ADOPTED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R148-99

Effective January 27, 2000

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

AUTHORITY: §§ 1-53, NRS 679B.130 and 695C.275.

Section 1. Chapter 695C of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 26, inclusive, of this regulation.

Sec. 2. ***"Medicare + Choice plan" means a plan of health insurance established pursuant to the program set forth in sections 1851 to 1859, inclusive, of the Social Security Act, 42 U.S.C. §§ 1395w-21 to -28, inclusive.***

Sec. 3. ***"Provider-sponsored organization" means an entity that satisfies all the requirements set forth in 42 U.S.C. § 1395w-25(d) and the federal regulations adopted pursuant thereto.***

Sec. 4. ***1. Except as otherwise provided in this chapter or in specific provisions of Title 57 of NRS, the provisions of Title 57 of NRS are not applicable to any provider-sponsored organization issued a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to Title 57 of NRS except with respect to its activities as a provider-sponsored organization authorized and regulated pursuant to this chapter.***

2. Solicitation of enrollees by a provider-sponsored organization issued a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. A provider-sponsored organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

Sec. 5. *1. The provisions of NRS 449.465, 679B.159, subsections 2, 4, 18, 19 and 32 of NRS 680B.010, NRS 680B.025 to 680B.060, inclusive, chapter 685B of NRS and NRS 695G.010 to 695G.260, inclusive, apply to a provider-sponsored organization.*

2. For the purposes of subsection 1, unless the context requires that a provision apply only to insurers, any reference in those sections to "insurer" must be replaced by "provider-sponsored organization."

Sec. 6. *1. To offer a Medicare + Choice plan in this state, a provider-sponsored organization must file an application with the commissioner and obtain a certificate of authority to operate as an organization pursuant to chapter 695C of NRS and the regulations adopted pursuant thereto.*

2. A provider-sponsored organization shall not offer health insurance or other benefits for health care services in this state except through a Medicare + Choice plan, unless the provider-sponsored organization is licensed to provide other services in this state.

Sec. 7. *For a provider-sponsored organization, an application for a certificate of authority must be verified by an officer or authorized representative of the applicant, must be in a form prescribed by the commissioner and must set forth or be accompanied by the following:*

1. A copy of the basic organizational document, if any, of the applicant, and all amendments thereto;

2. A copy of the bylaws, rules or regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant;

3. A list of the names, addresses and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers in the case of a corporation, and the partners or members in the case of a partnership or association;

4. A copy of any contract made or to be made between any providers or persons listed in subsection 3 and the applicant;

5. A statement generally describing the provider-sponsored organization, the location of facilities at which health care services will be regularly available to enrollees and the type of health care personnel who will provide the health care services;

6. Certified financial statements showing the assets, liabilities and sources of financial support of the applicant;

7. A financial plan that includes a 3-year projection of the initial operating results anticipated and the sources of working capital as well as any other sources of funding;

8. A description of the proposed method of marketing;

9. A power of attorney duly executed by the applicant appointing the commissioner and his duly authorized deputies as the true and lawful attorney of such applicant in and for this state upon whom all lawful process in any legal action or proceeding against the provider-sponsored organization on a cause of action arising in this state may be served;

10. A statement reasonably describing the geographic area to be served; and

11. A description of the procedures for the resolution of enrollee complaints.

Sec. 8. *Upon the receipt of an application for a certificate of authority, the commissioner will transmit a copy of the application and any accompanying documents to the state board of health for informational purposes. The commissioner will issue or deny a certificate of authority to any person filing an application pursuant to section 6 of this regulation within 90 days after the date that the commissioner receives the application for a certificate of authority to operate as a provider-sponsored organization. A certificate of authority must be issued upon payment of the fees prescribed in section 15 of this regulation if the commissioner is satisfied that the following conditions are met:*

1. The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations.

2. The provider-sponsored organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

(a) The financial soundness of the arrangements of the health care plan for health care services and the schedule of charges used in connection therewith;

(b) The adequacy of working capital;

(c) Any agreement with an insurer, a government or any other organization for insuring the payment of the cost of health care services;

(d) Any agreement with providers for the provision of health care services; and

(e) Any surety bond or deposit of cash or securities to guarantee that the obligations will be duly performed.

3. Nothing in the proposed method of operation, as shown by the information submitted pursuant to sections 6, 7 and 11 of this regulation or by independent investigation, is contrary to the public interest.

Sec. 9. *The commissioner may deny a certificate of authority only after he has complied with section 25 of this regulation.*

Sec. 10. *1. A provider-sponsored organization shall obtain a contract of insurance for the cost of providing a Medicare + Choice plan which exceeds, per enrollee, an amount to be determined by the commissioner.*

2. The contract of insurance may have an aggregate limit in an amount to be determined by the commissioner. Subject to that aggregate limit, the contract of insurance must:

(a) Include a provision which states that, in case of the insolvency of the provider-sponsored organization, the insurer will pay all claims made by an enrollee for the period during which a premium was paid to the provider-sponsored organization.

(b) Specifically provide for:

(1) The continuation of benefits to enrollees for the period during which prepayments were made to the provider-sponsored organization;

(2) The continuation of benefits for enrollees confined in a medical facility or facility for the dependent at the time of the insolvency of the provider-sponsored organization until the enrollee is discharged from the facility; and

(3) The payment of a provider who is not affiliated with the provider-sponsored organization and who provided medically necessary services, as described in the evidence of coverage, to an enrollee during the time in which payments were made to the provider-sponsored organization.

