REQUIRES TWO-THIRDS MAJORITY VOTE (§ 1)

S.B. 482

SENATE BILL NO. 482–COMMITTEE ON HEALTH AND HUMAN SERVICES

(ON BEHALF OF THE LEGISLATIVE COMMITTEE ON HEALTH CARE)

MARCH 25, 2019

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to health insurance. (BDR 57-531)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: Yes.

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

AN ACT relating to health insurance; authorizing the Commissioner of Insurance to enter into certain types of interstate compacts; authorizing the Commissioner to allow reciprocal licensure with certain states; establishing the Nevada Reinsurance Program; authorizing the Commissioner to apply to the Secretary of Health and Human Services for a certain waiver; removing certain waiting period requirements for health benefit plans for individuals not purchased on the Silver State Health Insurance Exchange; removing certain requirements for varying a premium rate on certain plans based on tobacco use and age; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

1 The McCarran-Ferguson Act reserves to the states the right to regulate the
2 business of insurance, except in certain situations where the United States Congress
3 explicitly regulates the business of insurance. (15 U.S.C. §§ 1011-1015) In 2010,
4 the United States Congress enacted the Patient Protection and Affordable Care Act,
5 through which the United States Congress authorized two or more states to enter
6 into healthcare choice compacts under which the issuer of any qualified health plan
7 to which the compact applies would be required to: (1) be licensed in each state; or
8 (2) submit to the jurisdiction of each such state. (42 U.S.C. § 18053(a)(1)(B)(ii))
9 Existing law authorizes the Commissioner of Insurance to enter into such compacts

10 with the regulatory officers in other states to further the uniform treatment of
11 insurers throughout the United States. (NRS 679B.220) **Section 2** of this bill
12 authorizes the Commissioner to enter into such compacts to also ensure: (1) market
13 stability; or (2) essential insurance is available to Nevada residents. **Section 1** of
14 this bill authorizes the Commissioner to allow reciprocal licenses to be issued to
15 health carriers that are licensed to do business in Arizona, California, Idaho,
16 Oregon or Utah without the health carrier first being required to obtain a certificate
17 of authority to do business in Nevada. **Section 1** additionally authorizes the
18 Commissioner to adopt regulations to carry out this reciprocal licensure program,
19 including regulations authorizing the Commissioner to establish any fees the
20 Commissioner deems appropriate to carry out this program. **Section 55** of this bill
21 makes conforming changes by requiring certain certificates to be filed only at the
22 request of the Commissioner.
23 The Patient Protection and Affordable Care Act established a transitional
24 reinsurance program to help stabilize premiums in the individual market for the
25 2014, 2015 and 2016 benefit years. (42 U.S.C. § 18061) This program expired on
26 December 31, 2016. **Sections 5-44** of this bill generally provide for the
27 establishment of the Nevada Reinsurance Program to replace the now defunct
28 federal transitional reinsurance program. **Section 23** of this bill establishes the
29 Nevada Reinsurance Program. **Sections 24-29** of this bill create the Board of
30 Directors of the Nevada Reinsurance Program and prescribe various procedures and
31 requirements of the Board. **Section 30** of this bill requires the Board to prepare, for
32 adoption by the Commissioner, a reinsurance plan of operation for the
33 administration of the Nevada Reinsurance Program. **Section 31** of this bill requires
34 this reinsurance plan of operation to establish certain procedures and requirements,
35 including procedures for determining: (1) the payment parameters made by the
36 Nevada Reinsurance Program that the Commissioner approves in **sections 33-35** of
37 this bill; and (2) any assessments to be charged or collected from eligible
38 contributors. **Section 36** of this bill provides the manner in which reinsurance
39 payments are calculated, and **section 37** of this bill provides the procedure for an
40 eligible health carrier to request reinsurance payments from the Nevada
41 Reinsurance Program. **Section 39** of this bill creates the Nevada Reinsurance
42 Program Account in the State General Fund and requires: (1) money received from
43 certain assessments and from certain federal and state funds to be deposited into the
44 Account; and (2) money deposited into the Account be expended for the operation
45 and administration of the Nevada Reinsurance Program and to make reinsurance
46 payments. **Section 41** of this bill requires the Board to submit to the Commissioner
47 and make available to the public a report summarizing the operations of the Nevada
48 Reinsurance Program for each benefit year. **Section 42** of this bill requires the
49 Board to: (1) hire and cooperate with an independent certified public accountant to
50 perform an audit for each benefit year of the Nevada Reinsurance Program; and (2)
51 submit this audit to the Commissioner and make it available to the public. **Section 3**
52 of this bill makes a conforming change.
53 Federal law authorizes a state to apply to the Secretary of Health and Human
54 Services for a waiver of various requirements of the Patient Protection and
55 Affordable Care Act with respect to health insurance coverage in the state for a
56 plan year. (42 U.S.C. § 18502) **Section 45** of this bill incorporates this federal
57 language into state law by authorizing the Commissioner to apply for such a waiver
58 for a plan year beginning on January 1, 2020. **Sections 46-54, 58 and 59** of this bill
59 make conforming changes.
60 Existing law requires any health benefit plan for individuals that is not
61 purchased on the Silver State Health Insurance Exchange to be: (1) made available
62 for purchase at any time during the calendar year; (2) subject to a waiting period of
63 not more than 90 days after the date on which the application was received; (3)
64 effective upon the first day of the month immediately after the month in which the

