provide such money, pledges, loans, notes, guarantees or other means as are proper to effectuate subsection 1, and assure payment of the contractual obligations of the impaired insurer pending action under subsection 1.

Sec. 17. NRS 686C.152 is hereby amended to read as follows:

686C.152 If a member insurer is an insolvent insurer, the Association shall:

1. Guarantee, assume ***, reissue*** or reinsure, or cause to be guaranteed, assumed ***, reissued*** or reinsured, the policies or contracts of the insolvent insurer; or

2. Ensure payment of the contractual obligations of the insolvent insurer and:

(a) Provide such money, pledges, loans, notes, guarantees or other means as are reasonably necessary to discharge its duties; or

(b) Provide benefits and coverages in accordance with NRS 686C.153 and 686C.154.

Sec. 18. NRS 686C.153 is hereby amended to read as follows:

686C.153 ***1.*** When proceeding pursuant to paragraph (b) of subsection 2 of NRS 686C.152, the Association shall:

~~[1.]~~ ***(a)*** With respect to ~~[life and health insurance]~~ ***covered*** policies ~~[and annuities,]~~ ***or contracts,*** ensure payment of benefits ~~[for premiums identical to the premiums and benefits, except for terms of conversion and renewability, which]~~ ***that*** would have been payable under ***the*** policies or contracts of the insolvent insurer, for claims incurred with respect to:

~~[(a)]~~ ***(1)*** A group policy or contract, not later than the earlier of the next renewal date under the policy or contract or 45 days, but in no event less than 30

days, after the date when the Association becomes obligated with respect to that policy or contract.

~~[(b)]~~ ***(2)*** A nongroup policy, contract or annuity, not later than the earlier of the next renewal date, if any, under the policy, contract or annuity or 1 year, but in no event less than 30 days, after the date when the Association becomes obligated with respect to that policy, contract or annuity.

~~[2.]~~ ***(b)*** Make diligent efforts to provide all known insureds ~~[or]~~ ***, policy or contract*** owners ***or enrollees*** with respect to group policies or contracts, or annuitants with respect to annuities, 30 days' notice of termination of the benefits provided pursuant to ~~[subsection 1.~~

~~3.]~~ ***paragraph (a).***

(c) With respect to nongroup life ~~[and]~~ ***insurance,*** health insurance ***or annuity*** policies ~~[and annuities,]~~ ***or contracts,*** make available substitute coverage on an individual basis, in accordance with the provisions of subsection ~~[4,]~~ ***2,*** to each known insured or annuitant, or owner if other than the insured ***, enrollee*** or annuitant, and to each natural person formerly insured, ***formerly an enrollee*** or formerly an annuitant, under a group policy ***or contract*** who is not eligible for replacement group coverage, if the insured ***, enrollee*** or annuitant had a right under law or the terminated policy ***, contract*** or annuity to convert coverage to individual coverage or to continue an individual policy ***, contract*** or annuity in force until a specified age or for a specified period, during which the ***member*** insurer had no right unilaterally to make changes in any provision of the policy ***, contract*** or annuity or had a right only to make changes in premium by class.

~~[4.]~~ ***2.*** In providing the substitute coverage required under ***paragraph (c) of*** subsection ~~[3,]~~ ***1,*** the Association may offer to reissue the terminated coverage or to issue an alternative policy ~~[that must be offered]~~ ***or contract at actuarially justified rates*** without requiring evidence of insurability or a waiting period or exclusion that would not have applied under the terminated policy ~~[,]~~ ***or contract*** and may reinsure any alternative or reinsured policy ~~[.]~~ ***or contract.***

Sec. 19. NRS 686C.154 is hereby amended to read as follows:

686C.154 1. Alternative policies ***or contracts*** adopted by the Association are subject to the approval of the Commissioner ***.*** ~~[and the court in the insolvent or impaired insurer's state which has jurisdiction over the conservation, rehabilitation or liquidation of the insurer.]~~ The Association may adopt alternative policies ***or contracts*** of various types for future issuance without regard to any particular impairment or insolvency.

2. An alternative policy ***or contract*** must contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates which it shall adopt. The premium must reflect the amount of insurance to be provided and the age and class of risk of each insured ~~[,]~~ ***or enrollee,*** but must not reflect any changes in the health of the insured ***or enrollee*** after the original policy ***or contract*** was last underwritten.

3. An alternative policy ***or contract*** issued by the Association must provide coverage of a type similar to that of the policy ***or contract*** issued by the impaired or insolvent insurer, as determined by the Association.

4. If the Association elects to reissue terminated coverage at a rate of premium different from that charged under the terminated policy ~~[,]~~ ***or contract,*** the premium must be set by the Association ***at an actuarially justified amount*** in accordance with the amount of insurance provided and the age and class of risk, subject to approval by the Commissioner ~~[and the court described in]~~ ***pursuant to*** subsection 1.

Sec. 20. NRS 686C.156 is hereby amended to read as follows:

686C.156 In carrying out its duties in connection with guaranteeing, assuming ***, reissuing*** or reinsuring a policy or contract under NRS 686C.150 and 686C.152, the Association ~~[, subject to the approval of the court in the insolvent or impaired insurer's state which has jurisdiction over the conservation, rehabilitation or liquidation of the insurer,]~~ may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract if:

1. In lieu of the index or other external reference stated in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends guaranteed as to minimum amount, or a different method of calculating interest or changes in value;

2. There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

3. The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

Sec. 21. NRS 686C.160 is hereby amended to read as follows:

686C.160 In carrying out its responsibilities under NRS 686C.152, the Association may, subject to approval by a court of this state:

1. Impose permanent liens on policies and contracts in connection with any guarantee, assumption or reinsurance if the Association finds that the amounts which can be assessed under this chapter are less than the amounts needed to ensure full and prompt performance of the Association's duties or that the economic or financial conditions as they affect member insurers are sufficiently adverse that the imposition of such permanent liens is in the public interest.

2. Impose temporary moratoriums or liens on payments of cash values and policy loans or any right to withdraw money held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of paying cash value or lending against the policy ~~[.]~~ ***or contract.*** In addition, in the event of a temporary moratorium or charge imposed by the court in the insolvent or impaired insurer's state which has jurisdiction over the conservation, rehabilitation or liquidation of the insurer on such payment or lending, or on any other right to withdraw money held in conjunction with policies or contracts, the Association may defer such payment, lending or withdrawal for the period of the moratorium or charge, except for claims covered by the Association to be paid in accordance with a procedure for cases of hardship established by the liquidator or rehabilitator and approved by the court.

