

LCB File No. R224-97

NOTICE OF INTENT TO ACT UPON A REGULATION

Notice of Hearing for the Amendment of Regulations of the
Department of Business and Industry, Division of Insurance

The department of Business and Industry 48 to 52 of AB 521 only apply to individual health benefit plan policy forms for which new business was written on or after July 16, 1997.

Sec.nd Industry, Division of Insurance (Division) will hold a public hearing at 10:00 a.m., on January 27, 1998 at the offices of the Division, 1665 Hot Springs Road, Suite 152, Carson City, Nevada. The purpose of the hearing is to receive comments from all interested persons regarding the amendment of regulations pertaining to chapters 686A, 689A, 689B, and 689C of the Nevada Administrative Code.

**REGULATION FOR HEALTH INSURANCE PORTABILITY AND
ACCOUNTABILITY AND UNFAIR TRADE PRACTICES**

The following information is provided pursuant to the requirements of NRS 233B.060:

1. The proposed regulation is needed to establish standards for the health insurance pursuant to chapter 586, Statutes of Nevada 1997, at page 2883.
2. The regulations provide for the portability and availability of health insurance; amend NAC 689C.160 concerning the annual report due on or before March 1 of each year; and amends chapter 686A of NAC to prohibit the denial of insurance in a takeover situation due to an actively at work provision.
3. Estimated economic effect of the regulation:

On the business which it is to regulate:

The regulation should have both an immediate and long-term adverse impact on carriers due to the increased cost to administer health benefit plans.

On the public:

The regulation should have no direct impact on the public. The regulation may have both an immediate and long-term indirect impact as the cost of insurance is passed on to the public.

4. The Division may incur some additional costs to enforce the regulation.
5. The Division is not aware of any overlap or duplication of the regulation with any state, local or federal regulation.

6. The regulation is required pursuant to chapter 586, Statutes of Nevada 1997, at page 2883, which was enacted in response to the Health Insurance Portability and Accountability Act of 1996, (HIPAA, Pub. L. 104-191).

7. The proposed regulation does not establish a new fee or increase an existing fee.

Las Vegas Library
833 Las Vegas Blvd.
North Las Vegas, NV 89101

Douglas County Library
1625 Library Lane
P.O. Box 337
Minden, NV 89423

Elko County Library
720 Court Street
Elko, NV 89801

Goldfield Public Library
Fourth & Cook Street
P.O. Box 430
Goldfield, NV 89013

Eureka Branch Library
10190 Monroe Street
P.O. Box 293
Eureka, NV 89316

Humboldt County Library
85 East 5th Street
Winnemucca, NV 89445

Battle Mountain Branch Library
P.O. Box 141
Battle Mountain, NV 89820

Lincoln County Library
93 Main Street
P.O. Box 330
Pioche, NV 89043

Lyon County Library
20 Nevin Way
Yerington, NV 89447

Mineral County Library
First & A Street
P.O. Box 1390
Hawthorne, NV 89415

Tonopah Public Library
171 Central Street
P.O. Box 449
Tonopah, NV 89049

Pershing County Library
1125 Central Avenue
P.O. Box 781
Lovelock, NV 89419

Storey County Library
95 South R Street
P.O. Box 449
Tonopah, NV 89049

Washoe County Library
1125 Central Avenue
P.O. Box 781
Lovelock, NV 89419

White Pine County Library
950 Campton Street
Ely, NV 89301

Clark County Library
1401 East Flamingo Road
Las Vegas, NV 89119

R224-97

Health Insurance Portability and Accountability and Unfair Trade Practices and Fraud Regulations

AUTHORITY: § 2, NRS 689A.655; § 3, NRS 689A.670; § 4, NRS 689A.690; § 5, NRS 689A.720; § 6, NRS 689A.700; §§ 7 and 8, NRS 689A.710; § 10, NRS 689B.480; § 11, NRS 689B.590; § 13, NRS 689C.157; § 14, NRS 689C.191; §§ 15-19, NRS 689C.355; § 20, NRS 689C.940; § 21, Section 223 of AB 521; §24, NRS 679B.130

Section 1. Chapter 689a of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 8, inclusive, of this regulation.

