ADOPTED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R081-16

Effective November 2, 2016

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

AUTHORITY: §§1 and 2, NRS 679B.130 and 686A.015; §3, NRS 679B.130; §4, NRS 679B.130, 687B.120 and 687B.430; §§5 and 6, NRS 679B.130 and 687B.430; §7, NRS 679B.130 and 695D.100; §8, NRS 679B.130.

A REGULATION relating to insurance; revising the requirements for the filing of certain reports and documentation with the Commissioner of Insurance and the Division of Insurance of the Department of Business and Industry; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law authorizes the Commissioner of Insurance to adopt reasonable regulations for the administration of the Nevada Insurance Code and as required to ensure compliance with federal law relating to insurance. (NRS 679B.130)

Sections 1 and 2 of this regulation specify the date by which certain annual certifications are required to be filed or made by an illustration actuary and an officer of an insurer regarding illustrations of nonguaranteed elements of a policy of life insurance.

Section 3 of this regulation specifies the date by which an insurer is required to submit an annual report to the Commissioner regarding the applications for long-term care insurance policies or contracts received by an insurer.

Existing law authorizes the Commissioner to adopt regulations relating to the form, content and sale of policies of insurance which provide for the payment of expenses which are not covered by Medicare. (NRS 687B.430) **Section 4** of this regulation specifies the date by which an issuer of such a policy is required to file certain information regarding those policies with the Division of Insurance of the Department of Business and Industry. **Section 5** of this regulation revises the date on which an issuer of such a policy is required to report multiple policies or certificates held by residents of this State. **Section 6** of this regulation revises the date on which an issuer of such a policy that contains a provision for a restricted network is required to report to the Commissioner certain information regarding its grievance procedure.

Section 7 of this regulation eliminates the requirement that an organization for dental care notify the Division quarterly of any changes in its list of providers.

Section 8 of this regulation repeals provisions that require a health maintenance organization or a provider-sponsored organization that applies for a certificate of authority to submit and update a list of the providers in its health care plan.

Section 1. NAC 686A.4775 is hereby amended to read as follows:

686A.4775 1. An illustration actuary shall certify that:

(a) The disciplined current scale used in illustrations authorized by the insurer comply with the "Actuarial Standard of Practice for Compliance with the NAIC Model Regulation on Life Insurance Illustrations" adopted by the Actuarial Standards Board; and

(b) The illustrated scales used in illustrations authorized by the insurer comply with the requirements of NAC 686A.460 to 686A.479, inclusive.

2. The illustration actuary shall file the certification with the insurer and the Commissioner:

(a) ~~[Annually]~~ ***On a date determined by the insurer but not later than December 31 of each year, for the current calendar year,*** for all policy forms for which illustrations are used ***;*** ~~[on a date determined by the insurer;]~~ and

(b) Before a new policy form is illustrated.

3. The illustration actuary shall disclose in the certification:

(a) Whether, since the last certification, a currently payable scale applicable for business issued within the previous 5 years and within the scope of the certification has been reduced for reasons other than changes in the experience factors underlying the disciplined current scale. If nonguaranteed elements illustrated for new policies are not consistent with those illustrated for similar policies that are in force, this fact must be disclosed in the certification. If nonguaranteed elements illustrated for new policies and policies that are in force are not consistent with the nonguaranteed elements actually being paid, charged or credited to the same or similar forms, this fact must be disclosed in the certification.

(b) The method used to allocate overhead expenses for all illustrations from one of the following methods:

(1) The fully allocated expense method;

(2) The marginal expense method; or

(3) A generally recognized expense table method based on fully allocated expenses that are representative of a significant portion of insurers in this State and is approved by the Commissioner.

4. If an error in a previous certification is discovered, the illustration actuary shall notify the insurer and the Commissioner promptly.

5. If an illustration actuary is unable to certify the disciplined current scale for an illustration the insurer intends to use, the actuary shall notify the insurer and the Commissioner promptly of his or her inability to certify that scale.

6. For the purposes of this section, the "Actuarial Standard of Practice for Compliance with the NAIC Model Regulation on Life Insurance Illustrations," adopted by the Actuarial Standards Board, is hereby adopted by reference. A copy of the standard may be obtained from the American Academy of Actuaries, 1850 M Street N.W., Suite 300, Washington, D.C. 20036, (202) 223-8196, and on the Internet at ~~[http://www.actuary.org/index.asp]~~ ***http://www.actuarialstandardsboard.org*** free of charge.