65 waiting period ends; and (4) not retroactive to the date on which the application for
66 coverage was received. (NRS 687B.480) **Section 56** of this bill removes these
67 requirements.
68 Federal law provides that, with respect to the premium rate charged by a health
69 insurance insurer for health insurance coverage offered in the individual or small
70 group market, the rate may vary with respect to a particular plan or coverage
71 involved only by: (1) age, except that such rate shall not vary by more than 3 to 1
72 for adults; and (2) tobacco use, except that such rate shall not vary by more than 1.5
73 to 1. (42 U.S.C. § 300gg(a)(1)(A)) Existing law incorporates federal law by
74 authorizing such a premium rate to vary with respect to the particular plan or
75 coverage involved based on the following characteristics: (1) tobacco use, except
76 that the rate shall not vary by more than 1.5 to 1 for individuals who vary in
77 tobacco use; and (2) age, except that the rate must not vary by a ratio of more than
78 3 to 1 for certain individuals that is consistent with the uniform age rating curve
79 established in the Federal Act. (NRS 687B.500) **Section 57** of this bill removes
80 these requirements from existing law and instead allows variations in a premium
81 rate based on: (1) tobacco use; and (2) age consistent with the uniform age rating
82 curve established in the Federal Act. The federal requirements for tobacco use and
83 age still apply to **section 57**.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

1 **Section 1.** Chapter 679B of NRS is hereby amended by adding
2 thereto a new section to read as follows:
3 ***1. The Commissioner may allow reciprocal licenses to be***
4 ***issued to health carriers licensed to do business in Arizona,***
5 ***California, Idaho, Oregon and Utah to enable said health carriers***
6 ***to do business in Nevada without completing a separate***
7 ***application for a certificate of authority in Nevada, other than a***
8 ***petition for recognition of their respective state's license with the***
9 ***grant of a reciprocal Nevada license.***
10 ***2. The Commissioner may adopt regulations to carry out the***
11 ***provisions of subsection 1, including, without limitation,***
12 ***regulations to establish any fees the Commissioner deems***
13 ***appropriate to carry out the provisions of subsection 1.***
14 **Sec. 2.** NRS 679B.220 is hereby amended to read as follows:
15 679B.220 1. The Commissioner shall communicate on
16 request of the regulatory officer for insurance in any state, province
17 or country any information which it is the duty of the Commissioner
18 by law to ascertain respecting authorized insurers.
19 2. The Commissioner may:
20 (a) Be a member of the National Association of Insurance
21 Commissioners or any successor organization;
22 (b) Exchange with the association or any successor organization
23 any information, not otherwise confidential, relating to applicants
24 and licensees under this title;

