PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R040-14

April 10, 2014

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

AUTHORITY: §§1-9, NRS 679B.130.

A REGULATION relating to insurance; allowing payments to a provider of health care who is not preferred under a policy of group health insurance to be based on the fee schedule or arrangements with preferred providers; allowing an insurer to provide the address of an Internet website which lists its preferred providers of health care and any geographic limitation on the availability of services; repealing provisions relating to the establishment of an experience rating program, standards for the acceptance or rejection of an employer's group, the limitation of benefits for preexisting conditions for certain employer's groups, the limitation on the frequency of increases in premium rates, annual reports and converted policies; and providing other matters properly relating thereto.

Section 1. NAC 687B.035 is hereby amended to read as follows:

687B.035 1. Except as otherwise provided in this subsection, the provisions of NAC 687B.005 to 687B.140, inclusive, apply to a long-term care insurance contract delivered or issued for delivery in this State on or after November 21, 1988. The provisions of NAC 687B.113, 687B.116 and 687B.118 apply to a long-term care insurance contract delivered or issued for delivery in this State on or after January 11, 1991.

2. The provisions of NAC 687B.005 to 687B.140, inclusive, do not supersede the obligations of entities subject to them to comply with other applicable regulations insofar as they do not conflict with the provisions of NAC 687B.005 to 687B.140, inclusive.

3. Applicable regulations governing contracts of insurance which supplement Medicare do not apply to long-term care insurance contracts.

4. Except as otherwise provided in subsection 6, a contract of insurance which is not advertised, marketed or offered as long-term care insurance or nursing home insurance is not required to comply with the provisions of NAC 687B.005 to 687B.140, inclusive.

5. NAC 688B.010 and 689B.010 to ~~[689B.080,]~~ ***689B.070,*** inclusive, do not apply to long-term care insurance contracts.

6. Except as otherwise expressly provided in NAC 687B.005 to 687B.140, inclusive, the provisions of NAC 687B.005 to 687B.140, inclusive, apply to:

(a) Any long-term care insurance contract, including a qualified long-term care insurance contract, partnership contract, annuity contract and life insurance policy that accelerates benefits for long-term care delivered or issued for delivery in this State on or after October 1, 2011, by insurers and all similar organizations.

(b) Policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance if:

(1) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services;

(2) The disability income policy is advertised, marketed or offered as insurance for long-term care services; or

(3) Benefits under the policy may commence after the policyholder has reached the normal retirement age for Social Security unless benefits are designated to replace lost income or pay for specific expenses other than long-term care services.

7. Notwithstanding any other provision of NAC 687B.005 to 687B.140, inclusive, any product advertised, marketed or offered as long-term care insurance is subject to the provisions of NAC 687B.005 to 687B.140, inclusive.

Sec. 2. NAC 689B.040 is hereby amended to read as follows:

689B.040 The rate charged by the insurer to a member or employer's group within the association must be based upon the experience of the entire association. ~~[Except as otherwise provided in NAC 689B.050, the]~~ ***The*** insurer may not use rebates, surcharges, adjustments or similar rating standards for an employer's group based upon the claims experience of the employer's group.

Sec. 3. NAC 689B.070 is hereby amended to read as follows:

689B.070 1. Any insurer wishing to exclude or limit the coverage in a policy issued to an association for any person based upon his or her evidence of insurability, must submit the standards for exclusion or limitation to the Division. These standards must comply with the provisions of this section.

2. For all the employer's groups within the association:

(a) The coverage provided to members of that employer's group must be a guaranteed renewable policy for as long as the association continues to renew that employer's group.

(b) Once the insurer accepts the employer's group, the insurer may not periodically underwrite the employer's group or use that underwriting to cancel the employer's group or any person within it or to transfer a member to another policy.

(c) If a new employee requests to be added to the employer's group, the insurer:

(1) Shall accept that employee and his or her dependents based upon the underwriting standards used at the time the employer's group was originally underwritten ~~[as required by~~

~~NAC 689B.060]~~ if the request is made within the time established in the policy or by the employer for the eligibility of new employees; and

(2) May request evidence of insurability from the employee and his or her dependents if the request for coverage is not made within the time established in the policy or by the employer for eligibility for new employees.