Sec. 2. NAC 686A.478 is hereby amended to read as follows:

686A.478 An officer of an insurer that sells policies of life insurance, other than the illustration actuary, shall certify ~~[annually]~~ ***on or before December 31 of each year, for the current calendar year,*** that:

1. The formats for the illustrations the insurer intends to use comply with the requirements of NAC 686A.460 to 686A.479, inclusive;

2. The scales used in illustrations authorized by the insurer are those scales certified by the illustration actuary; and

3. The insurer has provided its agents and brokers with information about the method that is used by the insurer to allocate expenses in its illustrations and is disclosed as required in subsection 3 of NAC 686A.4775.

Sec. 3. NAC 687B.057 is hereby amended to read as follows:

687B.057 ~~[An]~~ ***On or before April 1 of each year, for the preceding calendar year, an*** insurer shall report ~~[annually]~~ to the Commissioner using form NDOI-947, which is available from the Division:

1. The number of applications for long-term care insurance received by the insurer from residents of this State;

2. The number of applicants who declined to provide information on the worksheet described in subsection 9 of NAC 687B.056;

3. The number of applicants who did not meet the standards of suitability developed by the insurer pursuant to NAC 687B.056; and

4. The number of applicants who chose to purchase long-term care insurance after receiving the letter described in paragraph (b) of subsection 1 of NAC 687B.0565.

Sec. 4. NAC 687B.230 is hereby amended to read as follows:

687B.230 1. A policy to supplement Medicare or a certificate must not be delivered or issued for delivery in this State unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to the

policyholder or certificate holder the following amounts in the form of aggregate benefits provided under the policy, not including anticipated refunds or credits:

(a) In the case of a group policy, at least 75 percent of the aggregate amount of premiums earned.

(b) In the case of an individual policy, at least 65 percent of the aggregate amount of premiums earned. For the purposes of this paragraph, a policy issued as a result of any solicitation made by mail or by advertising using the mass media, including any written or broadcasted advertisement, shall be deemed to be an individual policy.

➥ The aggregate benefits must be calculated on the basis of incurred claims experience or incurred expenses for health care if coverage is provided by a health maintenance organization on the basis of payments made to the provider of health care rather than reimbursements made to the insured, and must be calculated in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization must not include:

(1) Home office and overhead costs;

(2) Advertising costs;

(3) Commissions and other acquisition costs;

(4) Taxes;

(5) Capital costs;

(6) Administrative costs; and

(7) Claims processing costs.

2. All filings of rates and rating schedules must demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience

as of the date of the filing. Filing of revisions of rates must also demonstrate that the anticipated loss ratio during the period for which the revised rates are computed can be expected to meet the appropriate standards for the loss ratio.

3. ~~[Each]~~ ***On or before May 31 of each year, each*** issuer providing a policy to supplement Medicare or a certificate in this State shall file ~~[annually]~~ with the Division ***, in a format prescribed by the Commissioner,*** its rates, rating schedule and supporting documentation, including ratios of incurred losses to earned premiums by policy duration, for approval by the Commissioner. The supporting documentation must:

(a) Demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate standards for loss ratios can be expected to be met during the entire period for which the rates are computed; and

(b) Exclude active life reserves.

➥ An expected third-year loss ratio that is greater than or equal to the applicable percentage must be demonstrated for policies to supplement Medicare or certificates in force less than 3 years.

4. As soon as practicable before the effective date of any enhancements to Medicare benefits, every issuer shall file with the Division in accordance with NRS 687B.120:

(a) Appropriate adjustments of premiums necessary to produce loss ratios as anticipated for the current premiums for the applicable policies or certificates, together with such supporting documents as are necessary to justify the adjustment; and

(b) Any appropriate riders, endorsements or policy forms needed to accomplish the modifications to the policy to supplement Medicare or the certificate which are necessary to eliminate any duplication of Medicare benefits. Any such riders, endorsements or policy forms

must provide a clear description of the benefits to supplement Medicare that are provided by the policy or certificate.