1 (c) Communicate with the association or any successor
2 organization concerning the business of insurance generally;
3 (d) Enter into compacts with the regulatory officers in other
4 states to [further] ***:***
5 ***(1) Further*** the uniform treatment of insurers throughout the
6 United States [;] ***;***
7 ***(2) Ensure market stability; or***
8 ***(3) Ensure essential insurance is made available to Nevada***
9 ***residents;*** and
10 (e) Participate in and support other cooperative activities of
11 public officers having supervision of the business of insurance.
12 **Sec. 3.** NRS 681A.150 is hereby amended to read as follows:
13 681A.150 No credit may be taken as an asset or as a deduction
14 from liability on account of reinsurance unless [the] ***:***
15 ***1. The*** reinsurer is authorized to transact insurance or
16 reinsurance in this state [or the] ***and the requirements of NRS***
17 ***681A.200 and 681A.210 are met;***
18 ***2. The*** requirements of NRS 681A.155 to 681A.190, inclusive,
19 and [in any of these cases] the requirements of NRS 681A.200 and
20 681A.210 [also] are met [.] ***; or***
21 ***3. The reinsurance is paid by the Nevada Reinsurance***
22 ***Program established in section 23 of this act.***
23 **Sec. 4.** Chapter 686B of NRS is hereby amended by adding
24 thereto the provisions set forth as sections 5 to 45, inclusive, of this
25 act.
26 **Sec. 5.** ***As used sections 5 to 44, inclusive, of this act, unless***
27 ***the context otherwise requires, the words and terms defined in***
28 ***sections 6 to 22, inclusive, of this act have the meanings ascribed***
29 ***to them in those sections.***
30 **Sec. 6.** ***"Administrator" means the entity chosen by the***
31 ***Board and approved by the Commissioner to administer the***
32 ***Reinsurance Program pursuant to section 23 of this act.***
33 **Sec. 7.** ***"Assessment" means a dollar amount that the Board,***
34 ***upon the approval of the Commissioner, charges to eligible***
35 ***contributors and uses to defray the cost of the Reinsurance***
36 ***Program pursuant to subsection 4 of section 39 of this act.***
37 **Sec. 8.** ***"Attachment point" means the threshold dollar***
38 ***amount for the costs of claims incurred by an eligible health***
39 ***carrier for the covered benefits of an enrolled individual in a***
40 ***benefit year above which the costs of claims for benefits are***
41 ***eligible for reinsurance payments under the Reinsurance***
42 ***Program.***
43 **Sec. 9.** ***"Benefit year" means the calendar year during which***
44 ***an eligible health carrier provides coverage through a health***
45 ***benefit plan for an individual.***

Sec. 10. ***"Board" means the Board of Directors of the Nevada Reinsurance Program created by section 24 of this act.***

Sec. 11. ***"Coinsurance rate" means the percentage rate at which the Reinsurance Program must reimburse a reinsurance eligible health benefit plan for the costs of claims incurred for the covered benefits of an enrolled individual in a benefit year above the attachment point and below the reinsurance cap.***

Sec. 12. ***"Eligible health carrier" means a health carrier offering reinsurance eligible health benefit plans in this State.***

Sec. 13. ***"Health benefit plan" has the meaning ascribed to it in NRS 687B.470.***

Sec. 14. ***"Health carrier" has the meaning ascribed to it in NRS 695G.024.***

Sec. 15. ***"Reinsurance cap" means the threshold dollar amount for the costs of claims incurred by a reinsurance eligible health benefit plan for the covered benefits of an enrolled individual in a benefit year above which the costs of claims for the benefits are no longer eligible for reinsurance payments.***

Sec. 16. ***"Reinsurance eligible health benefit plan" means a health benefit plan that provides coverage to persons and which:***

1. Is delivered or issued for delivery in this State on or after January 1, 2020; and

2. Is not a grandfathered plan as defined in NRS 679A.094.

Sec. 17. ***"Reinsurance eligible individual" means a natural person who is covered under a reinsurance eligible health benefit plan.***

Sec. 18. ***"Reinsurance payment" means the dollar amount paid by the Reinsurance Program to an eligible health carrier in accordance with section 36 of this act.***

Sec. 19. ***"Reinsurance payment parameters" means the attachment point, reinsurance cap and coinsurance rate for the Reinsurance Program established pursuant to sections 33, 34 and 35 of this act.***

Sec. 20. ***"Reinsurance plan of operation" means the plan of operation of the Reinsurance Program established pursuant to section 30 of this act.***