Sec. 22. NRS 686C.175 is hereby amended to read as follows:

686C.175 A deposit in this state, held pursuant to law or required by the Commissioner for the benefit of creditors, including ~~[owners of policies,]~~ ***, without limitation, policy or contract owners, certificate holders and enrollees,*** not turned over to the domiciliary receiver upon the entry of a final order of liquidation or order approving a plan of rehabilitation of ~~[an]~~ ***a member*** insurer domiciled in this state or a reciprocal state pursuant to NRS 696B.290 or 696B.300 must be promptly paid to the Association. The Association is entitled to retain a portion of an amount so paid to it that is equal to the percentage determined by dividing the aggregate amount of ~~[policy owners']~~ claims ***by policy or contract owners, certificate holders and enrollees that are*** related to that insolvency for which the Association has provided statutory benefits by the aggregate amount of all ~~[policy owners']~~ claims ***by policy or contract owners, certificate holders and enrollees*** in this state related

to that insolvency, and shall remit the remainder to the domiciliary receiver. The amount so remitted is a distribution of the assets of the ***member*** insurer for the purposes of chapter 696B of NRS.

Sec. 23. NRS 686C.190 is hereby amended to read as follows:

686C.190 The Association has standing:

1. To appear or intervene before a court or agency in this state which has jurisdiction over an impaired or insolvent insurer concerning which the Association is or may become obligated under this chapter or over any person or property against whom or which the Association may have rights through subrogation or otherwise. Its standing extends to all matters germane to the powers and duties of the Association, including proposals for reinsuring, ***reissuing,*** modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations.

2. To appear or intervene before a court or agency in another state which has jurisdiction over an impaired or insolvent insurer for which the Association is or may become obligated, or over any person or property against whom or which the Association may have rights through subrogation or otherwise.

Sec. 24. NRS 686C.200 is hereby amended to read as follows:

686C.200 1. A person receiving benefits under this chapter shall be deemed to have assigned his or her rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the Association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The Association may require an assignment to it of those rights and causes of action by any payee, ~~[owner of a]~~ policy or contract ~~[,]~~ ***owner, certificate holder, enrollee,*** beneficiary, insured or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this chapter upon that person.

2. The rights of the Association to subrogation under this subsection have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

3. In addition to the rights provided under subsections 1 and 2, the Association has all rights of subrogation at common law and any other equitable or legal remedy which would have been available to the impaired or insolvent insurer or the owner, beneficiary or payee of a policy or contract ***, a certificate holder or an enrollee*** with respect to the policy or contract, including, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received under this chapter, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment for it, except any such person responsible solely by reason of serving as an assignee under section 130 of the Internal Revenue Code, 26 U.S.C. § 130.

4. If the provisions of subsections 1, 2 and 3 are invalid or ineffective with respect to any person or any claim for any reason, the amount payable to the Association with respect to the related covered obligations is reduced by the amount realized by any other person with respect to the person or claim which is attributable to the policies ***or contracts*** or portions thereof covered by the Association.

5. If the Association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the Association has rights under subsections 1 to 4, inclusive, the person shall pay to the Association the portion of the recovery attributable to the policies ***or contracts*** or portions thereof covered by the Association.

Sec. 25. NRS 686C.210 is hereby amended to read as follows:

686C.210 1. The benefits that the Association may become obligated to cover may not exceed the lesser of:

(a) The contractual obligations for which the ***member*** insurer is liable or would have been liable if it were not an impaired or insolvent insurer;

(b) With respect to one life, regardless of the number of policies or contracts:

(1) Three hundred thousand dollars in death benefits from life insurance, but not more than $100,000 in net cash for surrender and withdrawal for life insurance; or

(2) Two hundred fifty thousand dollars in the present value of benefits from annuities, including net cash for surrender and withdrawal;

(c) With respect to health insurance for any one life:

(1) One hundred thousand dollars for coverages other than disability ***income*** insurance, ***health benefit plans or*** long-term care insurance, ~~[basic hospital, medical and surgical insurance or major medical insurance,]~~ including any net cash for surrender or withdrawal;

(2) Three hundred thousand dollars for disability ***income*** insurance or long-term care insurance; or

(3) Five hundred thousand dollars for ~~[basic hospital, medical and surgical insurance or major medical insurance;]~~ ***health benefit plans;***

(d) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, $250,000 in present value of benefits from the annuity in the aggregate, including any net cash for surrender or withdrawal; or

(e) With respect to each participant in a governmental retirement plan covered by an unallocated annuity contract which is owned by a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code, 26 U.S.C. §§ 401, 403(b) and 457, respectively, or the trustees of such a plan, and which is approved by the Commissioner, an aggregate of $250,000 in present-value annuity benefits, including the value of net cash for surrender and net cash for withdrawal, regardless of the number of contracts.

2. In no event is the Association obligated to cover more than:

(a) With respect to any one life or person under paragraphs (b) to (e), inclusive, of subsection 1:

(1) An aggregate of $300,000 in benefits, excluding benefits for ~~[basic hospital, medical and surgical insurance or major medical insurance;]~~ ***health benefit plans;*** or

(2) An aggregate of $500,000 in benefits, including benefits for ~~[basic hospital, medical and surgical insurance or major medical insurance.]~~ ***health benefit plans.***

(b) With respect to one owner of several nongroup policies of life insurance, whether the owner is a natural person or an organization and whether the persons insured are officers, managers, employees or other persons, more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

3. The limitations set forth in this section are limitations on the benefits for which the Association is obligated before taking into account its rights to subrogation or assignment or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies ~~[.]~~ ***or contracts.*** The cost of the Association's obligations under this chapter may be met by the use of assets attributable to covered policies ~~[,]~~ ***or contracts,*** or reimbursed to the Association pursuant to its rights to subrogation or assignment.

4. In performing its obligation to provide coverage under NRS 686C.150 and 686C.152, the Association need not guarantee, assume, reinsure ***, reissue*** or

perform, or cause to be guaranteed, assumed, reinsured ***, reissued*** or performed, the contractual obligations of the impaired or insolvent insurer under a covered policy or contract which do not materially affect the economic value or economic benefits of the covered policy or contract.

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

Sec. 26. NRS 686C.220 is hereby amended to read as follows:

686C.220 The Association may:

1. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter.

2. Sue or be sued, including the taking of any legal action necessary or proper for recovery of any unpaid assessments under NRS 686C.230 or to settle claims or potential claims against it.

3. Borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the Association not in default are legal investments for domestic ~~*[member]*~~ insurers and may be carried as admitted assets.

4. Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the Association, and to perform such other functions as become necessary or proper under this chapter.

5. Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims.

6. Exercise, for the purposes of this chapter and to the extent approved by the Commissioner, the powers of a domestic life or health insurer ~~[,]~~ ***or health maintenance organization,*** but in no case may the Association issue insurance policies or annuities other than those issued to perform its contractual obligations under this chapter.

7. Join an organization of one or more other state associations having similar purposes, to further the purposes and administer the powers and duties of the Association.

8. Organize itself as a corporation or in other legal form permitted by the laws of this state.

9. Request information from a person seeking coverage from the Association to aid the Association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request.

10. ***Except where otherwise provided by law, in accordance with the terms and conditions of the applicable policy or contract, file for actuarially justified rate or premium increases for any policy for which the Association provides coverage under the provisions of this chapter.***

11. Take other necessary or appropriate action to perform its duties and discharge its obligations under this chapter or to exercise its power under this chapter.

Sec. 27. NRS 686C.223 is hereby amended to read as follows:

686C.223 1. As used in this section, "coverage date" means the date on which the Association becomes liable for the obligations of a member insurer.

2. At any time after the coverage date, the Association may elect to succeed to the rights and obligations of the member insurer which accrue on or after the coverage date and relate to ***policies or*** contracts covered, in whole or in part, by the Association under any one or more agreements for indemnity reinsurance entered into by the member insurer as ceding insurer and selected by the Association. However, the Association may not exercise its right of election with respect to an agreement for reinsurance if the receiver, rehabilitator or liquidator of the member insurer has previously expressly disaffirmed the agreement. The election must be

effected by a notice to the receiver, rehabilitator or liquidator and the affected reinsurers. If the Association makes such an election:

(a) The Association is responsible for all unpaid premiums due under each agreement for periods both before and after the coverage date, and for the performance of all other obligations to be performed after the coverage date, in each case which relates to a ***policy or*** contract covered in whole or in part by the Association. The Association may charge a ***policy or*** contract covered in part by it, through reasonable methods of allocation, for the costs of reinsurance in excess of the obligations of the Association.

(b) The Association is entitled to any amount payable by the reinsurer under each agreement with respect to losses or events that occur in periods after the coverage date and relate to ***policies or*** contracts covered in whole or in part by the Association, but upon receipt of any such amount, the Association is obligated to pay, to the beneficiary under the ***policy or*** contract on account of which the amount was paid, that portion of the amount received by the Association that exceeds the benefits paid by the Association on account of the ***policy or*** contract less the retention by the impaired or insolvent ~~[member]~~ insurer applicable to the loss or event.

(c) The Association and each reinsurer shall, within 30 days after the election, calculate the net balance due to or from the Association under each agreement as of the date of the election, giving full credit for all items paid by the member insurer or its receiver, rehabilitator or liquidator, or the reinsurer, between the coverage date and the date of the election. The Association or the reinsurer shall pay the net balance within 5 days after the completion of the calculation. If a receiver, rehabilitator or liquidator has received any amount due the Association pursuant to paragraph (b), the recipient shall remit the amount to the Association as promptly as practicable.

(d) The reinsurer may not terminate an agreement for reinsurance insofar as it relates to ***policies or*** contracts covered by the Association in whole or in part, or set off any unpaid premium due for a period before the coverage date against the amount due the Association, if the Association, within 60 days after the election, pays the premiums due for periods both before and after the coverage date which relate to such ***policies or*** contracts.

3. If the Association transfers its obligation to another insurer, and the Association and the other insurer so agree, the other insurer succeeds to the rights and obligations of the Association under subsection 2 effective as of the agreed date, whether or not the Association has made the election described in subsection 2, except that:

(a) An agreement for indemnity reinsurance automatically terminates as to new reinsurance unless the reinsurer and the other insurer agree to the contrary;

(b) The obligation of the Association to the beneficiary under paragraph (b) of subsection 2 ceases on the date of the transfer to the other insurer; and

(c) This subsection does not apply if the Association has previously expressly determined in writing that it will not exercise its right of election under subsection 2.

4. The provisions of this section supersede an affected agreement for reinsurance which provides for or requires payment of proceeds of reinsurance, on account of a loss or event that occurs after the coverage date, to the receiver, rehabilitator or liquidator of the insolvent ~~[member]~~ insurer. The receiver, rehabilitator or liquidator remains entitled to any amounts payable by the reinsurer under the agreement with respect to losses or events that occur before the coverage date, subject to any applicable setoff.

5. Except as otherwise expressly provided, this section does not alter or modify the terms or conditions of any agreement of the insolvent insurer for reinsurance, abrogate or limit any right of a reinsurer to rescind an agreement for reinsurance, or give an owner or beneficiary of a policy ***or contract*** an independent cause of action against a reinsurer under an agreement for indemnity reinsurance that is not otherwise set forth in the agreement.

Sec. 28. NRS 686C.224 is hereby amended to read as follows:

686C.224 1. At any time within 180 days after the date of an order of liquidation, the Association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies or ~~[annuities]~~ ***contracts*** covered, in whole or in part, by the Association, in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the Association. Any such assumption must be effective on the date of the order of liquidation. The election must be carried out by the Association sending written notice, return receipt requested, to the affected reinsurers.

2. To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and to protect the financial position of the estate, the receiver and each reinsurer of the ceding ***member*** insurer shall make available upon request to the Association as soon as possible after commencement of formal delinquency proceedings:

(a) Copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed; and

(b) Notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

3. The following apply to reinsurance contracts assumed by the Association:

(a) The Association is responsible for all unpaid premiums due pursuant to the reinsurance contracts for periods both before and after the date of the order of liquidation, and is responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case which relates to policies or ~~[annuities]~~ ***contracts*** covered, in whole or in part, by the Association. The Association may charge policies or ~~[annuities]~~ ***contracts*** covered in part by the Association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the Association and shall provide notice and an accounting of these changes to the liquidator.

(b) The Association may be entitled to any amounts payable by the reinsurer pursuant to the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and which relate to policies or ~~[annuities]~~ ***contracts*** covered, in whole or in part, by the Association, provided that, upon receipt of any such amounts, the Association is obligated to pay to the beneficiary, under the policy or ~~[annuity]~~ ***contract*** on account of which the amounts were paid, a portion of the amount equal to the lesser of:

(1) The amount received by the Association; or

(2) The excess of the amount received by the Association over the amount equal to the benefits paid by the Association on account of the policy or ~~[annuity,]~~ ***contract,*** less the retention of the ***member*** insurer applicable to the loss or event.

