REVISED ADOPTED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R009-02

Effective July 11, 2002

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

AUTHORITY: §1, NRS 679B.130, 695B.280, 695D.100 and 695F.300; §§2-5, 17 and 18, NRS 679B.130; §6, NRS 679B.130 and 689B.027; §7, NRS 679B.130 and 689B.090; §§8, 9 and 12, NRS 679B.130 and 689C.155; §§10 and 11, NRS 679B.130, 689C.155 and 689C.283; §13, NRS 679B.130, 689C.155 and 689C.270; §§14 and 15, NRS 695B.280; §16, NRS 695B.172 and 695B.280; §19, NRS 695C.193; §20, NRS 679B.130, 689B.027, 689C.270, 695B.172 and 695C.193

Section 1. Chapter 687B of NAC is hereby amended by adding thereto a new section to read as follows:

1. If an insurer issues a health insurance policy or contract, health care plan, health benefit plan or plan for dental care, whether individual, group or blanket, that includes a grace period:

(a) The insurer shall not require the payment of an additional premium for the grace period. If a premium is not paid by the end of the grace period, the contract of insurance terminates retroactively to the end of the day next preceding the grace period.

(b) Except as otherwise provided in this paragraph, the insurer is not required to pay claims incurred during the grace period while a required premium remains unpaid and may seek reimbursement for any such claim erroneously paid during the grace period. The insurer is liable for any claims incurred during the grace period if the required premium payment is received during the grace period in accordance with the contract of insurance.

2. The commissioner will, pursuant to NRS 687B.130, disapprove or withdraw the approval of any form used by an insurer which provides that, in lieu of requiring during the grace period the payment of a premium due, the insurer may deduct the premium due from the payment of a claim.

3. As used in this section:

(a) "Grace period" means the time after the date that a premium is due during which the premium can be paid without penalty to keep the policy in force.

(b) "Insurer" means any insurer that issues any health insurance policy or contract, health care plan, health benefit plan or plan for dental care, whether individual, group or blanket, and includes any:

(1) Insurance company;

(2) Carrier;

(3) Nonprofit corporation for hospital, medical or dental service;

(4) Health maintenance organization;

(5) Organization for dental care; or

(6) Prepaid limited health service organization.

Sec. 2. Chapter 689B of NAC is hereby amended by adding thereto the provisions set forth as sections 3 to 7, inclusive, of this regulation.

Sec. 3. *As used in NAC 689B.300 and 689B.310, and section 4 of this regulation, unless the context otherwise requires, the words and terms defined in NRS 689B.350 to 689B.460, inclusive, have the meanings ascribed to them in those sections.*

Sec. 4. *1. A group health plan and a carrier that issues group health insurance pursuant to chapter 689B of NRS 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 and a carrier that issues group health insurance pursuant to chapter 689B of NRS 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. 5. *1. Except as otherwise provided in this section, an insurer that issues group health insurance in this state shall not increase the premium rates for the insurance 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 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 health benefit plan.

2. If an insurer issues group health insurance 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.

Sec. 6. *1. As part of the disclosure required by NRS 689B.027, 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 health benefit plan that the insurer provides to an insured.

Sec. 7. *An insurer that offers blanket accident and health insurance in this state shall comply with the provisions of sections 5 and 6 of this regulation.*

Sec. 8. Chapter 689C of NAC is hereby amended by adding thereto the provisions set forth as sections 9 to 13, inclusive, of this regulation.

Sec. 9. *1. A group health plan and a carrier that issues group health insurance pursuant to chapter 689C of NRS 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 and a carrier that issues group health insurance pursuant to chapter 689C of NRS 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. 10. *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 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 decision to approve or disapprove such a request within 30 days after receiving the request.

Sec. 11. ***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.

Sec. 12. ***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.

Sec. 13. ***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.

Sec. 14. Chapter 695B of NAC is hereby amended by adding thereto the provisions set forth as sections 15 and 16 of this regulation.

Sec. 15. ***1. Except as otherwise provided in this section, a nonprofit corporation for hospital, medical or dental services shall not increase the premium rates under a group contract for hospital, medical or dental services 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 contract for hospital, medical or dental services;

(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 contract for hospital, medical or dental services.

2. If a nonprofit corporation for hospital, medical or dental services issues a group contract for hospital, medical or dental services 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.

Sec. 16. *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.

Sec. 17. Chapter 695C of NAC is hereby amended by adding thereto the provisions set forth as sections 18 and 19 of this regulation.

Sec. 18. ***1. Except as otherwise provided in this section, an organization shall not increase the premium rates for a group health care 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 care 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 care plan.

2. If an organization issues a group health care 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.

Sec. 19. ***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.

Sec. 20. Sections 6, 13, 16 and 19 of this regulation apply to any disclosures given for health insurance, group contracts for hospital or medical service and group health care plans

offered by insurers, nonprofit corporations for hospital, medical or dental services and health maintenance organizations that are offered or issued on or after July 10, 2002.

NOTICE OF ADOPTION OF PROPOSED REGULATION
LCB File No. R009-02

The Commissioner of Insurance adopted regulations assigned LCB File No. R009-02 which pertain to group health insurance (chapters 687B, 689B, 389C, 695B and 695C of the Nevada Administrative Code) on April 15, 2002.

Notice date: January 23, 2002
Hearing date: February 20, 2002

Date of adoption by agency: 4/15/2002
Filing date: 5/23/2002

INFORMATIONAL STATEMENT

A hearing was held on February 20, 2002, at the offices of the Department of Business and Industry, Division of Insurance (Division), 788 Fairview Drive, Suite 300, Carson City, Nevada 89701, with a simultaneous video-conference conducted at the Bradley Building, 2501 E. Sahara Avenue, Manufactured Housing Division Conference Room, 2nd Floor, Las Vegas, Nevada 89104, regarding the adoption of the regulation concerning group health insurance.

Public comment was solicited by posting notice of the hearing in the following public locations: 788 Fairview Drive, Legislative Counsel Bureau, Capitol Building Lobby, Carson City Courthouse, State Library, County Libraries, Capitol Press Room and the Division's Las Vegas Office.

In addition, the Division maintains a list of interested parties, comprised mainly of insurance companies, agencies and other persons regulated by the Division. These persons were notified of the hearing and that copies of the regulation could be obtained from or examined at the offices of the Division in Carson City.

Written and oral testimony was received by the Division. Copies of any comments received by the Division can be obtained from the Division at 788 Fairview Drive, Suite 300, Carson City, Nevada 89701, (775) 687-4270.

Considering the comments by those attending the hearing or by those who submitted written comments, the Commissioner has issued an order adopting the regulation as a permanent regulation of the Division.

Based upon Mr. Kim's written comments and the testimony received at the hearing, the regulation was changed from the proposed regulation as follows:

1. Section 5 is amended to read as follows: "An insurer that issues group health insurance in this state shall not increase the premium rates for the insurance more frequently than every 6 months except for the following:

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

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

(c) There has been a change in federal or state statutes or regulations which affects the health benefit plan cost of providing services; or

(d) All employers within a class that have a common date of renewal."

2. Paragraph (b) of subsection 1 of section 6 is amended to read as follows: "A general description of the underwriting factors used to calculate premiums; and."

The economic impact of the regulation is as follows:

(a) Regulated Industry: None

(b) Public: None

The regulation imposes no direct costs upon members of the public at large. The regulation imposes no direct cost upon the agency to enforce the regulation.

This regulation does not duplicate or overlap any other regulation.