PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R131-98

August 21, 1998

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

AUTHORITY: §§ 1-6, NRS 679B.130 and 695F.300.

Section 1. Chapter 695F of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 5, 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. To offer a Medicare + Choice plan in this state, a provider-sponsored organization must obtain a certificate of authority to operate as an organization pursuant to chapter 695F 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.

Sec. 5. *1. A provider-sponsored organization shall obtain a contract of insurance for the cost of providing a Medicare + Choice plan which exceeds, per enrollee, in 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. 6. NAC 695F.210 is hereby amended to read as follows:

695F.210 1. Except as otherwise provided in subsection 2, each organization shall obtain a contract of insurance for the cost of providing limited health services which **[**exceed**]** *exceeds* in the aggregate, for an organization that has a free surplus of:

(a) Not more than $1,000,000, $30,000 per enrollee per year.

(b) More than $1,000,000 but not more than $2,000,000, $50,000 per enrollee per year.

(c) More than $2,000,000, $100,000 per enrollee per year.

2. The commissioner may authorize an organization to obtain a contract of insurance for the cost of providing limited health services which **[**exceed**]** *exceeds* in the aggregate per enrollee an amount which is less than the amount required pursuant to subsection 1 if the maximum benefit payable per enrollee is less than the amount required pursuant to subsection 1.

3. The contract of insurance may have an aggregate limit of $5,000,000. Subject to that limit, the contract must:

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

(b) Specifically provide for:

(1) The continuation of benefits to enrollees for the period **[**for**]** *during* which the subscribers have made prepayments to the 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 organization until the enrollee is discharged from the facility; and

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

4. A contract of insurance obtained by an organization pursuant to this section **[**may**]** *must* not be canceled unless the organization and insurer provide the commissioner with **[**90 days' prior**]** written notice **[**of**]** *at least 90 days before* the cancellation.

5. The provisions of this section do not apply to a provider-sponsored organization.