(c) Within 30 days after the Association's election, the Association and each reinsurer under the contracts assumed by the Association shall calculate the net balance due to or from the Association pursuant to each reinsurance contract on the election date with respect to policies or ~~[annuities]~~ ***contracts*** covered, in whole or in part, by the Association, which calculation must give full credit to all items paid by either the ***member*** insurer or its receiver or the reinsurer before the election date. The reinsurer shall pay the receiver any amounts due for losses or events before the

date of the order of liquidation, subject to any set-off for premiums unpaid for periods before the date, and the Association or reinsurer shall pay any remaining balance due to the other, in each case within 5 days after the completion of the aforementioned calculation. Any disputes over the amounts due to either the Association or the reinsurer must be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contracts contain no arbitration clause, as otherwise prescribed by law. If the receiver has received any amounts due to the Association under paragraph (d), the receiver shall remit the same to the Association as promptly as practicable.

(d) If the Association or receiver, on the Association's behalf, within 60 days after the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies or ~~[annuities]~~ ***contracts*** covered, in whole or in part, by the Association, the reinsurer is not entitled to terminate the reinsurance contracts for failure to pay premiums insofar as the reinsurance contracts relate to policies or ~~[annuities]~~ ***contracts*** covered, in whole or in part, by the Association, and is not entitled to set off any unpaid amounts due pursuant to the other contracts, or unpaid amounts due from parties other than the Association, against amounts due to the Association.

Sec. 29. NRS 686C.2245 is hereby amended to read as follows:

686C.2245 When policies or ~~[annuities,]~~ ***contracts,*** or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies or ~~[annuities]~~ ***contracts*** may also be transferred by the Association, in the case of ***policies or*** contracts assumed under NRS 686C.224, subject to the following:

1. Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred must not cover any new policies ~~[of insurance or annuities]~~ ***or contracts*** in addition to those transferred.

2. The obligations described in NRS 686C.224 no longer apply with respect to matters arising after the effective date of the transfer.

3. Notice must be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than 30 days before the effective date of the transfer.

Sec. 30. NRS 686C.2249 is hereby amended to read as follows:

686C.2249 1. Except as otherwise provided in NRS 686C.130 to 686C.226, inclusive, nothing in NRS 686C.224 to 686C.2249, inclusive, shall alter or modify the terms and conditions of any reinsurance contract.

2. Nothing in this section shall:

(a) Abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract;

(b) Give a ~~[policyholder]~~ ***policy or contract owner, certificate holder, enrollee*** or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract;

(c) Limit or affect the Association's rights as a creditor of the estate against the assets of the estate; or

(d) Apply to reinsurance agreements covering property or casualty risks.

Sec. 31. NRS 686C.225 is hereby amended to read as follows:

686C.225 The Association's obligations with respect to coverage under any policy ***or contract*** of the impaired or insolvent insurer or under any reissued or alternative policy ***or contract*** ceases on the date the ~~[coverage or]~~ policy ***or contract*** is replaced by another similar policy ***or contract*** by the ~~[policyholder, the insured]~~ ***policy or contract owner, certificate holder or enrollee*** or the Association.

Sec. 32. NRS 686C.240 is hereby amended to read as follows:

686C.240 1. The Board of Directors of the Association shall determine the amount of each assessment in Class A and may, but need not, prorate it. If an assessment is prorated, the Board may provide that any surplus be credited against future assessments in Class B. An assessment which is not prorated must not exceed $500 for each member insurer for any 1 calendar year.

2. The ***Board may determine the amount of each assessment in Class B for long-term care insurance written by an impaired or insolvent insurer according to a methodology included in the plan of operation established and approved pursuant to NRS 686C.290. The methodology must provide for the imposition of:***

(a) One-half of the assessment on member insurers that primarily provide accident and health insurance; and

(b) One-half of the assessment on member insurers that primarily provide life insurance and annuities.

3. Except as otherwise provided in subsection 5, the Board may allocate any assessment in Class B among the accounts ***and among the subaccounts of the Life and Annuity Account*** according to ***a formula based on*** the premiums or reserves of the impaired or insolvent insurer or any other standard which ~~[it]~~ ***the Board, in its sole discretion,*** considers fair and reasonable under the circumstances.

~~[3. Assessments]~~

4. Except as otherwise provided in subsection 5, assessments in Class B against member insurers for each account and subaccount must be in the proportion that the premiums received on business in this State by each assessed member insurer on policies or contracts covered by each account or subaccount for the 3 most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent bears to premiums received on business in this State for those calendar years by all assessed member insurers.

5. The Board shall allocate to:

(a) The Life and Annuity Account the percentage of an assessment in Class B for long-term care insurance written by an impaired or insolvent insurer that is equal to the quotient of:

(1) The difference between 0.5 and the percentage of the Health Account that was contributed by member insurers that primarily provide life insurance and annuities; and

(2) The difference between the percentage of the Life and Annuity Account that was contributed by member insurers that primarily provide life insurance and annuities and the percentage of the Health Account that was contributed by such member insurers.

(b) The Health Account the remainder of an assessment in Class B for long-term care insurance written by an impaired or insolvent insurer that is not allocated to the Life and Annuity Account pursuant to paragraph (a).

~~[4.]~~ ***6.*** Assessments for money to meet the requirements of the Association with respect to an impaired or insolvent insurer must not be authorized or called until necessary to carry out the purposes of this chapter. Classification of assessments under subsection 2 of NRS 686C.230 and computation of assessments under this section must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The Association shall notify each member insurer of its anticipated prorated share of an assessment authorized but not yet called within 180 days after it is authorized.

7. For the purposes of this section, a member insurer shall be deemed to:

(a) Primarily provide life insurance and annuities if the sum of the accessible in-state life insurance premiums and annuity premiums of the member insurer is equal to or greater than the accessible in-state health insurance

premiums of the member insurer. For the purposes of this paragraph, health insurance premiums:

(1) Include, without limitation, premiums for health maintenance organization coverage; and

(2) Do not include premiums for disability income and long-term care insurance.

(b) Primarily provide health insurance if the member insurer is not a member insurer described in paragraph (a).

Sec. 33. NRS 686C.250 is hereby amended to read as follows:

686C.250 1. The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the Board of Directors, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. If an assessment against a member insurer is abated or deferred in whole or in part, the amount by which that assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. As soon as the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a plan of repayment approved by the Association.

2. Except as otherwise provided in subsection 3, the total of all assessments authorized by the Association with respect to a member insurer for:

(a) The ***Life and Annuity*** Account ~~[for Life Insurance and Annuities]~~ and each of its subaccounts; and

(b) The ***Health*** Account **,** ~~[for Health Insurance,]~~

➥ respectively must not in any 1 calendar year exceed 2 percent of the ***member*** insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the 3 calendar years preceding the year in which the ***member*** insurer became impaired or insolvent.