3. A contract of insurance obtained by a provider-sponsored organization pursuant to this section must not be canceled unless the provider-sponsored organization and insurer provide the commissioner with written notice at least 90 days before the cancellation.

Sec. 11. *A provider-sponsored organization shall, unless otherwise provided for in this chapter, file a notice with the commissioner before any material modification of the operations described in the information required by section 7 of this regulation. The provider-sponsored organization 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 provider-sponsored organization, require the provider-sponsored organization to increase the amount of reserves, deposits, bonds or minimum net worth it is required to maintain. If the commissioner does not disapprove the modification within 90 days after filing of the notice, the modification is deemed approved.*

Sec. 12. *A provider-sponsored organization shall use accounting principles that are recognized by the laws of this state or approved by the commissioner for:*

1. All financial reports;

2. The accounting of investments and deposits; and

3. Transactions between affiliates and holding companies.

Sec. 13. *1. A provider-sponsored organization shall file with the commissioner on or before March 1 of each year a report showing its financial condition on the last day of the preceding calendar year. The report must be verified by at least two principal officers of the provider-sponsored organization.*

2. The report must be on forms prescribed by the commissioner and must include:

(a) A financial statement of the provider-sponsored organization, including its balance sheet and receipts and disbursements for the preceding calendar year;

(b) Any material changes in the information submitted pursuant to section 7 of this regulation;

(c) The number of persons enrolled during the year, the number of enrollees as of the end of the year, the number of enrollments terminated during the year and, if requested by the commissioner, a compilation of the reasons for such terminations;

(d) The number and amount of malpractice claims initiated against the provider-sponsored organization and any of the providers used by it during the year broken down into claims with and without form of legal process and the disposition, if any, of each such claim, if requested by the commissioner; and

(e) Such other information relating to the performance of the provider-sponsored organization as is necessary to enable the commissioner to carry out his duties pursuant to this chapter.

3. A provider-sponsored organization shall file with the commissioner annually an audited financial statement of the provider-sponsored organization prepared by an independent certified public accountant. The statement must cover the preceding 12-month period and must be filed with the commissioner within 120 days after the end of the fiscal year of the provider-sponsored organization. Upon written request, the commissioner may grant a 30-day extension.

4. If a provider-sponsored organization fails to file timely the report or financial statement required by this section, it shall pay an administrative penalty of $100 per day until

the report or statement is filed, except that the total penalty must not exceed $3,000. The attorney general shall recover the penalty in the name of the State of Nevada.

5. The commissioner may grant a reasonable extension of time for filing the report or financial statement required by this section if the request for an extension is submitted in writing and shows good cause.

Sec. 14. *All applications, filings and reports required under this chapter must be treated as public documents except as otherwise provided in this chapter.*

Sec. 15. *1. A provider-sponsored organization subject to this chapter shall pay to the commissioner the following fees:*

(a) For filing an application for a certificate of authority, $2,450.

(b) For issuance of a certificate of authority, $250.

(c) For an amendment to a certificate of authority, $100.

(d) For the renewal of a certificate of authority, $2,450.

(e) For filing each annual report, $25.

2. At the time of filing the annual report, the provider-sponsored organization shall forward to the department of taxation the tax and any penalty for nonpayment or delinquent payment of the tax in accordance with the provisions of chapter 680B of NRS.

3. All fees paid pursuant to this section shall be deemed earned when paid and may not be refunded.

Sec. 16. *A provider-sponsored organization shall have available for inspection the following information:*

1. A current statement of financial condition including a balance sheet and summary of receipts and disbursements;

2. A description of the organizational structure and operation of the provider-sponsored organization and a summary of any material changes since the issuance of the last report;

3. A description of services and information as to where and how to secure the services; and

4. A clear and understandable description of the method of the provider-sponsored organization for resolving enrollee complaints.

Sec. 17. *1. No provider-sponsored organization or representative thereof may cause or knowingly permit the use of advertising or solicitation which is untrue or misleading. For purposes of this chapter:*

(a) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan.

(b) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue if, in the total context in which such statement is made or such item of information is communicated, such statement or item of information may be reasonably understood by a reasonable person not possessing special knowledge regarding health care coverage as indicating any benefit or advantage or the absence of any exclusion, limitation or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan if such benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist.

2. NRS 686A.010 to 686A.310, inclusive, must be construed to apply to provider-sponsored organizations and health care plans except to the extent that the nature of provider-

sponsored organizations and health care plans render the sections therein clearly inappropriate.

3. An enrollee may not be canceled or not renewed except for the failure to pay the charge for such coverage or for cause as determined in the master contract.

4. No provider-sponsored organization, unless licensed as an insurer, may use in its name, contracts, or literature any of the words "insurance," "casualty," "surety," "mutual" or any other words descriptive of the insurance, casualty or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state.

5. No person not certificated pursuant to this chapter shall use in its name, contracts or literature the phrase "provider-sponsored organization" or the initials "PSO."

Sec. 18. *1. The commissioner will make an examination of the affairs of any provider-sponsored organization and providers with whom such provider-sponsored organization has contracts, agreements or other arrangements pursuant to its health care plan as often as he deems it necessary for the protection of the interests of the people of this state. An examination will be made not less frequently than once every 3 years.*

2. Every provider-sponsored organization and provider shall submit its books and records relating to the health care plan to an examination made pursuant to subsection 1 and in every way facilitate the examination. Medical records of natural persons and records of physicians providing service pursuant to a contract to the provider-sponsored organization are not subject to such examination, although the records are subject to subpoena upon a showing of good cause. For the purpose of examinations, the commissioner may administer oaths to, and examine the officers and agents of, the provider-sponsored organization and the principals of such providers concerning their business.

