ADOPTED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R161-22

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

AUTHORITY: §§ 1-3, NRS 679B.130; § 4, NRS 679B.130, 689C.155 and 695C.080.

A REGULATION relating to insurance; repealing certain duplicative and obsolete provisions; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law authorizes a producer of insurance or insurer to issue personal travel accident insurance policies by means of mechanical vending machines licensed by the Commissioner of Insurance. (NRS 683A.370) Existing regulations authorize the sale of insurance through a vending machine licensed by the Division of Insurance of the Department of Business and Industry. (NAC 680A.110-680A.150) **Section 4** of this regulation repeals these regulations, thereby removing requirements governing the sale of insurance using a vending machine that are provided in addition to the requirements prescribed by statute.

Existing regulations: (1) provide that the Commissioner will apply provisions of law governing electronic signatures to countersignatures by agents of insurers; (2) place certain duties on a countersigning producer of insurance; and (3) require the payment of commissions on property and casualty insurance which is sold by an agent or broker who is not licensed in Nevada and which covers a risk located in Nevada to be paid to a countersigning producer of insurance. (NAC 680A.405, 680A.410) **Section 4** repeals those specific requirements governing countersignatures, leaving countersigners subject to generally applicable laws and regulations, including laws and regulations governing electronic signatures and producers of insurance.

Existing law provides that words and terms defined in the Nevada Revised Statutes have the same meaning in corresponding provisions of the Nevada Administrative Code. (NRS 0.024) Existing regulations define certain terms for which a definition is currently set forth in NRS. (NRS 679A.060, 688C.030, 688C.040, 688C.050, 688C.070, 688C.080, 688C.090, 688C.110, 688C.130, 690C.070, 690C.080; NAC 688C.020, 688C.030, 688C.040, 688C.090-688C.120, 690C.020, 690C.030, 690C.040) **Section 4** removes these duplicative definitions from the Nevada Administrative Code.

Assembly Bill No. 521 of the 1997 Legislative Session removed a provision prohibiting a carrier that issues a health benefit plan for small employers from denying, excluding or limiting coverage for preexisting conditions during the 6 months immediately following the effective date of coverage if the employee had existing coverage continuously for up to not more than 90 days before the effective date of coverage under the health benefit plan. (Section 190 of Assembly Bill No. 521, chapter 586, Statutes of Nevada 1997, at page 2943) Existing law now prohibits such a carrier from: (1) denying, excluding or limiting coverage based on the health status of the

insured; or (2) requiring an insured to pay a higher premium, deductible, copay or coinsurance because of health status. (NRS 689C.190) **Section 4** repeals the interpretation of "existing coverage" for the purposes of that provision as it existed before 1997 because the term is no longer used in the relevant section. **Section 4** also repeals obsolete requirements concerning disclosure when a carrier charges a higher premium or denies coverage based on health status.

Assembly Bill No. 425 of the 2013 Legislative Session and Assembly Bill No. 83 of the 2017 Legislative Session repealed requirements that the Commissioner adopt regulations requiring certain health insurers to file a disclosure summarizing the policy of insurance offered by the insurer. (Section 119 of Assembly Bill No. 425, chapter 541, Statutes of Nevada 2013, at page 3661; section 168 of Assembly Bill No. 83, chapter 376, Statutes of Nevada 2017, at page 2406) **Section 4** repeals sections of the Nevada Administrative Code governing such disclosures.

Existing regulations require the Division of Public and Behavioral Health of the Department of Health and Human Services to study each application for a certificate of authority to establish and operate a health maintenance organization. (NAC 695C.125) **Section 4** repeals this requirement.

Existing law requires a health maintenance organization to be a member of the Nevada Life and Health Insurance Guaranty Association, which protects enrollees against failure in the performance of contractual obligations because of the impairment or insolvency of the health maintenance organization. (NRS 686C.130) **Section 4** repeals requirements that a health maintenance organization also carry insurance and maintain financial reserves to protect against insolvency.

Sections 1-3 of this regulation make conforming changes by removing references to repealed sections of the Nevada Revised Statutes and Nevada Administrative Code.