3. If two or more assessments are authorized in 1 calendar year with respect to ***member*** insurers that became impaired or insolvent in different calendar years, the average annual premiums received for the purposes of the limitation provided in subsection 2 are equal and limited to the higher of the 3-year annual premiums for the applicable account or subaccount as calculated pursuant to this section.

4. If the maximum assessment, together with the other assets of the Association in an account, does not provide in any 1 year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional money must be assessed as soon thereafter as permitted by this chapter.

5. If the maximum assessment for a subaccount of the ***Life and Annuity*** Account ~~[for Life Insurance and Annuities]~~ in any 1 year does not provide an amount sufficient to carry out the responsibilities of the Association, then pursuant to subsection ~~[3]~~ ***4*** of NRS 686C.240, the Board shall assess the other subaccount for the necessary additional amount, subject to the maximum stated in subsection 2.

6. The Board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment is insufficient to cover anticipated claims.

Sec. 34. NRS 686C.260 is hereby amended to read as follows:

686C.260 The Board of Directors may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each ***member*** insurer to that account, the amount by which the assets of the account exceed the amount the Board finds is necessary to carry out during the coming year the obligations of the Association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account

to provide funds for the continuing expenses of the Association and for future claims.

Sec. 35. NRS 686C.270 is hereby amended to read as follows:

686C.270 It is proper for any member insurer, in determining its rates of premium and dividends to owners of policies ***or contracts*** as to any kind of insurance ***or coverage offered by a health maintenance organization*** within the scope of this chapter, to consider the amount reasonably necessary to meet its obligations for assessment under this chapter.

Sec. 36. NRS 686C.280 is hereby amended to read as follows:

686C.280 1. The Association shall issue to each ***member*** insurer paying an assessment under this chapter, other than an assessment in Class A, a certificate of contribution, in a form prescribed by the Commissioner, for the amount of the assessment so paid. All outstanding certificates are of equal dignity and priority without reference to amounts or dates of issue. A member insurer may show a certificate of contribution as an asset in its financial statement in such form, for such amount, if any, and for such period as the Commissioner may approve.

2. A member insurer may offset against its liability for premium tax to this state, accrued with respect to business transacted in a calendar year, an amount equal to 20 percent of the amount certified pursuant to subsection 1 in each of the 5 calendar years following the year in which the assessment was paid. If ~~[an]~~ ***a member*** insurer ceases to transact business, it may offset all uncredited assessments against its liability for premium tax for the year in which it so ceases.

3. ***A member insurer that is exempt from its liability for premium tax described in subsection 2 may recoup its assessments under this chapter by imposing a surcharge on its premiums in an amount approved by the Commissioner. The Commissioner shall approve such a surcharge upon determining that the amount of the surcharge is reasonably calculated to recoup the assessments over a reasonable period of time. Any amount recouped under this subsection shall not be deemed to constitute a premium for any purpose relating to this Code.***

4. If a member insurer recoups a larger amount through a surcharge imposed pursuant to subsection 3 than it paid in assessments over a period of time prescribed in the plan of operation established and approved pursuant to NRS 686C.290, the member insurer shall remit the excess amount to the Association. The Association shall apply such excess amounts to reduce future assessments in the appropriate account in accordance with the plan of operation.

5. Any sum acquired by refund from the Association pursuant to NRS 686C.260 which previously had been written off by the contributing ***member*** insurer and offset against premium taxes as provided in subsection 2 must be paid to the Department of Taxation and deposited by it with the State Treasurer for credit to the State General Fund. The Association shall notify the Commissioner and the Department of Taxation of each refund made.

Sec. 37. NRS 686C.290 is hereby amended to read as follows:

686C.290 1. The Association shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to ensure the fair, reasonable and equitable administration of the Association. The plan of operation and any amendments thereto become effective upon approval in writing by the Commissioner, or 30 days after submission if the Commissioner has not disapproved them. All member insurers shall comply with the plan of operation.

2. If at any time the Association fails to submit suitable amendments to the plan, the Commissioner shall adopt, after notice and hearing, such reasonable regulations as are necessary or advisable to effectuate the provisions of this chapter. The regulations continue in force until modified by the Commissioner or

superseded by a plan submitted by the Association and approved by the Commissioner.

3. In addition to satisfying the other requirements of this chapter, the plan of operation must:

(a) Establish procedures for handling the assets of the Association.

(b) Establish the amount and method of reimbursing members of the Board of Directors under NRS 686C.140.

(c) Establish regular places and times for meetings of the Board.

(d) Establish procedures for records to be kept of all financial transactions of the Association, its agents and the Board.

(e) Establish the procedures whereby selections for the Board will be made and submitted to the Commissioner.

(f) Establish ***the methodology required by subsection 2 of NRS 686C.240 and*** any additional procedures for assessments under NRS 686C.230 to 686C.270, inclusive.

(g) ***Establish the period of time over which a member insurer must determine whether the member insurer has recouped an excess amount pursuant to subsection 4 of NRS 686C.280, the manner in which the member insurer must remit any excess amount to the Association and the manner in which the Association must apply any such excess amount to reduce future assessments.***

(h) Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

4. The plan of operation may provide that any or all powers and duties of the Association, except those under subsection 3 of NRS 686C.220 and NRS 686C.230 to 686C.285, inclusive, are delegated to a corporation, Association or other organization which performs or will perform functions similar to those of this Association, or its equivalent, in two or more states. Such an organization must be reimbursed for any payments made on behalf of the Association and paid for its performance of any function of the Association. A delegation under this subsection takes effect only with the approval of the Board of directors and the Commissioner, and may be made only to an organization that extends protection not substantially less favorable and effective than that provided by this chapter.

Sec. 38. NRS 686C.300 is hereby amended to read as follows:

686C.300 1. In addition to the duties and powers otherwise provided in this chapter, the Commissioner:

(a) Shall, upon request of the Board of Directors, provide the Association with a statement of the premiums in this and any other appropriate states for each member insurer.

(b) Shall, when an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the insurer is notice to its stockholders, if any. The failure of the insurer to comply with such demand promptly does not excuse the Association from the performance of its powers and duties under this chapter.

(c) Must, in any liquidation or rehabilitation involving a domestic ***member*** insurer, be appointed as the liquidator or rehabilitator.