Sec. 2. An individual carrier must file its basic health benefit plans and the standard health benefit plans in accordance with Bulletin No. 87-4, Policy and Form Filing Procedures, with the following exceptions.

1. Clearly stamp the word "HIPAA" on the filing documentation form, FFD100.
2. Subsection (c), (d) and (e) of section 2 of Bulletin No. 87-4 does not apply.

Sec. 3. An individual risk-assuming or reinsuring carrier that wishes to change its status must notify the commissioner of its new election at least 30 days prior to the expiration of the current election period. An individual carrier which fails to notify the commissioner of its election within 30 days prior to the expiration of an election period will be deemed to have elected not to change its status for the next election period.

An individual risk-assuming or reinsuring carrier may, at any time, apply to the commissioner to change its status. The application, on a form prescribed by the commissioner, will be considered if adequate justification is provided that a change in status is necessary for the carrier to meet its contractual and statutory obligations to present and future policyholders. A carrier may request the application be kept confidential if disclosure could adversely affect the carrier's financial solvency or promote unfair competition in the marketplace. The commissioner shall notify the carrier in writing of the decision to approve or disapprove the application within 60 days after its receipt.

Sec. 4. The annual actuarial certification required pursuant to section 51 of AB 521 must also include the following information:

- 1) The number of individual health benefit plan rating blocks established by the carrier;

- 2) After adjusting for rating characteristics and plan benefit design, the ratio of written premium per exposure for the highest individual health benefit plan rating block to written premium per exposure for the lowest individual health benefit rating block;
- 3) After adjusting for rating characteristics and plan benefit design, the ratio of written premium per exposure for the basic and standard health benefit plan rating block or blocks to written premium per exposure for the lowest individual health benefit plan rating block; and
- 4) For each rating factor, the ration of the highest factor to the lowest factor.

- Sec. 5. An individual who is unable to obtain a certificate of creditable coverage pursuant to NRS 689A.720 may provide, and a carrier must accept, evidence which reasonably establishes prior creditable coverage. This evidence may include, but is not limited to, a copy of a policy or evidence of coverage, premium billing statements, canceled checks, insurance identification card, explanation of benefits, COBRA notification letter, evidence received from the liquidator, or a statement from the insured which includes the name of the last carrier along with its telephone number.
- Sec. 6. Sections 48 to 52 of AB 521 only apply to individual health benefit plan policy forms for which new business was written on or after July 16, 1997.
- Sec. 7. An individual carrier must offer it's two most popular health benefit plans to an eligible person effective 1-1-98, unless the individual carrier has filed and obtained approval for a basic health benefit plan and a standard health benefit plan approved by the commissioner.
- Sec. 8. An individual carrier which provides a quote for a health benefit plan must disclose to an agent or broker how much the quote can deviate for health status.
- Sec. 9. Chapter 689b of NAC is hereby amended by adding thereto the provisions set forth as sections 10 to 11, inclusive, of this regulation.
- Sec. 10. An individual who is unable to obtain a certificate of creditable coverage pursuant to NRS 689B.490 may provide and a carrier must accept, evidence which reasonably establishes prior creditable coverage. This evidence may include, but is not limited to, a copy of a policy or evidence of coverage, premium billing statements, canceled checks, insurance identification card, explanation of benefits, COBRA notification letter, evidence received from the liquidator, or a statement from the insured which includes the name of the last carrier along with its telephone number.

Sec. 11. A carrier which offers conversion policies must, not less than 60 days prior to each annual renewal date, send notice informing each conversion policyholder of his right to elect a basic or standard health benefit plan as a substitute conversion policy. This notice must include the required premium for the basic and standard health benefit plans.

A carrier must spread any losses on its conversion policies across its entire book of health benefit plan business. A carrier which issues health benefit plans to both small and large group employers in this state may, allocate group conversion premium and loss experience to its small or large group employer blocks of business based on the number of small or large group conversion policyholders relative to the total number of group policyholders. Group conversion premium and loss experience may also be allocated to a carriers' small and large group books of business based on the proportion of total premium earned in its small or large group employer health benefit plan book of business relative to the total premium earned from all group health benefit plans in the experience period.