Section 1. NAC 688C.010 is hereby amended to read as follows:

688C.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in NAC ~~[688C.020]~~ ***688C.050*** to ~~[688C.120,]~~ ***688C.080,*** inclusive, have the meanings ascribed to them in those sections.

Sec. 2. NAC 695B.010 is hereby amended to read as follows:

695B.010 1. The point at which an insured's payment for coinsurance is no longer required to be paid for preferred providers of health care and for providers who are not preferred in a group contract for hospital, medical or dental services pursuant to subsection 6 of NRS 695B.185 must be disclosed to the insured ***.*** ~~[and included in the disclosure filed pursuant to NRS 695B.172.]~~

2. Each form of contract filed with the Commissioner must include a sample calculation of a claim using the method of calculation selected by the corporation.

3. The Commissioner will not approve a contract if the point at which an insured's payment for coinsurance is no longer required to be paid for preferred providers of health care and for providers who are not preferred is misleading or deceptively affects the risk purported to be assumed.

Sec. 3. NAC 695C.130 is hereby amended to read as follows:

695C.130 1. Except as otherwise provided in this section, a health maintenance organization which receives a certificate of authority shall maintain and report on its financial statement filed with the Commissioner pursuant to NRS 695C.210 a minimum net worth in an amount which is the greater of:

(a) One million five hundred thousand dollars;

(b) Two percent of the first $150,000,000 earned as revenue from premiums collected in the preceding 12-month period, plus 1 percent of the amount in excess of $150,000,000 earned as revenue from premiums collected in the preceding 12-month period; or

(c) The amount of risk-based capital determined in the manner set forth in NRS 681B.550 and the regulations adopted pursuant thereto.

2. In addition to the requirements set forth in subsection 1, a health maintenance organization which receives a certificate of authority shall maintain:

(a) A separate surety bond or deposit of not less than $250,000 of cash or securities for the protection of enrollees of this State;

(b) ~~[A contract of stop-loss insurance as required by NAC 695C.135 for new health maintenance organizations;~~

[(c)] Blanket fidelity coverage issued by an authorized insurer as required by NAC 695C.120 for new health maintenance organizations; and

[(d)] ***(c)*** The operating and insolvency reserves required for new health maintenance organizations.

3. In addition to the requirements set forth in subsections 1 and 2, a domestic health maintenance organization which receives a certificate of authority shall maintain a portion of not less than $500,000 of the required minimum net worth in the form of a deposit of cash or securities eligible for deposit under NRS 682B.030 for the sole benefit and protection of enrollees of this State.

4. If the Commissioner determines that the financial condition of a health maintenance organization fails to comply with the conditions set forth in NRS 695C.090, he or she may require the organization to:

(a) Maintain a net worth that is greater than the amount required by subsection 1;

(b) Obtain a written guarantee from a business which has sufficient surplus and an adequate history of generating net income to guarantee the maintenance of the minimum net worth of the health maintenance organization required by subsection 1 and obtain approval of the written guarantee and guarantor from the Commissioner; or

(c) Comply with paragraphs (a) and (b).

5. If a health maintenance organization proposes to make a material modification to its approved plan of operations, it shall submit a copy of its proposed modification to the Commissioner. The Commissioner may, as a condition of approval for the proposed modification by the health maintenance organization, require the health maintenance organization to increase the amount of reserves, deposits, bonds or minimum net worth it is required to maintain. The

Commissioner may, in making such a determination, consider the conditions set forth in NRS 695C.090.

Sec. 4. NAC 680A.110, 680A.120, 680A.130, 680A.140, 680A.150, 680A.405, 680A.410, 688C.020, 688C.030, 688C.040, 688C.090, 688C.095, 688C.100, 688C.110, 688C.120, 689C.100, 689C.170, 689C.172, 689C.175, 689C.205, 689C.220, 690C.010, 690C.020, 690C.030, 690C.040, 695B.035, 695C.125, 695C.135, 695C.137, 695C.290 and 695C.295 are hereby repealed.