2. The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance ***or operate a health maintenance organization*** in this state ***, as applicable,*** of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the Commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. The forfeiture may not exceed 5 percent of the unpaid assessment per month, but no forfeiture may be less than $100 per month.

3. A final action of the Board of Directors or the Association may be appealed to the Commissioner by any member insurer if the appeal is taken within 60 days after the insurer receives notice of the final action. A final action or order of the Commissioner is subject to judicial review in a court of competent jurisdiction pursuant to the procedure provided in chapter 233B of NRS for contested cases.

4. The liquidator, rehabilitator or conservator of any impaired insurer may notify all interested persons of the effect of this chapter.

Sec. 39. NRS 686C.306 is hereby amended to read as follows:

686C.306 1. The Commissioner shall notify the commissioners of insurance of all the other states within 30 days after the Commissioner takes any of the following actions against a member insurer:

(a) Revokes a member insurer's license;

(b) Suspends a member insurer's license; or

(c) Makes any formal order that a member insurer is to restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of the owners of its policies ***or contracts*** or its creditors.

2. The Commissioner shall report to the Board of Directors when the Commissioner has taken any of the actions set forth in subsection 1, or has received a report from any other commissioner indicating that any such action has been taken in another state. The report to the Board must contain all significant details of the action taken or the report received from another commissioner.

3. The Commissioner shall report to the Board of Directors when the Commissioner has reasonable cause to believe from an examination of a member insurer, whether completed or in process, that the insurer may be impaired or insolvent.

4. The Commissioner shall furnish to the Board the ratios of the "Insurance Regulatory Information System" developed by the National Association of Insurance Commissioners and listings of companies not included in those ratios, and the Board may use the information contained therein in carrying out its duties and responsibilities under this chapter. Such reports and the information contained therein must be kept confidential by the Board until such time as made public by the Commissioner or other lawful authority.

Sec. 40. NRS 686C.310 is hereby amended to read as follows:

686C.310 1. The Board of Directors may, upon majority vote, notify the Commissioner of any information indicating any member insurer may be impaired or insolvent.

2. The Board may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any person seeking admission to transact insurance ***or operate a health maintenance organization*** in this state. These reports and recommendations are not open to public inspection.

3. The Commissioner may seek the advice and recommendations of the Board concerning any matter affecting the duties and responsibilities of the Commissioner regarding the financial condition of member insurers and of persons seeking admission to transact insurance ***or operate a health maintenance organization*** in this state.

4. The Board may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of the insolvency of ***member*** insurers.

Sec. 41. NRS 686C.330 is hereby amended to read as follows:

686C.330 1. This chapter does not reduce the liability for unpaid assessments of the insureds of an impaired insurer operating under a plan with liability for assessments.

2. Records must be kept of all meetings of the Board of Directors to discuss the activities of the Association in carrying out its powers and duties under NRS 686C.150 to 686C.220, inclusive. The records of the Association with respect to an impaired or insolvent insurer may not be disclosed before the termination of a proceeding for liquidation, rehabilitation or conservation involving the impaired or insolvent insurer or the termination of the impairment or insolvency of the insurer, except upon the order of a court of competent jurisdiction. This subsection does not limit the duty of the Association to render a report of its activities under NRS 686C.350.

3. For the purpose of carrying out its obligations under this chapter, the Association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee pursuant to NRS 686C.200. Assets of the impaired or insolvent insurer attributable to covered policies ***or contracts*** must be used to continue all covered policies ***and contracts*** and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. Assets attributable to covered policies ~~[,]~~ ***or contracts,*** as used in this subsection, are that proportion of the assets which the reserves that should have been established for covered policies ***or contracts*** bear to the reserves that should have been established for all policies ~~[of insurance]~~ ***or contracts*** written by the impaired or insolvent insurer.

4. As a creditor of the impaired or insolvent insurer under subsection 3 and consistent with NRS 696B.415, the Association and other similar associations are entitled to receive a disbursement out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within 120 days after a final determination of insolvency of ~~[an]~~ ***a member*** insurer by the court in the insolvent or impaired insurer's state which has jurisdiction over the conservation, rehabilitation or liquidation of the ***member*** insurer, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, the Association is entitled to make application to the court for approval of its own proposal to disburse those assets.

5. Before the termination of any proceeding for liquidation, rehabilitation or conservation, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders ~~[and]~~ ***, policy or contract*** owners ~~[of policies and contracts]~~ ***, certificate holders and enrollees*** of the impaired or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership of the impaired or insolvent insurer. In making such a determination, consideration must be given to the welfare of the ***policy or contract*** owners ~~[of policies issued by]~~ ***, certificate holders and enrollees of*** the continuing or successor insurer. No distribution to stockholders, if any, of an impaired or insolvent insurer may be made until the total amount of valid claims of the Association, with interest thereon, for money expended in exercising its powers and performing its duties under NRS 686C.150 to 686C.155, inclusive, with respect to that insurer have been fully recovered by the Association.

Sec. 42. NRS 686C.333 is hereby amended to read as follows:

686C.333 1. If an order for liquidation or rehabilitation of ~~[an]~~ ***a member*** insurer domiciled in this state has been entered, the receiver appointed under such

order is entitled to recover on behalf of the ***member*** insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the ***member*** insurer on its capital stock, made at any time during the 5 years preceding the petition for liquidation or rehabilitation, subject to the limitations of subsections 2, 3 and 4.

2. No distribution is recoverable if the ***member*** insurer shows that when paid the distribution was lawful and reasonable, and that the ***member*** insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the ***member*** insurer to fulfill its contractual obligations.

3. Any person who was an affiliate that controlled the ***member*** insurer at the time the distributions were paid is liable up to the amount of distributions the person received. Any person who was an affiliate that controlled the ***member*** insurer at the time the distributions were declared, is liable up to the amount of distributions the person would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

4. The maximum amount recoverable pursuant to this subsection is the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer.