3. The expenses of examinations pursuant to this section must be assessed against the provider-sponsored organization being examined and remitted to the commissioner.

4. In lieu of such examination, the commissioner may accept the report of an examination made by the insurance commissioner or the state board of health of another state.

Sec. 19. *1. To determine its financial condition, fulfillment of its contractual obligations and compliance with law, the commissioner will, as often as he deems advisable, examine the affairs, transactions, accounts, records and assets of a provider-sponsored organization and of any person as to any matter relevant to the financial affairs of the provider-sponsored organization or to the examination. Except as otherwise provided in the Nevada Insurance Code, the commissioner will examine each provider-sponsored organization at least once every 3 years.*

2. The commissioner will examine each provider-sponsored organization applying for an initial certificate of authority.

3. In lieu of making his own examination, the commissioner may, in his discretion, accept a full report of the last recent examination of a foreign or alien provider-sponsored organization, certified to by the supervisory officer of insurance of another state.

4. To the extent that it is practical, the examination of a foreign or alien provider-sponsored organization must be made in cooperation with the insurance supervisory officers of other states in which the provider-sponsored organization transacts business.

Sec. 20. *1. If the commissioner examines a provider-sponsored organization pursuant to section 19 of this regulation, he will designate one or more examiners and instruct them as*

to the scope of the examination. The examiner shall, upon demand, exhibit his official credentials to the provider-sponsored organization being examined.

2. The commissioner will conduct each examination in an expeditious, fair and impartial manner.

3. The commissioner, or the examiner if he is authorized in writing by the commissioner, may administer oaths and examine under oath any person concerning any matter relevant to the examination.

4. Each provider-sponsored organization and its officers, attorneys, employees, agents and representatives shall make available to the commissioner or his examiners the accounts, records, documents, files, information, assets and matters of the provider-sponsored organization in his possession or control relating to the subject of the examination and shall facilitate the examination.

5. If the commissioner or examiner finds any accounts or records to be inadequate or inadequately kept or posted, he will so notify the provider-sponsored organization and give the provider-sponsored organization a reasonable opportunity to reconstruct, rewrite, post or balance the account or record. If the provider-sponsored organization fails to maintain, complete or correct the records or accounting after the commissioner or examiner has given the provider-sponsored organization written notice and a reasonable opportunity to do so, the commissioner may employ experts to reconstruct, rewrite, post or balance the account or record at the expense of the provider-sponsored organization being examined.

6. The commissioner or an examiner will not remove any record, account, document, file or other property of the provider-sponsored organization being examined from the office or place of business of the provider-sponsored organization unless the commissioner or examiner

has the written consent of an officer of the provider-sponsored organization before the removal or pursuant to an order of a court. This provision does not prohibit the commissioner or examiner from making or removing copies or abstracts of a record, account, document or file.

Sec. 21. *1. The provider-sponsored organization being examined shall pay the expense of an examination. The expenses to be paid include only the reasonable and proper travel and lodging expenses of the commissioner and his examiners and assistants, including, without limitation, expert assistance, reasonable compensation to the examiners and assistants and incidental expenses as necessarily incurred in the examination. The commissioner will consider the scales and limitations recommended by the National Association of Insurance Commissioners regarding the expense and compensation for an examination.*

2. The provider-sponsored organization shall promptly pay to the commissioner the expenses of the examination upon presentation by the commissioner of a reasonably detailed written statement thereof.

Sec. 22. *The commissioner will use the procedures required by:*

1. NRS 679B.230 to 679B.290, inclusive, when conducting an examination of a provider-sponsored organization.

2. NRS 679B.310 to 679B.370, inclusive, when conducting a hearing involving a provider-sponsored organization.

Sec. 23. *Any rehabilitation, liquidation or conservation of a provider-sponsored organization shall be deemed to be the rehabilitation, liquidation or conservation of an insurance company and will be conducted under the supervision of the commissioner*

pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies.

Sec. 24. *1. The commissioner may suspend or revoke any certificate of authority issued to a provider-sponsored organization pursuant to the provisions of this chapter if he finds that any of the following conditions exist:*

(a) The provider-sponsored organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to sections 6, 7 or 11 of this regulation, unless any amendments to those submissions have been filed with and approved by the commissioner;

(b) The provider-sponsored organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(c) The continued operation of the provider-sponsored organization would be hazardous to its enrollees; or

(d) The provider-sponsored organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of section 25 of this regulation.

3. If the certificate of authority of a provider-sponsored organization is revoked, the provider-sponsored organization shall proceed to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the provider-sponsored organization. The commissioner may by written order permit such further

operation of the provider-sponsored organization as he may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 25. *1. When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority to operate a provider-sponsored organization exist, or that grounds for the suspension or revocation of a certificate of authority for a provider-sponsored organization exist, he will notify the provider-sponsored organization in writing specifically stating the grounds for denial, suspension or revocation and fixing a time at least 30 days thereafter for a hearing on the matter.*

2. After the hearing, or upon the failure of the provider-sponsored organization to appear at the hearing, the commissioner will take action as is deemed advisable on the written findings which must be mailed to the provider-sponsored organization. The actions of the commissioner are subject to review by the First Judicial District Court of the State of Nevada in and for Carson City. The court may, in disposing of the issue before it, modify, affirm or reverse the order of the commissioner in whole or in part.