Sec. 4. NAC 689B.120 is hereby amended to read as follows:

689B.120 A policy of group health insurance issued pursuant to NRS 689B.061:

1. Must include a definition for preferred providers of health care and providers of health care who are not preferred.

2. Must include an explanation of the amount of disincentives to be paid for using the services of providers of health care who are not preferred.

3. Must include in the schedule of benefits the amounts for deductibles and coinsurance payable for preferred providers of health care and providers of health care who are not preferred.

4. Must include a description of the type of plan used for preferred providers of health care and whether it is limited to specific services only, such as services obtained from a physician or hospital or for prescription drugs.

5. Must provide that the services covered, if provided by preferred providers of health care, are the same for providers of health care who are not preferred.

6. Must include a statement that the insured should verify whether a provider of health care is a preferred provider of health care.

7. Must provide that, if the insured is confined in a facility which is a preferred provider of health care at a time when the facility terminates its agreement with the insurer, coverage will be

provided for the period of confinement at the rate negotiated for that facility before it terminated its agreement and at no additional cost to the insured.

8. Must provide that, if the insured obtains prior authorization for health care services to be rendered by a preferred provider of health care and the provider subsequently terminates his or her agreement with the insurer, coverage will be provided for those services at the rate negotiated for that provider before terminating the agreement and at no additional cost to the insured.

9. ~~[May not require that the payments to a provider of health care who is not preferred be based upon the fee schedule or arrangements for preferred providers of health care.~~

~~10.]~~ May not provide for more than a 50 percent difference or reduction in any payment of otherwise eligible expenses for not complying with any procedures requiring the prior authorization of care or notification that treatment was received for an emergency.

Sec. 5. NAC 689B.150 is hereby amended to read as follows:

689B.150 An insurer offering a policy of group health insurance pursuant to NRS 689B.061 shall include with its health disclosure form ~~[a]~~ ***filed pursuant to NRS 689B.027:***

1. A list of its preferred providers of health care and a description of any geographic limitation to the availability of services ~~[.]~~ ***; or***

2. The address of the Internet website on which a list of preferred providers of health care and a description of any geographic limitation to the availability of services may be found.

Sec. 6. NAC 689B.195 is hereby amended to read as follows:

689B.195 A policy of group health insurance issued pursuant to chapter 689B of NRS:

1. Must not, for the determination of benefits payable for the coordination of benefits, provide for the consideration of any benefits payable pursuant to any ~~[individual health~~

~~insurance,]~~ health insurance under a franchise plan, no-fault automobile insurance or automobile medical insurance.

2. Must provide for the payment of benefits without regard to any benefits payable pursuant to any ~~[individual health insurance,]~~ health insurance under a franchise plan, no-fault automobile insurance or automobile medical insurance.

Sec. 7. NAC 689B.280 is hereby amended to read as follows:

689B.280 An insurer that offers blanket accident and health insurance in this State shall comply with the provisions of NAC 689B.205 ***.*** ~~[and 689B.230.]~~

Sec. 8. NAC 689B.295 is hereby amended to read as follows:

689B.295 As used in ***this section and*** NAC ~~[689B.295 to 689B.310, inclusive,]~~ ***689B.300 and 689B.305,*** 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. 9. NAC 689B.050, 689B.060, 689B.080, 689B.230, 689B.260 and 689B.310 are hereby repealed.

TEXT OF REPEALED SECTIONS

689B.050 Establishment of program for rating experience. (NRS 679B.130)

1. An insurer may establish an experience rating program which compares the loss experience of an employer's group to the loss experience of the entire association and which may result in different premiums. An insurer which establishes such a program must establish its

classes or class distinctions and schedules for different premiums based upon commonly accepted actuarial principles. Such a program may not result in rates that exceed the standards established in NRS 686B.050 and 686B.060 or are unfairly discriminatory as described in NRS 686A.100.

2. Upon receiving a request from a customer or the Division, the insurer shall demonstrate, with appropriate statistical evidence, the appropriateness of its classes and class distinctions and the premiums charged.