5. If any person liable under subsection 3 is insolvent, all its affiliates that controlled it at the time the dividend was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Sec. 43. NRS 686C.390 is hereby amended to read as follows:

686C.390 It is unlawful for ~~[an]~~ ***a member*** insurer, agent or affiliate of ~~[an]~~ ***a member*** insurer, or other person to make, publish, circulate or place before the public, or cause any other person to do so, in any publication, notice, circular, letter or poster, or over any radio or television station, any advertisement or statement, written or oral, which uses the existence of the Association for the sale, solicitation or inducement to purchase any form of insurance ***or coverage offered by a health maintenance organization that is*** covered by the Association. This section does not apply to the association or any other person that does not sell or solicit insurance ~~[.]~~ ***or coverage offered by a health maintenance organization.***

Sec. 44. NRS 689A.540 is hereby amended to read as follows:

689A.540 ~~[1.]~~ "Health benefit plan" ~~[means a policy, contract, certificate or agreement offered by a carrier to provide for, deliver payment for, arrange for the payment of, pay for or reimburse any of the costs of health care services. Except as otherwise provided in this section, the term includes catastrophic health insurance policies and a policy that pays on a cost-incurred basis.~~

~~2. The term does not include:~~

~~(a) Coverage that is only for accident or disability income insurance, or any combination thereof;~~

~~(b) Coverage issued as a supplement to liability insurance;~~

~~(c) Liability insurance, including general liability insurance and automobile liability insurance;~~

~~(d) Workers' compensation or similar insurance;~~

~~(e) Coverage for medical payments under a policy of automobile insurance;~~

~~(f) Credit insurance;~~

~~(g) Coverage for on-site medical clinics;~~

~~(h) Other similar insurance coverage specified in federal regulations issued pursuant to Public Law 104-191 under which benefits for medical care are secondary or incidental to other insurance benefits;~~

~~(i) Coverage under a short-term health insurance policy; and~~

~~(j) Coverage under a blanket student accident and health insurance policy.~~

~~3. The term does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of a health benefit plan:~~

~~(a) Limited scope dental or vision benefits;~~

~~(b) Benefits for long-term care, nursing home care, home health care or community-based care, or any combination thereof; and~~

~~(c) Such other similar benefits as are specified in any federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.~~

~~4. The term does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid for a claim without regard to whether benefits are provided for such a claim under any group health plan maintained by the same plan sponsor:~~

~~(a) Coverage that is only for a specified disease or illness; and~~

~~(b) Hospital indemnity or other fixed indemnity insurance.~~

~~5. The term does not include any of the following, if offered as a separate policy, certificate or contract of insurance:~~

~~(a) Medicare supplemental health insurance as defined in section 1882(g)(1) of the Social Security Act, 42 U.S.C. § 1395ss, as that section existed on July 16, 1997;~~

~~(b) Coverage supplemental to the coverage provided pursuant to the Civilian Health and Medical Program of Uniformed Services, CHAMPUS, 10 U.S.C. §§ 1071 et seq.; and~~

~~(c) Similar supplemental coverage provided under a group health plan.~~**]** ***has the meaning ascribed to it in NRS 687B.470.***

Sec. 45. NRS 439B.260 is hereby amended to read as follows:

439B.260 1. A major hospital shall reduce or discount the total billed charge by at least 30 percent for hospital services provided to an inpatient who:

(a) Has no policy of health insurance or other contractual agreement with a third party that provides health coverage for the charge;

(b) Is not eligible for coverage by a state or federal program of public assistance that would provide for the payment of the charge; and

(c) Makes reasonable arrangements within 30 days after the date that notice was sent pursuant to subsection 2 to pay the hospital bill.

2. A major hospital shall include on or with the first statement of the hospital bill provided to the patient after his or her discharge a notice of the reduction or discount available pursuant to this section, including, without limitation, notice of the criteria a patient must satisfy to qualify for a reduction or discount.

3. A major hospital or patient who disputes the reasonableness of arrangements made pursuant to paragraph (c) of subsection 1 may submit the dispute to the Bureau for Hospital Patients for resolution as provided in NRS 232.462.

4. A major hospital shall reduce or discount the total billed charge of its outpatient pharmacy by at least 30 percent to a patient who is eligible for Medicare.

5. As used in this section, "third party" means:

(a) An insurer, as that term is defined in NRS 679B.540;

(b) A health benefit plan, as that term is defined in NRS ~~[689A.540,]~~ ***687B.470,*** for employees which provides coverage for services and care at a hospital;

(c) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a

system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; or

(d) Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.

➥ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

Sec. 46. NRS 439B.665 is hereby amended to read as follows:

439B.665 1. On or before February 1 of each year, a nonprofit organization that advocates on behalf of patients or funds medical research in this State and has received a payment, donation, subsidy or anything else of value from a manufacturer, third party or pharmacy benefit manager or a trade or advocacy group for manufacturers, third parties or pharmacy benefit managers during the immediately preceding calendar year shall:

(a) Compile a report which includes:

(1) For each such contribution, the amount of the contribution and the manufacturer, third party or pharmacy benefit manager or group that provided the payment, donation, subsidy or other contribution; and

(2) The percentage of the total gross income of the organization during the immediately preceding calendar year attributable to payments, donations, subsidies or other contributions from each manufacturer, third party, pharmacy benefit manager or group; and

(b) Except as otherwise provided in this paragraph, post the report on an Internet website that is maintained by the nonprofit organization and accessible to the public. If the nonprofit organization does not maintain an Internet website that is accessible to the public, the nonprofit organization shall submit the report compiled pursuant to paragraph (a) to the Department.

2. As used in this section, "third party" means:

(a) An insurer, as that term is defined in NRS 679B.540;

(b) A health benefit plan, as that term is defined in NRS ~~[689A.540,]~~ ***687B.470,*** for employees which provides coverage for prescription drugs;

(c) A participating public agency, as that term is defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; or

(d) Any other insurer or organization that provides health coverage or benefits in accordance with state or federal law.

➥ The term does not include an insurer that provides coverage under a policy of casualty or property insurance.

Sec. 47. NRS 449A.162 is hereby amended to read as follows:

449A.162 1. Except as otherwise provided in subsection 3, if a hospital provides hospital care to a person who has a policy of health insurance issued by a third party that provides health coverage for care provided at that hospital and the hospital has a contractual agreement with the third party, the hospital:

(a) Shall proceed with any efforts to collect on any amount owed to the hospital for the hospital care in accordance with the provisions of NRS 449A.159.

(b) Shall not collect or attempt to collect from the patient or other responsible party more than the sum of the amounts of any deductible, copayment or coinsurance payable by or on behalf of the patient under the policy of health insurance.

(c) Shall not collect or attempt to collect that amount from:

(1) Any proceeds or potential proceeds of a civil action brought by or on behalf of the patient, including, without limitation, any amount awarded for medical expenses; or

(2) An insurer other than an insurer that provides coverage under a policy of health insurance or an insurer that provides coverage for medical payments under a policy of casualty insurance.

2. If the hospital collects or receives any payments from an insurer that provides coverage for medical payments under a policy of casualty insurance, the hospital shall, not later than 30 days after a determination is made concerning coverage, return to the patient any amount collected or received that is in excess of the deductible, copayment or coinsurance payable by or on behalf of the patient under the policy of health insurance.