Sec. 26. *1. The commissioner may, in lieu of suspension or revocation of a certificate of authority of a provider-sponsored organization pursuant to section 24 of this regulation, levy an administrative penalty in an amount not more than $2,500 for each act or violation if reasonable notice in writing is given of the intent to levy the penalty.*

2. If the commissioner for any reason has cause to believe that any violation of this chapter has occurred or is threatened, the commissioner may give notice to the provider-sponsored organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their

authorized representatives to attempt to determine the facts relating to the suspected violation, and, if it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

3. The proceedings conducted pursuant to the provisions of subsection 2 will not be governed by any formal procedural requirements and may be conducted in such manner as the commissioner may deem appropriate under the circumstances.

4. The commissioner may issue an order directing a provider-sponsored organization or a representative of a provider-sponsored organization to cease and desist from engaging in any act or practice in violation of the provisions of this chapter.

5. Within 30 days after service of the order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this chapter have occurred. The hearing will be conducted pursuant to the provisions of chapter 233B of NRS and judicial review will be available as provided therein.

6. In the case of any violation of the provisions of this chapter, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection 4, the commissioner may institute a proceeding to obtain injunctive relief, or seek other appropriate relief in the district court of the judicial district of the county in which the violator resides.

Sec. 27. NAC 695C.010 is hereby amended to read as follows:

695C.010 As used in this chapter, unless the context otherwise requires, the words and terms defined in:

1. NAC 695C.019 to 695C.090, inclusive, ***and sections 2 and 3 of this regulation*** have the meanings ascribed to them in those sections; and

2. NRS 695C.030 have the meanings ascribed to them in that section.

Sec. 28. NAC 695C.060 is hereby amended to read as follows:

695C.060 "Organization" means a health maintenance organization ~~[.]~~ ***or a provider-sponsored organization.***

Sec. 29. NAC 695C.120 is hereby amended to read as follows:

695C.120 An application for a certificate of authority must be accompanied by all forms specifically required by chapter 695C of NRS and provided by the division and by:

1. All documents describing the financing and ownership of the organization, including financial statements and copies of any contracts made or to be made between any member of the governing board or committee, the officers of the corporation or partners of a partnership or association, or providers, and the proposed organization. The financial statements must depict a net worth of not less than $1,500,000 ~~[.]~~ ***for a health maintenance organization.*** All financial statements must be certified by an independent certified public accountant.

2. ~~[A]~~ ***For a health maintenance organization, a*** surety bond or deposit of cash or securities for the protection of the enrollees in the amount of $250,000 or more which is deposited with the commissioner. The bond must include a provision preventing cancellation except after written notice to the commissioner of not less than 90 days. ~~[An]~~ ***A health maintenance*** organization which has made a deposit of securities pursuant to this subsection may withdraw them if it makes an equivalent deposit of cash, securities or a combination of cash and securities acceptable to the commissioner.

3. ~~[A]~~ ***For a health maintenance organization, a*** blanket fidelity bond in an amount of not less than $1,000,000 in the aggregate to cover every director, officer, partner and employee of

the ***health maintenance*** organization who may receive, collect, disburse or invest funds in connection with the activities of the ***health maintenance*** organization.

4. A proposed plan of operation for the first 3 years of operation based on projected total income and projected total expenses. The amounts stated for the cost of medical services and the use of them in the proposed plan must be certified by a qualified actuary. The plan must project income and expected costs allocated to:

(a) Coverage for emergencies or medically necessary services rendered outside of the ~~[organization's]~~ specified geographic area of service ~~[;]~~ ***of the organization;***

(b) Per capita payments to primary physicians;

(c) Fees to other providers of health care;

(d) Supplemental benefits;

(e) A contract of stop loss insurance;

(f) Expenses of administration; and

(g) Amortization of necessary costs for the establishment of the organization.

Sec. 30. NAC 695C.123 is hereby amended to read as follows:

695C.123 1. Any ~~[health maintenance]~~ organization which holds a certificate of authority issued by the commissioner and is seeking qualification ~~[under]~~ ***as a health maintenance organization pursuant to*** 42 U.S.C. § ~~[300e-9(d)]~~ ***300e-9(c) or qualifies as a provider-sponsored organization by satisfying all the requirements set forth in 42 U.S.C. § 1395w-25(d) and the federal regulations adopted thereto*** shall submit to the division information concerning that qualification, including:

(a) The date and time of the inspection to be conducted by the Federal Government;

(b) The name and address of the federal officer responsible for investigating the organization; and

(c) A copy of any report by the Federal Government qualifying or denying the qualification of the organization.

2. Any organization which has been so qualified shall submit to the division a copy of any:

(a) Notice of deficiency received from the Federal Government concerning its qualification; and

(b) Report presented to the Federal Government to maintain its qualification.

3. Each organization shall file with the division, for informational purposes, any documents received from or sent to the Federal Government if those documents materially affect the operation and marketing of the organization in Nevada.

Sec. 31. NAC 695C.124 is hereby amended to read as follows:

695C.124 1. Any person wishing to review an application for issuance of a certificate of authority for ~~[a health maintenance]~~ ***an*** organization shall submit a request to the division in writing. The application may be reviewed at the offices of the division at 1665 Hot Springs Road, Carson City, Nevada, or a copy of the application may be requested. If a copy of the application is requested, money to reimburse the division for the cost of postage and of preparing the copy must be submitted with the request.