3. The premium for an employer's group may be adjusted, pursuant to an experience rating program, at the time the policy is renewed if:

(a) The insurer has mailed a notice to the employer's group at least 60 days before the renewal date, which clearly explains the amount of the increase and the rationale for it; and

(b) The employer's group experienced a loss ratio that was at least 150 percent greater than the loss ratio of the association as a whole.

4. If an employer's group has its premium increased pursuant to this section, the increase may not be greater than 100 percent of the premium for the entire association. The calculation of this limitation may not include the amount of any increases in premiums which have been applied to the entire association.

689B.060 Standards for acceptance or rejection of employer's group. (NRS 679B.130) At the time that an employer's group requests membership in an association, the insurer may accept or reject that group in accordance with the following standards:

1. For employer's groups with more than 10 persons, if information on insurability is collected by the insurer, the insurer may use this information only to determine whether or not it

will accept the employer's entire group. No member of the employer's group may be excluded from the association by the insurer through the use of a waiver or other device.

2. For employer's groups of 10 persons or less:

(a) The insurer may request information concerning evidence of insurability for the individual members of the employer's group.

(b) After the review of this information, the insurer may reject, because of insurability, any member of the employer's group.

689B.080 Limiting benefits to certain employer's groups for preexisting conditions.

1. An insurer offering an association to an employer's group with less than 25 members may limit its benefits from those benefits offered pursuant to NRS 689B.065, if the insurer has filed a plan with the Commissioner which expressly provides for exclusions from coverage for preexisting conditions and the exclusions:

(a) Do not exceed a period of more than 12 months from the effective date of the policy; and

(b) Limit payment for medical treatment to less than $1,000 for each preexisting condition for the 12-month period.

2. The employer shall sign and date a copy of a notice calling the exclusions and reductions in benefits to his or her attention. A copy of the signed disclosure must be maintained by the agent for 3 years after the policy is issued or renewed pursuant to NRS 683A.351.

3. For the purpose of this section, "preexisting condition" means a medical condition of a person for which he or she has received treatment during the 12 months preceding the effective date of the policy.

4. The provisions of this section do not modify the employer's duty to notify employees of these exclusions as a reduction in benefits pursuant to subsection 2 of NRS 689B.065.

689B.230 Limitation on frequency of increases; exceptions. (NRS 679B.130)

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.

689B.260 Annual report. (NRS 679B.130, 689B.029)

1. An insurer shall submit its annual report regarding its system for resolving complaints as required pursuant to NRS 689B.029 on or before June 1 of each year. The insurer 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 insurer is not required to include in the annual report information concerning an oral inquiry by an insured relating to a misunderstanding or miscommunication if the misunderstanding or miscommunication was resolved within 1 working day after the inquiry was

made. If the misunderstanding or miscommunication was not resolved within 1 working day, the insurer shall report it as a complaint in the annual report.

689B.310 Converted policies. (NRS 679B.130, 689B.590)

1. If a person is issued a converted policy before the date on which basic and standard health benefit plans were required to be offered pursuant to subsection 1 of NRS 689B.590, the carrier shall notify the person in writing, not less than 60 days before the annual renewal date of the converted policy, of the right to elect a basic or standard health benefit plan as a substitute to the current converted policy. The notice must include, without limitation, the premium rates charged by the carrier for the basic and standard health benefit plans.

2. A carrier that issues health benefit plans to small employers and large employers in this State shall allocate premium and loss experience on its converted policies issued pursuant to NRS 689B.590 based on:

(a) The number of persons with converted policies whose most recent coverage was under a health benefit plan issued to a small employer or a large employer relative to the total number of persons with converted policies; or

(b) The proportion of total premiums earned in the book of health benefit plan business containing small employers or large employers relative to the total premiums earned from all health benefit plans for small employers and large employers during the period of experience.

3. As used in this section:

(a) "Large employer" has the meaning ascribed to it in 42 U.S.C. § 300gg-91(e)(2).

(b) "Small employer" has the meaning ascribed to it in NRS 689C.095.