Sec. 21. ***"Reinsurance Program" means the Nevada Reinsurance Program established by section 23 of this act.***

Sec. 22. ***"Threshold dollar amount" means the dollar amount that an eligible health carrier or reinsurance eligible health benefit plan must pay before it is eligible to receive reinsurance payments under the Reinsurance Program.***

Sec. 23. ***1. The Nevada Reinsurance Program is hereby established as a nonprofit entity. The goal of the Reinsurance Program is to stabilize the rates and premiums for health benefit***

1 *plans for individuals and provide greater financial certainty to*
2 *consumers of health insurance in this State.*
3 *2. The Board shall administer the Reinsurance Program and:*
4 *(a) Prepare a reinsurance plan of operation pursuant to*
5 *section 30 of this act and submit it to the Commissioner for*
6 *approval;*
7 *(b) Conduct all activities required by the approved reinsurance*
8 *plan of operation pursuant to section 31 of this act;*
9 *(c) With the approval of the Commissioner, enter into such*
10 *contracts as are necessary or proper to carry out the*
11 *administration of the Reinsurance Program pursuant to sections 5*
12 *to 44, inclusive, of this act, including, without limitation, entering*
13 *into contracts with:*
14 *(1) Similar programs of reinsurance administered by other*
15 *states for the joint performance of common functions; or*
16 *(2) Persons or other organizations for the performance of*
17 *administrative functions that relate to programs of reinsurance;*
18 *(d) Take any legal action necessary or proper to:*
19 *(1) Recover assessments and penalties, as applicable, for or*
20 *on behalf of the Reinsurance Program; or*
21 *(2) Avoid the payment of claims that are improper against*
22 *the Reinsurance Program;*
23 *(e) Sue or be sued for reinsurance payments, including,*
24 *without limitation, taking any legal action necessary or proper to*
25 *recover any assessment for, on behalf of or against:*
26 *(1) Health carriers;*
27 *(2) Third-party administrators or other administrators*
28 *participating in the Reinsurance Program; or*
29 *(3) Other persons participating in the Reinsurance*
30 *Program;*
31 *(f) Require the Reinsurance Program to be audited:*
32 *(1) By an independent certified public accountant to assure*
33 *the general accuracy of the financial data submitted to the*
34 *Reinsurance Program; and*
35 *(2) In compliance with the audit procedures designed*
36 *pursuant to paragraph (g);*
37 *(g) Design audit procedures that govern an audit conducted*
38 *pursuant to paragraph (f);*
39 *(h) Borrow and repay such funds as, in the judgment of the*
40 *Board, may be necessary for the administration of the*
41 *Reinsurance Program; and*
42 *(i) Perform any other functions necessary to:*
43 *(1) Carry out the reinsurance plan of operation; and*
44 *(2) Implement any of the purposes of the Reinsurance*
45 *Program.*

3. The Board, in administering the Reinsurance Program pursuant to subsection 2, may:

(a) Appoint appropriate advisory committees and subcommittees, pursuant to section 28 of this act, as necessary to provide assistance in the administration of the Reinsurance Program; and

(b) Consider, when designing the audit procedures pursuant to paragraph (g) of subsection 2, the criteria and methods used in carrying out the risk adjustment activities pursuant to 42 U.S.C. § 18063.

Sec. 24. *1. The Board of Directors of the Nevada Reinsurance Program is hereby created. The Board consists of the following 13 members:*

(a) Ten voting members appointed by the Commissioner as follows:

(1) Six persons who represent insurers that provide health insurance coverage to individuals pursuant to chapter 689A of NRS;

(2) Two persons who represent the enrolled individual in the individual market; and

(3) Two persons who represent health care providers;

(b) One voting member appointed by the Senate Majority Leader;

(c) One voting member appointed by the Speaker of the Assembly; and

(d) The Commissioner, or his or her designated representative, as an ex officio, nonvoting member of the Board.

2. When making an appointment to the Board pursuant to subsection 1, the Commissioner, the Senate Majority Leader and the Speaker of the Assembly shall:

(a) Consider the collective expertise and experience of the existing voting members of the Board; and

(b) Attempt to make each appointment so that the voting members of the Board represent a range and diversity of:

(1) Skills;

(2) Knowledge;

(3) Experience; and

(4) Geographic and stakeholder perspectives.