5. An issuer shall make such adjustments to premiums pursuant to paragraph (a) of subsection 4 as are necessary to produce an expected loss ratio that conforms to the minimum standards for loss ratios for policies to supplement Medicare or certificates which are expected to result in a loss ratio that is at least as great as the ratio originally anticipated for the rates used by the issuer to calculate current premiums for the policy to supplement Medicare or the certificate. An adjustment to premiums which modifies the loss ratio, other than an adjustment made pursuant to this section, may not be made at any time other than upon the renewal of the policy or certificate or its anniversary date. If an issuer makes an adjustment to premiums which is not acceptable to the Commissioner, the Commissioner may order an adjustment to premiums, a refund or a credit which he or she deems necessary to achieve the loss ratio required by this section.

6. The Commissioner may conduct a hearing to obtain information concerning a request submitted by an issuer for an increase in the rates for a policy to supplement Medicare or a certificate if the experience incurred during the reporting period does not comply with the applicable standard for loss ratios. The Commissioner will determine whether the experience complies with the applicable standard without considering any refund or credit required for the reporting period.

7. The provisions of this section apply to any policy to supplement Medicare or any certificate delivered or issued for delivery in this State, regardless of the date of its delivery or issuance.

Sec. 5. NAC 687B.283 is hereby amended to read as follows:

687B.283 1. On or before ~~[March 1]~~ ***May 31*** of each year, an issuer shall report the number of the policy, the certificate number and the date of issuance for each resident of this State for whom the issuer has in force more than one policy to supplement Medicare or certificate. The report must include all this information for each individual policyholder in a format prescribed by the Commissioner.

2. The provisions of this section apply to an issuer of a policy to supplement Medicare delivered or issued for delivery in this State, regardless of the date the policy was delivered or issued for delivery.

Sec. 6. NAC 687B.370 is hereby amended to read as follows:

687B.370 1. A Medicare select issuer shall have written procedures for hearing complaints and resolving written grievances made by policyholders and certificate holders under a Medicare select policy or certificate. The procedures may include the utilization of arbitration if the Medicare select issuer and the policyholder or certificate holder or the policyholder's or certificate holder's spouse mutually agree to use it.

2. The procedure for addressing grievances must be described in all policies and certificates and in the outline of coverage provided to applicants for coverage pursuant to NAC 687B.368.

3. The Medicare select issuer shall provide detailed information to the policyholder or certificate holder at the time the policy or certificate is issued that describes how to file a grievance with the Medicare select issuer.

4. The Medicare select issuer shall begin evaluating a grievance filed with it within 10 working days after the filing date by transmitting the grievance to the person who has authority to investigate the issue fully and take corrective action to address it.

5. If a grievance is found to be valid, corrective action must commence within 48 hours after the determination or within 72 hours after the determination if a holiday occurs within the 48-hour period.

6. All concerned parties must be notified of the determination made with regard to the grievance.

7. The Medicare select issuer shall report to the Commissioner ~~[no later than March]~~ ***on or before May*** 31 of each year regarding its grievance procedure. The report must ***be submitted in a format prescribed by the Commissioner and must*** contain the number of grievances filed in the past year and a summary of the nature and resolution of those grievances.

Sec. 7. NAC 695D.200 is hereby amended to read as follows:

695D.200 An organization shall notify ~~[:~~

~~1. The Division in writing at the end of each quarter of each calendar year of any changes in its list of providers. If there are no changes, a statement to that effect may be filed with the organization's annual statement.~~

~~2. A]~~ ***a*** member in writing of the disassociation of his or her dentist from the organization within 30 working days after the disassociation occurs.

Sec. 8. NAC 695C.200 is hereby repealed.

TEXT OF REPEALED SECTION

695C.200 List of providers: Submission; changes; extension of submission date; excessive reduction. (NRS 679B.130, 695C.070, 695C.275)

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 organization shall notify:

(a) For a health maintenance organization, the Division and the State Board of Health in writing not later than 14 days after the end of each quarter of each calendar year of any changes in its list of providers unless an extension is granted pursuant to this paragraph. On or before the date on which the notification is due, the health maintenance organization may submit a request to the Commissioner for an extension of time in which to provide the notification of not more than 30 days after the date on which the notification is due.

(b) For a provider-sponsored organization, the Division in writing not later than 14 days after the end of each quarter of each calendar year of any changes in its list of providers unless an

extension is granted pursuant to this paragraph. On or before the date on which the notification is due, the provider-sponsored organization may submit a request to the Commissioner for an extension of time in which to provide the notification of not more than 30 days after the date on which the notification is due.

(c) An enrollee in writing of the disassociation of his or her 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. The organization may rebut this presumption by providing written information to the Division within 14 days after the notice is sent to 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.