TEXT OF REPEALED SECTIONS

680A.110 Conditions. Insurance companies licensed to do an insurance business in Nevada may merchandise any type of insurance permitted by the Division through any type of vending machine under the following conditions:

1. All policy forms must be filed with, and approved by, the Commissioner in accordance with the filing procedures for other policy forms.

2. Reasonable means, as determined by the Commissioner, must be provided for informing the prospective purchaser of the coverage and restrictions of the policy.

3. The name of the insurer, the location of its home office, the name of the responsible producer of insurance appointed by the insurer and his or her office address, and the serial number of the machine must be clearly displayed on each machine.

4. Prompt refund of money inserted in a defective machine and for which no insurance, or a lesser amount than paid for, must be provided to the applicant or prospective applicant.

5. Vending machines must be constructed and operated to retain a copy of the application showing the date of application, name and address of the applicant and of the beneficiary and the amount of insurance afforded by each policy issued.

6. All machines must be operated under the supervision of a producer of insurance appointed by the insurer issuing the policies.

7. Vending machines must be constructed and operated to affix the facsimile signature of the producer of insurance appointed by the insurer upon all policies issued therefrom, unless the producer of insurance appointed by the insurer is on the premises and personally countersigns them.

680A.120 License; fee. No vending machine may be placed in use until an application has been made for a license for that machine, payment of all applicable fees has been made to the Division and the license has been issued.

680A.130 Special licenses.

1. The Commissioner may issue a special vending machine license to the responsible agent. The license will apply to a specific machine or machines, and specify the name of the insurer and agent and the serial number or numbers of all machines included under that license.

2. The license is subject to annual continuation, expiration, suspension or revocation at the same time as the license of the agent.

3. Proof of the existence of a license for each vending machine in use may be required by the Commissioner.

680A.140 Inspection. Each licensed agent shall cause each vending machine to be inspected and tested with reasonable frequency, but not less than once each 7 days. If a machine is not in good working condition the agent shall cause a notice to be prominently displayed on the machine indicating that it is out of order. The notice must be maintained as long as the condition exists.

680A.150 Rental fees. The payment of excessive rental fees for insurance vending machines located in Nevada may result in withdrawal of approval by the Division of the forms authorized for use in the machines.

1. Fair and reasonable fees are:

(a) Where the annual premium volume is less than $50,000, the maximum rental payment may not exceed 13 percent of gross sales.

(b) Where the annual premium volume is between $50,000 and $100,000, the maximum rental fee payment may not exceed 17 1/2 percent of gross sales.

(c) Where the annual premium volume is in excess of $100,000, the maximum rental fee payment may not exceed 25 percent of gross sales.

2. A contract which provides for a flat guaranteed rental which exceeds the permitted percentage of premium income is void.

3. Any contract which binds an insurance company, its agents or representatives, the fee for which exceeds the rental fees permitted by this section, may not be renewed except for the rental fee authorized by this section.

680A.405 Countersignatures: Generally. The Commissioner will apply the provisions of chapter 719 of NRS to any countersignature that is required by NRS 680A.300.

680A.410 Countersignatures: Property and casualty insurance.

1. Countersignature fees and commissions may be negotiated for services required of a countersigning producer of insurance appointed by an insurer.

2. A countersigning producer of insurance appointed by an insurer shall maintain complete records of countersignature transactions, including daily reports, correspondence, names of agents and brokers who wrote the policies, and evidence of fees and commissions charged.

3. A countersigning producer of insurance appointed by an insurer shall handle normal problems arising between agents and customers, and is answerable to the Division for complaints and problems relating to policies which he or she has countersigned.

4. All commissions on property and casualty insurance which was sold by an agent or broker who is not licensed in Nevada and which covers a risk located in Nevada must be paid to a countersigning producer of insurance appointed by the applicable insurer.

688C.020 "Broker of viatical settlements" defined. "Broker of viatical settlements" has the meaning ascribed to it in NRS 688C.030.

688C.030 "Business of viatical settlements" defined. "Business of viatical settlements" has the meaning ascribed to it in NRS 688C.040.

688C.040 "Chronically ill" defined. "Chronically ill" has the meaning ascribed to it in NRS 688C.050.

688C.090 "Policy" defined. "Policy" has the meaning ascribed to it in NRS 688C.070.