2. If any person wishes to be notified of a pending application or hearing concerning the denial of a certificate of authority, he must request in writing that he be placed on a list maintained by the division for this purpose.

Sec. 32. NAC 695C.125 is hereby amended to read as follows:

695C.125 1. The health division 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 ***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 health division 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.

Sec. 33. NAC 695C.1255 is hereby amended to read as follows:

695C.1255 ~~[Before the state board of health reports to the commissioner whether the organization meets the requirements of NRS 695C.080, the]~~

1. An organization ***applying for a certificate of authority*** must establish that:

~~[1.]~~ ***(a)*** The organization has an adequate number of providers in each category of provider of health care necessary to serve its members in each geographic location in its service area;

~~[2.]~~ ***(b)*** The providers of health care with whom the organization has contracted to provide services are located so that the members may obtain health care without unreasonable travel;

~~[3.]~~ ***(c)*** Nonemergency services are available and accessible during normal business hours and emergency services are available at any time;

~~[4. Members]~~ ***(d) For a health maintenance organization, members*** can schedule appointments within a reasonable time, as determined by the state board of health;

~~[5. Members]~~ ***(e) For a health maintenance organization, members*** are not required to wait for an unreasonable period of time in the office of a provider for a scheduled appointment, as determined by the state board of health;

~~[6.~~ ***(f)*** Members have access to their primary physician through on-call procedures after normal business hours;

~~[7.~~ ***(g)*** It requires the providers of health care with whom the organization has contracted to provide service to maintain records of the health care of its members which are accessible to other professionals within the organization;

~~[8.~~ ***(h)*** It provides a health care professional who is primarily responsible for coordinating the overall health care services offered to members;

~~[9.~~ ***(i)*** It has established a quality assurance program as required pursuant to NAC 695C.400; and

~~[10.~~ ***(j)*** The organization has established a system to collect data related to the health care services provided to members.

2. A health maintenance organization must satisfy the requirements of subsection 1 before the state board of health reports to the commissioner whether the health maintenance organization meets the requirements of NRS 695C.080.

Sec. 34. NAC 695C.126 is hereby amended to read as follows:

695C.126 If an applicant ***for a certificate of authority to establish and operate a health maintenance organization*** submits information changing its application after review by the state board of health, the division will deny the application.

Sec. 35. NAC 695C.127 is hereby amended to read as follows:

695C.127 1. Any applicant for a certificate of authority who is licensed to operate ~~[a health maintenance]~~ ***an*** organization in another state or whose affiliate or subsidiary is so licensed shall include in its application a copy of that license and, if available, a certificate of good standing from that state's agency which regulates ~~[health maintenance]~~ organizations.

2. Any organization already authorized in ~~[Nevada who]~~ ***this state who*** obtains a license as ~~[a health maintenance]~~ ***an*** organization in another state or whose affiliate or subsidiary obtains such a license shall furnish a copy of that license to the commissioner within 30 days after receipt of the license.

3. An organization also licensed in another state shall notify the division of any disciplinary action taken by that state and file copies of all documents relating to that action with the division within 10 days after receipt of the documents by the organization.

Sec. 36. NAC 695C.128 is hereby amended to read as follows:

695C.128 1. If an organization holding a certificate of authority in ~~[Nevada]~~ ***this state*** is licensed in a state contiguous to ~~[Nevada]~~ ***this state*** and wishes to contract with providers in that state for services for enrollees in ~~[Nevada,]~~ ***this state,*** the organization shall submit to the division, for its review and approval, two copies of:

(a) The ~~[organization's]~~ plan ***of the organization*** for operation in that ***other*** state;

(b) A copy of the evidence of coverage to be issued, if it has not been previously filed with the division;

(c) Its list of providers and agreements with the providers; and

(d) Any other materials concerning the administration of the plan necessary for the ~~[division's]~~ decision ***of the division*** concerning ~~[it.]~~ ***the organization.***

2. The division will consider such a plan to be a material modification of the ~~[organization's]~~ operations ***of the organization*** in ~~[Nevada]~~ ***this state*** and ***, for a health maintenance organization,*** will submit copies of all documents to the state board of health for its review.

3. The division, before it approves such a plan, will consider whether the other state will approve the plan.

Sec. 37. NAC 695C.129 is hereby amended to read as follows:

695C.129 1. Any person not entitled to a hearing pursuant to NRS 695C.340 ***or section 25 of this regulation*** who is aggrieved by an action of the commissioner in his approval, denial or revocation of a certificate of authority for ~~[a health maintenance]~~ ***an*** organization may request a hearing as provided in NRS 679B.310.

2. Any person who wants to intervene in any proceeding held pursuant to NRS 695C.340 ***or section 25 of this regulation*** may request that intervention as provided in NAC 679B.460, 679B.470 and 679B.480.

3. Any administrative proceeding under chapter 695C of NRS and this chapter will be held pursuant to the procedures in NAC 679B.161 to 679B.480, inclusive.

Sec. 38. NAC 695C.130 is hereby amended to read as follows:

695C.130 1. Except as otherwise provided in this section, ~~[an]~~ ***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:

(a) Equal to $1,500,000; or

(b) Equal to 2 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,

FLUSH whichever is greater.

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

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

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

(c) A blanket fidelity bond as required by NAC 695C.120 for new ***health maintenance*** organizations.

(d) The operating, premium tax and insolvency reserves required for new ***health maintenance*** organizations.