Sec. 12. Chapter 689c of NAC is hereby amended by adding thereto the provisions set forth in sections 13 to 22, inclusive, of this regulation.

Sec. 13. An carrier must file its basic health benefit plans and the standard health benefit plans in accordance with Bulletin No. 87-4, Policy and Form Filing Procedures with the following exceptions:

1. Clearly stamp the word "HIPAA" on the filing documentation form, FFD100; and
2. Subsection (c), (d) and (e) of section 2 of Bulletin No. 87-4 does not apply.

Sec. 14. An individual who is unable to obtain a certificate of creditable coverage pursuant to NRS 689c.192 may provide, and a carrier must accept, evidence which reasonably establishes prior creditable coverage. This evidence may include, but is not limited to, a copy of a policy or evidence of coverage, premium bill statements, canceled checks, insurance identification card, explanation of benefits, COBRA notification letter, evidence received from the liquidator, or a statement from the insured which includes the name of the last carrier along with its telephone number.

Sec. 15. A small group carrier shall not unfairly discriminate in the benefits it offers on the basis of the size of the group. A small group carrier that offers benefits to a small employer group shall offer the same benefits to any other small employer group.

- Sec. 16. A small group carrier which provides a quote for a small employer group health benefit plan must disclose how much the quote can deviate for health status.
- Sec. 17. An agent or broker may request a copy of the disclosure required pursuant to NRS 689C.270 on behalf of a small employer.
- Sec. 18. An individual carrier that issues franchise plans pursuant to NRS 689A.370 must report the following information on or before March 1 of each calendar year:
1. The number of franchise plans in force as of 6-30-97;
 2. The number of franchise plans in force as of 12-31 of the preceding calendar year;
 3. The number of employer groups that authorized a list billing for a franchise plan in the preceding calendar year;
 4. The size of the largest employer group that authorized a list billing for franchise plan in the preceding calendar year; and
 5. The number of employees denied or not offered coverage under franchise plans in the preceding calendar year.
- Sec. 19. A small employer carrier must accept applications for a small group health plan on the following state of Nevada Group Enrollment Form:

STATE OF NEVADA
GROUP ENROLLMENT FORM
2-50 EMPLOYEES

NEW GROUP ADD-ON QUALIFIED LATE ENROLEE NON-QUALIFIED LATE ENROLEE GROUP #

EMPLOYEE INFORMATION

Employee Name First Name MI Social Security # Date of Birth Sex Marital Status

Employee Address Apt. # City State Zip Home Tel. # () Work Tel. # ()

Employer Name Hire Date Effective Date HMO PPO

Height Weight Employee's PCP (HMO ONLY) ID No.

Do you or any of your dependents have other health coverage including Medicare? Yes No Name of Policy Holder Insurance Carrier Policy/Group #

Spouse Social Security # Spouse Employer Name of Beneficiary Relationship

Coverage status: Employee Only Employee/Spouse Employee/Child(ren) Employee/Family

Coverage Applied for: Life: Yes No Amount: \$ Dental: Yes No Vision: Yes No
 STD: Yes No LTD: Yes No If yes to STD and/or LTD, Annual Salary: \$

CONTINUATION OF COVERAGE INFORMATION

Indicate continuation coverage desired. You may not elect to add persons to your current coverage: (i.e. "SELF ONLY" TO "SELF/FAMILY") unless you have a change in family status.
 Employee Only Employee/Spouse Employee/Child(ren) Employee/Family

QUALIFYING EVENT INFORMATION

Qualifying Event	Date Event Occurred	Qualifying Event	Date Event Occurred
<input type="checkbox"/> Death of Employee		<input type="checkbox"/> Legal Separation	
<input type="checkbox"/> Termination of Employee Employment		<input type="checkbox"/> Ineligibility of Dependent Child	
<input type="checkbox"/> Reduction of Employee Work Hours		<input type="checkbox"/> Selection of Medicare by Employee as Primary Coverage	
<input type="checkbox"/> Divorce			