688C.095 "Provider of viatical settlements" defined. "Provider of viatical settlements" has the meaning ascribed to it in NRS 688C.080.

688C.100 "Purchaser of viatical settlements" defined. "Purchaser of viatical settlements" has the meaning ascribed to it in NRS 688C.090.

688C.110 "Terminally ill" defined. "Terminally ill" has the meaning ascribed to it in NRS 688C.110.

688C.120 "Viatical settlement" defined. "Viatical settlement" has the meaning ascribed to it in NRS 688C.130.

689C.100 "Existing coverage" interpreted. For the purposes of subsection 2 of NRS 689C.190, the Commissioner will interpret "existing coverage" as not including coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, accident insurance only policies, credit insurance, plans for dental care, optometric plans, coverage provided as a supplement to Medicare, coverage for long-term care, disability income or specified disease, hospital confinement indemnity, or limited benefit health insurance if the requirements of NRS 689C.105 are satisfied.

689C.170 Contents of disclosure form. The disclosure required to be filed with the Commissioner pursuant to NRS 689C.270 must be on a form which is in at least 10-point type and include:

1. The name, address and telephone number of the carrier;

2. The name, address and telephone number of the agent, broker and administrator, if applicable;

3. A statement describing the principal benefits and the type of coverage provided; and

4. 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.

689C.172 Disclosures in advertising and sales materials; inclusion of certain information in health benefit plan.

1. As part of the disclosure required by NRS 689C.270, a carrier serving small employers shall disclose in the advertising and sales materials that the carrier provides to small employers:

(a) The term of the contract applicable to the premium rates;

(b) A general description of the underwriting factors that the carrier used to calculate premiums; and

(c) A description of the class of business in which the small employer is included.

2. A carrier serving small employers shall include a copy of the information described in paragraph (c) of subsection 1 in the health benefit plan that the carrier provides to an insured.

689C.175 Request for copy of disclosure. On behalf of a small employer, a producer may request a copy of the disclosure required to be filed with the Commissioner pursuant to NRS 689C.270.

689C.205 Disclosure of variance in premium rate. 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. 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.

690C.010 Definitions. As used in this chapter, unless the context otherwise requires, the words and terms defined in NAC 690C.020, 690C.030 and 690C.040 have the meanings ascribed to them in those sections.

690C.020 "Commissioner" defined. "Commissioner" means the Commissioner of Insurance.

690C.030 "Provider" defined. "Provider" has the meaning ascribed to it in NRS 690C.070.

690C.040 "Service contract" defined. "Service contract" has the meaning ascribed to it in NRS 690C.080.

695B.035 Disclosures in advertising and sales materials; inclusion of certain information in contract for hospital or medical service.

1. As part of the disclosure required by NRS 695B.172, an insurer shall disclose in the advertising and sales materials that the insurer provides to employers:

(a) The term of the contract applicable to the premium rates;

(b) A general description of the underwriting factors that the insurer used to calculate premiums; and

(c) A description of the class of business in which the employer is included.

2. An insurer shall include a copy of the information described in paragraph (c) of subsection 1 in the contract for hospital or medical service that the insurer provides to a subscriber.

695C.125 Application of health maintenance organization: Evaluation by Division of Public and Behavioral Health.

1. The Division of Public and Behavioral Health shall study each application for a certificate of authority to establish and operate a health maintenance organization and give the State Board of Health the opinion whether or not the applicant has:

(a) Adequate arrangements in his or her health maintenance organization to provide health care; and

(b) Adequate procedures established to develop, compile, evaluate and report statistical data concerning:

(1) The cost of its operations;

(2) The pattern of utilization, availability and accessibility of its services; and

(3) Such other matters as the Board may reasonably require.

2. The Division of Public and Behavioral Health shall present the results of the study, along with the application and other relevant documents, to the State Board of Health as soon as practicable.

3. The applicant may be represented at the meeting of the State Board of Health.

695C.135 Contract of insurance for health maintenance organization: Amount required; provision concerning insolvency of organization; notice of cancellation.