3. If the commissioner determines that the financial condition of ~~[an]~~ ***a health maintenance*** organization fails to comply with the conditions set forth in NRS 695C.090, he 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 ~~[organization's]~~ 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).

4. If ~~[an]~~ ***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 ~~[organization's]~~ 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. 39. NAC 695C.135 is hereby amended to read as follows:

695C.135 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 an organization in operation for 2 years or less, $30,000 per enrollee per year;

(b) For ~~[an]~~ ***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 ~~[an]~~ ***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 ~~[an]~~ ***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 ~~[an]~~ ***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 ~~[an]~~ ***a health maintenance*** organization under this section may be canceled 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 sum held by the ***health maintenance*** organization in assets and investments authorized by chapter 695C of NRS as its surplus and for its uncovered expenditures.

Sec. 40. NAC 695C.137 is hereby amended to read as follows:

695C.137 1. Each ***health maintenance*** organization shall retain as reserves an amount:

(a) Equal to the premium taxes owed pursuant to chapter 680B of NRS; and

(b) After the first year of operation, as a protection against insolvency, equal to twice its actual average monthly uncovered expenditures for the previous year of operation or $500,000, whichever is greater.

2. Payments for premium taxes may be made from the account maintained for reserves.

3. Except as otherwise provided in subsection 2, no ***health maintenance*** organization may reduce the reserves for protection against insolvency unless it notifies the commissioner in writing and receives his 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.

4. All reserves maintained by ~~[an]~~ ***a health maintenance*** organization pursuant to this section:

(a) Must be deposited in a trust account in a federally insured financial institution located in Nevada. 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.

Sec. 41. NAC 695C.165 is hereby amended to read as follows:

695C.165 1. Any organization which wants to expand its geographic area of service from that stated in its application shall submit to the division:

(a) A copy of a written description of the area it proposes to serve;

(b) A list of the providers who will offer comprehensive health care services to the ~~[organization's]~~ enrollees ***of the organization*** in that area;

(c) A copy of the contract with those providers;

(d) A statement describing the effect of the expansion on the operation and financial position of the organization and certifying that the organization is financially able to expand;

(e) A statement describing the method of marketing and the projected number of enrollees from the new area;

(f) Proof that the organization has notified its insurers for its contracts of surety, fidelity and stop loss insurance of the proposed changes; and

(g) The fee for amending its certificate of authority.

2. ~~[The]~~ ***A health maintenance*** organization ***that wants to expand its geographic area*** shall send one copy of its submission to the state board of health for its review.

3. Any request by an organization to expand the area of its service will be treated by the division as a material modification of the ~~[organization's operation .]~~ ***operation of the organization.*** If the organization subsequently submits information amending the request for expansion, the division will presume that the original request has been withdrawn and the period for approval or disapproval will be computed from the date of receipt of the amended request.

Sec. 42. NAC 695C.170 is hereby amended to read as follows:

695C.170 1. The comprehensive health care services offered by ~~[an]~~ ***a health maintenance*** organization in its evidence of coverage must provide for basic and preventive medical care for the enrollee which is medically necessary, including:

(a) Services in an emergency provided by a hospital or physician;

(b) Any care received as an admitted patient at a hospital;

(c) Care by a physician; and

(d) Medical services as an outpatient.

2. The ***health maintenance*** organization, as a part of its comprehensive services, must offer to the subscriber optional plans for optometric, dental and pharmaceutical care. The subscriber may be subject to an additional charge for these types of care.

Sec. 43. NAC 695C.200 is hereby amended to read as follows:

695C.200 1. Each applicant for a certificate of authority shall:

(a) Submit a list of the providers in its health care plan and a description of the type of providers based upon a projected number of enrollees;

(b) Sufficiently describe its list of providers to demonstrate the accessibility and availability of health care to its enrollees; and

(c) Describe a plan for increasing the number of providers based upon increased enrollment.

2. The ~~[health maintenance]~~ organization shall notify:

(a) ~~[The]~~ ***For a health maintenance organization, the*** division and the state board of health in writing at the end of each quarter of each calendar year of any changes in its list of providers; ~~[and]~~

(b) ***For a provider-sponsored organization, the division in writing at the end of each quarter of each calendar year of any changes in its list of providers; and***

(c) An enrollee in writing of the disassociation of his primary physician from the organization not later than 30 working days after such disassociation.

3. Based upon the current list of providers of an organization, an overall reduction of more than 30 percent in the number of primary physicians in a geographic area of service or a material change in the panel of specialists ~~[,]~~ shall be deemed by the division to jeopardize the ability of the organization to meet its obligations to its enrollees, and the division will so notify the ***organization, and for a health maintenance organization, the division will also notify the*** state board of health ***.*** ~~[and the organization.]~~ The organization may rebut this presumption by providing written information to the division within 14 days after the notice is sent to ~~[the state board of health and]~~ the organization.

4. The provisions of subsection 3 do not apply if the organization:

(a) Notifies the division in writing;

(b) Submits information concerning the number of persons enrolled in the organization and the reasons for any reductions; and

(c) Obtains the approval of the division in advance for the reduction.

Sec. 44. NAC 695C.215 is hereby amended to read as follows:

695C.215 1. An organization may establish schedules for nominal copayments to be made by an enrollee to a provider. A copayment may be not more than 50 percent of the total cost of providing any single service to an enrollee or, ***for a health maintenance organization,*** in the aggregate, not more than 20 percent of the total cost of providing all of the basic health care services described in NAC 695C.170.

