PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R041-14

April 14, 2014

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

AUTHORITY: §1, NRS 679B.130, 689C.203 and 689C.270; §2, NRS 679B.130 and 689C.203; §3, NRS 679B.130, 689C.155 and 689C.203; §§4 and 5, NRS 679B.130.

A REGULATION relating to insurance; revising the contents of a disclosure required to be filed by a carrier serving small employers; revising provisions relating to preexisting conditions and rules of eligibility or premium or contribution rates to apply only to grandfathered plans; repealing provisions relating to waiting periods for new employees, minimum care and services under a health benefit plan, notification of conversion privileges, annual reports, development of a rate manual and calculation of rates, limitations on the frequency of increases in premium rates, disclosure of variances in premium rates, requirements for a denial of coverage and change of status by a carrier; and providing other matters properly relating thereto.

Section 1. NAC 689C.170 is hereby amended to read as follows:

689C.170 The disclosure required to be filed with the Commissioner pursuant to NRS 689C.270 must **[**~~be~~**]** ***:***

1. ***Be*** on a form which is in at least 10-point type and include:

[~~1.~~**]** ***(a)*** The name, address and telephone number of the carrier;

[~~2.~~**]** ***(b)*** The name, address and telephone number of the agent, broker and administrator, if applicable;

[~~3.~~**]** ***(c)*** A statement describing the principal benefits and the type of coverage provided; and

[~~4.~~**]** ***(d)*** A description of any provision of the policy which significantly excludes, eliminates, reduces or limits the payment of benefits, including limitations on access to an emergency room,

requirements concerning prior authorization, and limitations relating to the use of preferred or other providers ~~[.]~~ ***; or***

2. Include a summary of benefits and coverage issued pursuant to 42 U.S.C. § 300gg-15 and 45 C.F.R. § 147.200.

Sec. 2. NAC 689C.190 is hereby amended to read as follows:

689C.190 A carrier serving small employers shall, with regard to employees that had existing coverage continuously under a different health plan in the 90-day period immediately preceding the effective date of the new coverage, deem satisfied any provision in ~~[the policy]~~ ***a grandfathered plan*** which requires the passage of a fixed period before coverage is provided for a preexisting condition. The previous carrier shall provide information concerning the previous coverage within 10 working days after receipt of a written request by the current carrier.

Sec. 3. NAC 689C.195 is hereby amended to read as follows:

689C.195 1. A group health plan ***which is a grandfathered plan*** and a carrier that issues group health insurance pursuant to chapter 689C of NRS ***which is a grandfathered plan*** shall not include or establish any rule of eligibility, including continued eligibility, for any individual to enroll for benefits under the terms of the group health plan or group health insurance that discriminates based upon any health status-related factor that relates to the individual or a dependent of the individual.

2. A group health plan ***which is a grandfathered plan*** and a carrier that issues group health insurance pursuant to chapter 689C of NRS ***which is a grandfathered plan*** shall not include or establish any rule of eligibility, or set a premium or contribution rate, for any individual based on whether the individual is:

(a) Confined to a hospital or other health care institution; or

(b) Actively at work, including whether an individual is continuously employed, unless the group health plan or group health insurance treats absence from work because of a health factor as being actively at work.

3. As used in this section, "rule of eligibility" includes, without limitation, any rule of eligibility relating to:

(a) The effective date of coverage;

(b) Waiting or affiliation periods;

(c) Late and special enrollment periods; or

(d) Eligibility for benefit packages, including rules pursuant to which individuals may change their selection among benefit packages.

Sec. 4. NAC 689C.210 is hereby amended to read as follows:

689C.210 A carrier serving small employers shall ~~[, in accordance with the provisions of NRS 689C.200,]~~ take reasonable steps to market its health benefit plans to small employers located in the carrier's established geographic area.

Sec. 5. NAC 689C.110, 689C.140, 689C.150, 689C.160, 689C.200, 689C.202, 689C.205, 689C.220, 689C.260 and 689C.265 are hereby repealed.

TEXT OF REPEALED SECTIONS

689C.110 Adoption of waiting period for new employees not prohibited. (NRS 679B.130, 689C.190) The Commissioner will interpret the provisions of NRS 689C.190 as not

prohibiting an employer from adopting a waiting period for new employees to become eligible for participation in a plan of health insurance offered by the employer.

689C.140 Minimum care and services required. (NRS 679B.130, 689C.115, 689C.155, 689C.203) A health benefit plan offered pursuant to chapter 689C of NRS must include basic medical and hospital care, including at least:

1. Emergency care;
2. Inpatient and outpatient hospital services;
3. Physicians' services;
4. Outpatient medical services;
5. Laboratory services; and
6. X-ray services.

689C.150 Notification of conversion privilege; coverage of eligible dependent. (NRS 679B.130, 689C.203, 689C.330)

1. A certificate of coverage for a health benefit plan must include notification of the conversion privilege provided by NRS 689C.330.