1. Each health maintenance organization shall obtain a contract of insurance for the cost of providing basic health care services which exceed in the aggregate:

(a) For a health maintenance organization in operation for 2 years or less, $30,000 per enrollee per year;

(b) For a health maintenance organization in operation for more than 2 years which has a free surplus of $2,000,000 or less, $50,000 per enrollee per year;

(c) For a health maintenance organization in operation for more than 2 years which has a free surplus of more than $2,000,000, $100,000 per enrollee per year;

(d) For a health maintenance organization in operation for more than 3 years which has a free surplus of more than $4,000,000, $150,000 per enrollee per year; and

(e) For a health maintenance organization in operation for more than 5 years which has a free surplus of more than $8,000,000, $200,000 per enrollee per year.

2. The contract of insurance must include a provision that, in the case of the insolvency of the health maintenance organization, the insurer will pay all claims made by an enrollee for the period for which a premium has been paid to the health maintenance organization. The contract may have an aggregate limit of $5,000,000 but must specifically provide for the:

(a) Continuation of benefits to enrollees for the period for which the subscribers have made prepayments to the health maintenance organization;

(b) Continuation of benefits for those enrollees confined in a medical facility or facility for the dependent at the time of the insolvency of the health maintenance organization until the enrollee is discharged from the facility; and

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

3. Any contract of insurance obtained by a health maintenance organization under this section may be cancelled only after 90 days' written notice of the cancellation is given to the Division by the health maintenance organization and its insurer.

4. As used in this section:

(a) "Basic health care services" includes hospitalization but excludes any benefits under an optional plan for dental, vision or pharmaceutical benefits.

(b) "Free surplus" means the total capital and surplus, as reported on the National Association of Insurance Commissioners' form of annual statement.

695C.137 Health maintenance organization: Reserves.

1. After the first year of operation, as a protection against insolvency, each health maintenance organization shall retain as reserves an amount equal to twice its actual average monthly uncovered expenditures for the previous year of operation or $500,000, whichever is greater.

2. A health maintenance organization may not reduce the reserves for protection against insolvency unless it notifies the Commissioner in writing and receives his or her written approval of the reduction. Any unauthorized reduction in this reserve creates a presumption that the health maintenance organization is in an unsound financial condition.

3. All reserves maintained by a health maintenance organization pursuant to this section:

(a) Must be deposited in a trust account in a bank chartered by this State or a bank that is a member of the Federal Reserve System and has been approved by the Commissioner. All income earned by the account belongs to the health maintenance organization and may be credited and paid to the health maintenance organization and used for its operations.

(b) Are in addition to those reserves established by the health maintenance organization according to good business and accounting practices for incurred but not reported claims and other similar claims.

695C.290 Filing, contents and delivery of disclosure summarizing coverage by health maintenance organization.

1. Each health maintenance organization shall file with the Commissioner, for his or her approval, a disclosure summarizing the coverage provided by a group health care plan offered by the health maintenance organization.

2. The disclosure must:

(a) Be in at least 10-point type;

(b) Include the name, address and telephone number of the health maintenance organization;

(c) Include the name, address and telephone number of the agent, broker and administrator, if applicable;

(d) Include a statement describing the principal benefits and the type of coverage being provided;

(e) Include a description of any provision of the health care plan which significantly excludes, eliminates, reduces or in any other manner operates to limit the payment of the benefits;

(f) Include a statement concerning the renewal provisions of the health care plan; and

(g) Define the term "usual and customary" or any similar term used in the plan.

3. The agent for the organization, the organization after a response to a direct-response solicitation or the broker representing the group policyholder shall deliver the approved disclosure summary to the proposed group policyholder as provided in NRS 695C.195.

695C.295 Disclosures in advertising and sales materials; inclusion of certain information in health care plan.

1. As part of the disclosure required by NRS 695C.193, an organization shall disclose in the advertising and sales materials that the organization provides to employers:

(a) The term of the contract applicable to the premium rates;

(b) A general description of the underwriting factors that the organization used to calculate premiums; and

(c) A description of the class of business in which the employer is included.

2. An organization shall include a copy of the information described in paragraph (c) of subsection 1 in the health care plan that the organization provides to an enrollee.