2. An organization shall not impose additional copayments against an enrollee in a calendar year if the copayments actually paid in that calendar year are 200 percent or more of the total annual premium the enrollee would pay if he were enrolled under a health care plan, offered by the organization, which had no copayment. The organization shall submit to the division copies of the procedure it uses to notify an enrollee and his primary physician when the ~~[enrollee's]~~ costs ***of the enrollee*** exceed that limit.

3. The amount of each copayment listed in the schedule given to the enrollee and submitted to the division for approval must be stated in dollars and must not be expressed as a percentage of the cost of the service or the item supplied.

4. With each filing of a schedule of copayment, the organization shall submit a:

(a) Certificate, signed by an officer of the organization, stating that the schedule meets the requirements of this section; and

(b) Copy of the calculations demonstrating that the schedule meets those requirements.

5. If the division fails to notify the organization of the denial of the schedule within 30 days after it has been filed, the schedule shall be deemed to be approved as submitted by the organization.

Sec. 45. NAC 695C.230 is hereby amended to read as follows:

695C.230 ***1.*** To obtain approval of a system for resolving complaints of enrollees concerning health care services covered by ~~[an]~~ ***a health maintenance*** organization as required pursuant to NRS 695C.260 and 695G.200, the ***health maintenance*** organization must submit to the division:

~~[1.]~~ ***(a)*** The name and title of the employee responsible for the system;

~~[2.]~~ ***(b)*** A description of the procedure used to notify an enrollee of the decision regarding his complaint; and

~~[3.]~~ ***(c)*** A copy of the explanation of rights and procedures which is to be provided to an enrollee pursuant to NRS 695C.260 and 695G.230.

~~[4. An]~~ ***2. A health maintenance*** organization may not delegate the responsibility for the operation of a system to resolve complaints to a delivery system intermediary.

Sec. 46. NAC 695C.235 is hereby amended to read as follows:

695C.235 1. ~~[An]~~ ***A health maintenance*** organization shall submit its annual report regarding its system for resolving complaints as required pursuant to NRS 695C.260 and 695G.220 on or before June 1 of each year. The ***health maintenance*** organization shall retain a copy of the annual report for at least 3 years or until the next examination conducted by the division, whichever is longer.

2. The ***health maintenance*** organization is not required to include in the annual report information concerning an oral inquiry by an enrollee relating to a misunderstanding or miscommunication if the misunderstanding or miscommunication was resolved within 24 hours after the inquiry was made. If the misunderstanding or miscommunication was not resolved within 24 hours, the ***health maintenance*** organization shall report it as a complaint in the annual report.

Sec. 47. NAC 695C.240 is hereby amended to read as follows:

695C.240 ~~[An]~~ ***A health maintenance*** organization shall notify the division of the names and addresses of enrollees nominated to its joint board on consumer satisfaction within 6 months after the ***health maintenance*** organization first enrolls persons in its health care plan.

Sec. 48. NAC 695C.270 is hereby amended to read as follows:

695C.270 1. Each organization shall file its annual report on the form designated "Health Maintenance Organizations, Association Edition," by the National Association of Insurance Commissioners, as it existed on August 1, 1990. That form, which is hereby adopted by reference, may be obtained at a cost of ~~[$6.75 plus the cost of mailing from Brandon Insurance Service Company, P.O. Box 22238, Nashville, Tennessee 37202-2238.]~~ ***$18 from Global Financial Press, 1845 Walnut Street, Philadelphia, Pennsylvania 19103, telephone: (215) 977-7458.*** The organization shall follow the instructions accompanying that form.

2. Each organization shall include in its annual report the number and amount of claims of malpractice initiated against it during that year. The report must include claims made with or without legal process and the disposition, if any, of each claim.

3. Each organization shall furnish a copy of any annual report it distributes to its enrollees to the division 30 days before that distribution with a notice of its intent to distribute it.

4. If an organization is required by federal law to submit quarterly reports to the Office of Health Maintenance Organizations, it shall submit copies of those reports to the division.

5. If deemed appropriate, the commissioner will require that a financial statement be submitted to him more frequently than annually. If a quarterly statement is required, it must be:

(a) Filed on the most current form for quarterly statements for an organization adopted by the National Association of Insurance Commissioners; and

(b) Completed in accordance with the instructions accompanying that form.

6. ~~[The]~~ ***For a health maintenance organization, the*** financial statement of the organization filed pursuant to subsection 3 of NRS 695C.210 is a separate document from the annual statement required to be filed pursuant to paragraph (a) of subsection 2 of NRS 695C.210. ***For a provider-sponsored organization, the financial statement of the organization filed pursuant to subsection 3 of section 13 of this regulation is a separate document from the annual statement required to be filed pursuant to paragraph (a) of subsection 2 of section 13 of this regulation.*** The financial statement filed pursuant to subsection 3 of NRS 695C.210 ***or subsection 3 of section 13 of this regulation*** must be filed for each individual organization not later than 90 days after the end of its fiscal year. Consolidated statements for organizations that are members of an insurance holding company are not acceptable.

7. The commissioner will, if appropriate, take disciplinary action pursuant to NRS 695C.340 or 695C.350 ***or section 25 or 26 of this regulation*** against an organization which fails to file its financial statements on the prescribed forms, or by the prescribed date. The commissioner will grant, for good cause and upon advance written request, an extension for filing a statement.