3. This section does not apply to:

(a) Amounts owed to the hospital which are not covered under the policy of health insurance; or

(b) Medicaid, Medicare, the Children's Health Insurance Program or any other public program which may pay all or part of the bill.

4. This section does not limit any rights of a patient to contest an attempt to collect an amount owed to a hospital, including, without limitation, contesting a lien obtained by a hospital.

5. As used in this section, "third party" means:

(a) An insurer, as defined in NRS 679B.540;

(b) A health benefit plan, as defined in NRS ~~[689A.540,]~~ ***687B.470,*** for employees which provides coverage for services and care at a hospital;

(c) A participating public agency, as defined in NRS 287.04052, and any other local governmental agency of the State of Nevada which provides a system of health insurance for the benefit of its officers and employees, and the dependents of officers and employees, pursuant to chapter 287 of NRS; or

(d) Any other insurer or organization providing health coverage or benefits in accordance with state or federal law.

Sec. 48. 1. The amendatory provisions of sections 10, 13, 14, 15, 18, 22, 24, 26, 30, 31, 35, 38, 40, 41 and 43 of this act apply to any policy or contract for coverage by a health maintenance organization which has been delivered, or which is delivered, issued for delivery or renewed in this State on or after January 1, 2020.

2. Any other amendatory provisions of this act that revise the coverage that the Nevada Life and Health Insurance Guaranty Association is required to provide apply to any policy or contract for coverage to which the provisions would otherwise apply that has been delivered, or that is delivered, issued for delivery or renewed in this State on or after January 1, 2020.

3. As used in this section, "health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

Sec. 48.5. **NRS 695B.227, 695C.3175 and 695C.3185 are hereby repealed.**

Sec. 49. This act becomes effective:

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

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

TEXT OF REPEALED SECTIONS

695B.227 Required contract with insurance company for provision of insurance, indemnity or reimbursement against cost of hospital, medical and dental services; required provisions.

1. A corporation organized under this chapter shall contract with an insurance company licensed in this State or authorized to do business in this State for the provision of insurance, indemnity or reimbursement against the cost of hospital services, medical services and dental services which are provided by the corporation.

2. The contract of insurance required by subsection 1 must include a provision that, in the case of the insolvency or impairment of the corporation, the insurance company will pay all claims made by an insured for the period for which a premium has been or will be paid to the corporation for the insured. The contract of insurance required by subsection 1 must specifically provide for the:

(a) Continuation of benefits to each insured for the period for which a premium has been or will be paid to the corporation for the insured until the expiration or termination of the insured's contract with the corporation;

(b) Continuation of benefits for each insured who is receiving inpatient services in a medical facility or facility for the dependent at the time of the insolvency or impairment of the corporation until the inpatient services are no longer medically necessary and the insured is discharged from the medical facility or facility for the dependent; and

(c) Payment of a provider of health care not affiliated with the corporation who provided medically necessary services to an insured, as described in the insured's contract with the corporation, the insured's policy or the insured's evidence of coverage.

3. As used in this section:

(a) "Facility for the dependent" has the meaning ascribed to it in NRS 449.0045.

(b) "Impairment" means that a corporation organized under this chapter is not insolvent and has been:

(1) Deemed to be impaired pursuant to NRS 695B.150; or

(2) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(c) "Insolvency" or "insolvent" means that a corporation organized under this chapter has been:

(1) Deemed to be insolvent pursuant to NRS 695B.150;

(2) Declared insolvent by a court of competent jurisdiction; or

(3) Placed under an order of liquidation by a court of competent jurisdiction.

(d) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(e) "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

(f) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

695C.3175 Required contract with insurance company for provision of insurance, indemnity or reimbursement against cost of health care services; required provisions.

1. A health maintenance organization shall contract with an insurance company licensed in this State or authorized to do business in this State for the provision of insurance, indemnity or reimbursement against the cost of health care services which are provided by the health maintenance organization.

2. The contract of insurance required by subsection 1 must include a provision that, in the case of the insolvency or impairment of the health maintenance organization, the insurance company will pay all claims made by an enrollee for the period for which a premium has been or will be paid to the

health maintenance organization for the enrollee. The contract of insurance required by subsection 1 must specifically provide for the:

(a) Continuation of benefits to each enrollee for the period for which a premium has been or will be paid to the health maintenance organization for the enrollee until the expiration or termination of the enrollee's contract with the health maintenance organization;

(b) Continuation of benefits for each enrollee who is receiving inpatient services in a medical facility or facility for the dependent at the time of the insolvency or impairment of the health maintenance organization until the inpatient services are no longer medically necessary and the enrollee is discharged from the medical facility or facility for the dependent; and

(c) Payment of a provider of health care not affiliated with the health maintenance organization who provided medically necessary services to an enrollee, as described in the enrollee's evidence of coverage.

3. As used in this section:

(a) "Facility for the dependent" has the meaning ascribed to it in NRS 449.0045.

(b) "Impairment" means that a health maintenance organization is not insolvent and has been:

(1) Deemed to be impaired pursuant to NRS 695C.318; or

(2) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(c) "Insolvency" or "insolvent" means that a health maintenance organization has been:

(1) Deemed to be insolvent pursuant to NRS 695C.318;

(2) Declared insolvent by a court of competent jurisdiction; or

(3) Placed under an order of liquidation by a court of competent jurisdiction.

(d) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(e) "Medically necessary" has the meaning ascribed to it in NRS 695G.055.

(f) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

695C.3185 Plan for continuation of benefits if health maintenance organization becomes insolvent or impaired; approval by Commissioner; contents.

1. Each health maintenance organization shall develop, submit to the Commissioner for approval and, after such approval, put into effect a plan to provide for the continuation of benefits to enrollees in the event of the insolvency or impairment of the health maintenance organization, including, without limitation, the benefits described in subsection 2 of NRS 695C.3175. A plan developed pursuant to this subsection must include, without limitation:

(a) A contract of insurance which complies with the requirements of NRS 695C.3175; and

(b) Provisions in each contract between the health maintenance organization and a provider which obligate the provider, in the event of the health maintenance organization's insolvency or impairment, to provide all covered services as described in the contract to enrollees through the periods of time described in subsection 2 of NRS 695C.3175.

2. Before approving a plan submitted pursuant to subsection 1, the Commissioner may require the health maintenance organization to include in the plan:

(a) Reserves or additional reserves for protection against insolvency or impairment;

(b) Letters of credit acceptable to the Commissioner; and

(c) Any other arrangements determined by the Commissioner to be appropriate to ensure the continuation of benefits as described in subsection 2 of NRS 695C.3175 to enrollees.