ENROLLMENT INFORMATION

Eligible Dependents	Last Name	First Name	MI	Date of Birth	Height	Weight	Primary Care Physician (HMO Only)	PCP ID. # (HMO Only)
<input type="checkbox"/> Husband <input type="checkbox"/> Wife								
<input type="checkbox"/> Son <input type="checkbox"/> Daughter								
<input type="checkbox"/> Son <input type="checkbox"/> Daughter								
<input type="checkbox"/> Son <input type="checkbox"/> Daughter								

INSURANCE WAIVER Must be completed and signed if you/your dependents are not enrolling for coverages elected by your employer. I have been given an opportunity for Group Medical Insurance provided by my employer. I am not applying for:

- Employee Medical Family Medical Spouse Medical Child(ren) Medical Dental
- The reason I am not applying for the coverage:
 Covered by Spouse's Employer Plan Other:

Policy # Single Family Other

Name of Spouse's Employer Name of Insurance Company

I understand that I will be required to provide evidence of insurability for myself and/or my dependents, at my expense, should I desire to apply at a later date.

Date _____ Employee Signature _____

STATE OF NEVADA
GROUP ENROLLMENT FORM
2-50 EMPLOYEES

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Does anyone smoke?	<input type="checkbox"/>	<input type="checkbox"/>	b). Had ulcers, hernia(s), chronic diarrhea, colitis, or other digestive problems?
<input type="checkbox"/>	<input type="checkbox"/>	2. Does anyone have prescriptions for, or currently take, any prescribed medicines, drugs, pills, shots or have physical therapy?	<input type="checkbox"/>	<input type="checkbox"/>	11a). Had any prostate problems, kidney or urinary tract problems?
<input type="checkbox"/>	<input type="checkbox"/>	3. Has anyone been told of a need, or possible need for, or is anyone planning or scheduled for, physical therapy, a specialist consultation, surgery, hospitalization, medical treatment, psychotherapy, counseling, EKG, stress test, CT/MRI scan, blood test or any other medical tests or examinations?	<input type="checkbox"/>	<input type="checkbox"/>	b). Had problems of the reproductive system, menstrual problems, or breast disorders?
<input type="checkbox"/>	<input type="checkbox"/>	4. Does anyone have any physical or mental birth defect, developmental or learning disability, behavior disorder, or is anyone pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	c). Had venereal disease (such as gonorrhea, syphilis, genital herpes, chlamydia) or other infectious disease?
<input type="checkbox"/>	<input type="checkbox"/>	5. Is anyone pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	12. Had shortness of breath, chronic cough, bronchitis, tuberculosis, asthma, emphysema, pneumonia, or other respiratory or lung problem?
<input type="checkbox"/>	<input type="checkbox"/>	In the past 5 years has anyone:	<input type="checkbox"/>	<input type="checkbox"/>	13. Been unconscious, had epilepsy, seizures, convulsions, migraine headaches, paralysis, dizziness or other neurological condition?
<input type="checkbox"/>	<input type="checkbox"/>	6. Been told by a doctor, health care provider, counselor, therapist, or any medical specialist of the need to reduce or discontinue the use of alcohol or drugs, or been treated for the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	14. Received counseling, psychotherapy, group therapy, or had depression, stress, anxiety, or any mental/nervous condition?
<input type="checkbox"/>	<input type="checkbox"/>	7. Had any surgery, hospitalization, observation room stay, or hospital emergency room treatment or minor emergency clinic, urgent care clinic or outpatient treatment?	<input type="checkbox"/>	<input type="checkbox"/>	15. Had cancer, tumors, fibroids, cysts or growths of any kind? If yes, was it <input type="checkbox"/> Benign <input type="checkbox"/> Malignant
<input type="checkbox"/>	<input type="checkbox"/>	8. Been to or consulted a doctor, chiropractor, counselor, therapist, health care provider or any medical specialist, had blood tests (other than for HIV antibody), other medical tests or been referred to a medical specialist?	<input type="checkbox"/>	<input type="checkbox"/>	16a). Had diabetes, thyroid disorder, endocrine (glandular) condition?
<input type="checkbox"/>	<input type="checkbox"/>	9a). Had any chest pain or pressure, heart trouble, heart attack, heart murmur, rapid, slow or irregular heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	b). Had anemia or disorder of the blood, blood cells, clotting system?
<input type="checkbox"/>	<input type="checkbox"/>	b). Had high blood pressure, stroke, or other circulatory problems?	<input type="checkbox"/>	<input type="checkbox"/>	c). Had any disorder of the lymph nodes, lymph system or immune system?
<input type="checkbox"/>	<input type="checkbox"/>	c). Had an EKG or stress test?	<input type="checkbox"/>	<input type="checkbox"/>	17a). Had any back, neck or spinal problems; bone, jaw or muscle condition?
<input type="checkbox"/>	<input type="checkbox"/>	10a). Had liver or gallbladder problems, hepatitis or cirrhosis?	<input type="checkbox"/>	<input type="checkbox"/>	b). Had arthritis, gout or joint disorder?
					19. Had lupus, multiple sclerosis, muscular dystrophy?
					20. Been treated for or diagnosed as having any disease or disorder of the immune system?