2. An eligible dependent is entitled to be covered under a policy of health insurance issued pursuant to NRS 689C.330.

689C.160 Annual report. (NRS 679B.130, 689C.250)

1. A carrier serving small employers that offers a health benefit plan shall, on or before March 1 of each calendar year, file with the Commissioner a report concerning the operation of the carrier during the preceding calendar year. The report must include:

(a) A statement indicating whether the carrier intends to continue to offer health benefit plans;

(b) A list of the health benefit plans offered by the carrier, including the name of each health benefit plan and a name or number of the form filed pursuant to NAC 689C.180 for each health benefit plan;

(c) The total claims incurred in the preceding calendar year for health benefit plans for small employers in this State;

(d) The index rate as of December 31 of the preceding calendar year; and

(e) For each calendar quarter of the preceding calendar year:

(1) The total premiums earned from health benefit plans for small employers in this State;

(2) The number of health benefit plans that were in effect for small employers in this State;

(3) The number of health benefit plans that were in effect for small employers in this State that employed not less than 2 nor more than 10 employees; and

(4) The total number of natural persons covered by health benefit plans for small employers in this State.

2. The Commissioner will keep confidential the index rate that is submitted pursuant to this section.

3. As used in this section, "index rate" has the meaning ascribed to it in paragraph (b) of subsection 3 of NRS 689C.230.

689C.200 Development of rate manual; calculation of rates. (NRS 679B.130, 689C.155, 689C.203)

1. A carrier serving small employers shall develop a rate manual for each class of business established by the carrier. Base premium rates and new business premium rates charged to small employers by the carrier must be computed solely from the applicable rate manual. To the extent

that a portion of the premium rates charged by a carrier is based on the carrier's discretion, the manual must specify the criteria and factors considered by the carrier in exercising its discretion.

2. The rate manual must specify the risk characteristics and rate factors to be applied by the carrier in establishing premium rates for the class of business.

3. A carrier shall keep on file for at least 7 years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

689C.202 Limitation on frequency of increases in premium rates; exceptions. (NRS 679B.130, 689C.155, 689C.203)

1. Except as otherwise provided in this section, a carrier serving small employers shall not increase the premium rates for a group health benefit plan more frequently than every 6 months unless the increase in the premium rates is being made because:

(a) An employer has requested a change in its group health benefit plan;

(b) There has been a change in the number of employees covered by an employer that would affect the insurance premium rate of the employer; or

(c) There has been a change in federal or state law which affects the cost of providing services under the group health benefit plan.

2. If a carrier issues a group health benefit plan to a class of employers that consists solely of bona fide associations and uses a common date of renewal for that class, an increase in the premium rates for that class does not violate the provisions of subsection 1 solely because at least one but not all the members of that class will have an increase in premium rates more frequently than every 6 months.

689C.205 Disclosure of variance in premium rate. (NRS 679B.130, 689C.155, 689C.203) If a carrier serving small employers quotes a premium rate for a health benefit plan to a producer or a small employer who seeks health insurance coverage from the carrier, the carrier shall disclose how much the premium rate may vary from the quoted premium rate because of the health status of a person to be covered by the health insurance.

689C.220 Requirement upon denial of coverage. (NRS 679B.130, 689C.155, 689C.203) If a carrier serving small employers denies coverage in a health benefit plan to a small employer on the basis of a risk characteristic, the denial must be in writing and state the reasons for the denial, subject to any restrictions related to confidentiality of medical information.

689C.260 Prior notification of desire to change status as risk-assuming or reinsuring carrier. (NRS 679B.130, 689C.155, 689C.283)

1. If a carrier serving small employers wishes to change its election to operate as a risk-assuming or reinsuring carrier pursuant to NRS 689C.283 at the end of the current period of election, the carrier must notify the Commissioner not later than 30 days before the expiration of the current period of election.

2. If no such notice is provided, the carrier shall be deemed to have elected to operate with the same status for the next period of election.

689C.265 Application for change of status as risk-assuming or reinsuring carrier: Filing; action by Commissioner; confidentiality. (NRS 679B.130, 689C.155, 689C.283)

1. To change its status as a risk-assuming or a reinsuring carrier in accordance with NRS 689C.283, a carrier serving small employers must file an application for a change of status with the Commissioner.

2. The Commissioner will approve such an application for a change of status if the carrier provides evidence satisfactory to the Commissioner that the requested change of status is necessary for the carrier to meet its contractual and statutory obligations.

3. The Commissioner will notify the carrier in writing of his or her decision to approve or disapprove the application for a change of status within 60 days after receiving the application.

4. The carrier may request that the information in its application for a change of status be kept confidential, if disclosure of the information would adversely affect the financial solvency of the carrier or would promote unfair competition among other carriers serving small employers. The Commissioner will notify the carrier in writing of his or her decision to approve or disapprove such a request within 30 days after receiving the request.