Sec. 49. NAC 695C.275 is hereby amended to read as follows:

695C.275 1. Each ***health maintenance*** organization which receives a certificate of authority shall include the following information in its annual report submitted to the commissioner pursuant to NRS 695C.210:

(a) The number and percentage of women who were continuously enrolled in the health care plan of the ***health maintenance*** organization for the previous 2 calendar years:

(1) Who were at least 52 years of age, but not more than 64 years of age; and

(2) Who during that time had a mammogram.

(b) The number and percentage of women who were continuously enrolled in the health care plan of the ***health maintenance*** organization for the previous 3 calendar years:

(1) Who were at least 21 years of age, but not more than 64 years of age; and

(2) Who during that time obtained a medical examination which included a pap smear.

(c) The number and percentage of infants born to women who were enrolled in the health care plan of the ***health maintenance*** organization during the previous calendar year that weighed:

(1) Less than 1,500 grams at birth.

(2) More than 1,500 grams, but less than 2,500 grams at birth.

(d) The number and percentage of women enrolled in the health care plan of the ***health maintenance*** organization:

(1) Who gave birth to a child who survived childbirth during the previous calendar year;

(2) Who were continuously enrolled in the health care plan for not less than 12 months before the birth of the child; and

(3) Who received obstetrical care during pregnancy.

FLUSH The ***health maintenance*** organization shall include in the report the number of times that each such woman visited an obstetrician during the first trimester of pregnancy and during the entire pregnancy.

(e) The number and percentage of women enrolled in the health care plan of the ***health maintenance*** organization during the previous calendar year who had a cesarean section performed on them.

(f) Any medical screening or other activities related to preventative health care offered by the ***health maintenance*** organization during the previous calendar year.

(g) The number and percentage of providers of the ***health maintenance*** organization who filed at least one written complaint, excluding any complaints relating to the payment of a claim. The ***health maintenance*** organization shall summarize the reasons for the complaints and the manner in which each complaint was resolved.

2. The ***health maintenance*** organization shall provide the health division with a copy of the information included in the annual report pursuant to this section at the same time that it files its annual report with the commissioner.

Sec. 50. NAC 695C.300 is hereby amended to read as follows:

695C.300 Each examination of an organization, including one made pursuant to NRS 695C.310 ~~[,]~~ ***or section 18 of this regulation,*** must be conducted in accordance with the requirements found in the handbooks and manuals adopted by reference in NAC 679B.033 and the provisions of NRS 679B.250 to 679B.300, inclusive.

Sec. 51. NAC 695C.310 is hereby amended to read as follows:

695C.310 1. As part of the examination of the quality of health care services ***for a health maintenance organization*** required pursuant to NRS 695C.310, the state board of health will

review or cause the health division to review and report the results of an examination of the organization conducted by:

(a) The Federal Government for federal qualification as a health maintenance organization;

(b) A group which is nationally recognized to provide accreditation of health maintenance organizations; or

(c) A person approved by the board pursuant to subsection 2.

2. The state board of health shall maintain a list of not less than two persons whom the board has approved to assist the board in conducting the examination of ~~[an]~~ ***a health maintenance*** organization.

3. During an examination, the ***health maintenance*** organization shall provide such information as the board or health division deems necessary and shall allow the board or the health division to review any relevant books, records and operations necessary at the place of business of the ***health maintenance*** organization.

Sec. 52. NAC 695C.320 is hereby amended to read as follows:

695C.320 1. Not less than 90 days after an examination is completed, the health division shall mail to the ***health maintenance*** organization by certified mail, return receipt requested, the proposed findings of its review. The proposed findings must include, without limitation, any deficiencies discovered within the ***health maintenance*** organization and its proposed recommendations to be given by the state board of health to the commissioner regarding the certification of the ***health maintenance*** organization.

2. The ***health maintenance*** organization may mail to the health division any written objections to the proposed findings of the examination not later than 30 days after the date upon which the proposed findings were mailed pursuant to subsection 1.

3. If the ***health maintenance*** organization objects to the proposed findings, the health division shall attempt to resolve the dispute. If the dispute is not resolved within 30 days from the date upon which the objections were mailed pursuant to subsection 2, the health division shall inform the board of the dispute. The board will then provide for a hearing as soon as practicable. A written copy of any final decision of a hearing must be sent to the commissioner.

4. If the ***health maintenance*** organization does not object to the proposed findings of the health division or if any dispute has been resolved, the health division shall provide its proposed findings to the board. After reviewing the proposed findings, the board will mail its proposed findings and recommendations to the commissioner.

Sec. 53. NAC 695C.510 is hereby amended to read as follows:

695C.510 1. An organization which enters into a health service contract with a delivery system intermediary shall file a copy of the health service contract with the commissioner as a material modification of operations pursuant to NRS 695C.140 ~~[.]~~ ***or section 11 of this regulation.***

2. In addition to complying with the provisions of NAC 695C.505, the contract must be signed by the organization and the delivery system intermediary and include:

(a) All exhibits, attachments, addenda, schedules or any other documents relating to the contract; and

(b) A statement of a qualified actuary that the contract:

(1) Is a financially sound transaction;

(2) Does not cause excessive payments to the delivery system intermediary;

(3) Provides for reasonable incentives to the delivery system intermediary for the containment of costs; and

(4) Does not substantially or unreasonably contribute to the increase in the cost of providing health care services to enrollees or subscribers.

3. The information required by subsection 2 is not required to include the monetary value of the services which will be provided pursuant to the health service contract, but that information must be made available to the commissioner upon request.

4. As used in this section, “qualified actuary” has the meaning ascribed to it in NAC 681B.155.