NOTE: If any of the above questions are answered "YES", please give full details below. Use additional paper, if necessary. Sign and date ALL pages.

Question No/Letter	Name of Person	Diagnosis of illness or injury Treatment, Testing or Medical Attention. Please be specific	Date Mo. Yr.	Duration of Condition or Problem	Any Remaining Symptoms or Problems	Names and Address Of Doctors, Hospitals, etc.

I understand the pre-existing conditions limitations in the plan (if any). I understand that I am entitled to a copy of this form.

If applicable, notification of acceptance or rejection of this application will be sent by the insurance company to the employee and to the group. When applicant is accepted the effective date will be indicated.

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief. I agree that they shall be the basis of my acceptance for membership. I realize that any misrepresentation or omission regarding the pre-existing conditions or disease may result in rescission of my coverage.

I hereby authorize and request any hospital, clinic, institution, or other person to furnish complete information of diagnosis, treatment, medical history, or any other information and conclusions concerning the mental and physical condition of the above applicant(s) and to accept as valid a photocopy of this authorization and my signature. This authorization is valid for thirty (30) months from the date below.

Employee's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Sec. 20. A policy issued as a stop loss policy is a health benefit plan if the specific attachment point is less than \$10,000 or the aggregate attachment point is less than 115% of expected claims.

Sec. 21. A small employer means any person or governmental entity actively engaged in a business:

- a) which, with respect to a calendar year and a plan year, employed on business days during the preceding calendar year an average of at least 2, but not more than 50 employees who have a normal work week of 30 hours or more, and which employs at least 2 employees on the first day of the plan year;
- b) which was not formed primarily for the purpose of purchasing insurance;
and
- c) in which a relationship between the employer and the employees exists in good faith.

For an employer who was not in existence throughout the calendar year preceding the year in which the determination of whether the employer is a small employer is made, the determination is based on the average number of eligible employees the employer expects to employ on business days in the calendar year in which the determination is made.

Sec. 22. NAC 689C.160 is hereby amended by adding

As part of its annual report due on or before March 1 of each year. A carrier which has written or renewed health benefit plans for small employers in the preceding calendar year must submit to the commissioner:

- 1) for the last day of each quarter in the preceding calendar year;
 - a) Premium earned from small employer health benefit plans in Nevada;
 - b) The number of small employer health benefit plans in force;
 - c) The number of health benefit plans in force for small employers size 2 to 10; and
 - d) Total number of lives covered under small employer health benefit plans in Nevada.

- 2) total claims incurred for small employer health benefit plans in Nevada for the preceding calendar.
- 3) on a separate form, the index rate, as defined in NRS 689C.230, as of December 31 of the preceding calendar year. The Commissioner shall keep the index rate confidential.

Sec. 23. Chapter 686A of NAC is hereby amended by adding thereto the provisions set forth as section 24 of this regulation.

Sec. 24. An insurer, HMO or other entity licensed under Title 57 of NRS may not deny any benefits for life insurance, health insurance, disability income, accidental death benefits or any other benefits for an employee or his dependents on the basis that the employee is not actively at work on the date a new insurer, HMO or other entity licensed under Title 57 of NRS takes over the business if the employee is otherwise eligible for benefits as defined by the employer.