3. Members of the Board shall serve without compensation except that while engaged in the business of the Board, each member is entitled to receive the per diem allowance or travel expenses provided for state officers and employees generally, to be paid from the proceeds of the assessments received by the Reinsurance Program as an administrative expense of the Reinsurance Program.

Sec. 25. ***1. The term of each voting member of the Board appointed pursuant to section 24 of this act is 3 years, except that the initial terms of the voting members of the first Board must be staggered as follows:***

Voting Member of the Board Category	*Number of Members*	*Initial Term In Years*
Represent carriers that provide health insurance	*2*	*1*
	2	*2*
	2	*3*
Represent the enrolled individual in the individual market	*1*	*1*
	1	*2*
Represent health care providers	*1*	*1*
	1	*2*
Appointed by the Nevada Senate Majority Leader	*1*	*3*
Appointed by the Speaker of the Assembly	*1*	*3*

2. A voting member of the Board may be reappointed.

3. A voting member of the Board may not serve more than two terms.

4. The Commissioner, Senate Majority Leader or Speaker of the Assembly may remove a voting member of the Board that he or she appointed as a voting member of the Board if the voting member of the Board:

(a) Neglects his or her duty; or

(b) Commits misfeasance, malfeasance or nonfeasance while serving as a member of the Board.

5. At the expiration of the term of a voting member of the Board, or if a voting member of the Board resigns or is otherwise unable to complete his or her term, the Commissioner, the Senate Majority Leader or the Speaker of the Assembly, as applicable, shall appoint a replacement not later than 30 days after the vacancy occurs. All vacancies of the Board must be filled in the same manner of appointment as the voting member of the Board who created the vacancy.

6. Upon the expiration of his or her appointment, a voting member of the Board may continue to serve until:

(a) He or she is reappointed, if applicable; or

(b) A person is appointed as a successor.

Sec. 26. ***1. The Board shall elect a Chair of the Board from among its members who shall serve for a term of 2 years.***

2. If a vacancy occurs, the members of the Board shall elect a replacement Chair of the Board from among its members who shall serve for the remainder of the unexpired term.

3. The Chair of the Board may be reelected to one or more terms.

Sec. 27. ***1. The Board shall meet:***

(a) Until a reinsurance plan of operation has been approved by the Commissioner pursuant to section 30 of this act, at least twice each year;

(b) After a reinsurance plan of operation has been approved by the Commissioner pursuant to section 30 of this act, at least once each year; and

(c) At such other times as the Commissioner or the Chair of the Board deems necessary.

2. A majority of the voting members of the Board constitutes a quorum for the transaction of business.

3. A voting member of the Board may not vote by proxy.

Sec. 28. ***1. The Board may appoint:***

(a) The Administrator to carry out the provisions of sections 5 to 44, inclusive, of this act; and

(b) Subcommittees and advisory committees composed of members of the Board, former members of the Board or members of the general public who have experience with or knowledge of matters relating to health care or reinsurance to consider specific problems or other matters within the scope of the powers, duties and functions of the Board.

2. To the extent practicable, the members of such a subcommittee or advisory committee must be representative of a range and diversity of:

(a) Skills;

(b) Knowledge;

(c) Experience; and

(d) Geographic and stakeholder perspectives.

3. A member of such a subcommittee or advisory committee shall not be compensated or reimbursed for travel or other expenses relating to any duties as a member of the subcommittee or advisory committee.

Sec. 29. ***The Board and any subcommittee or advisory committee appointed by the Board shall comply with the provisions of chapter 241 of NRS.***

Sec. 30. ***1. Not later than 120 days after the initial appointment of the Board, the Board shall submit to the Commissioner a reinsurance plan of operation that ensures the***

fair, reasonable and equitable administration of the Reinsurance Program. Once a reinsurance plan of operation has been approved by the Commissioner, the Board may amend the reinsurance plan of operation as needed, subject to the approval of the Commissioner.

2. The Commissioner shall, after notice and a hearing, approve a reinsurance plan of operation and any amendment to the reinsurance plan of operation submitted for his or her approval if he or she determines that the plan or amendment is suitable to ensure the fair, reasonable and equitable administration of the Reinsurance Program, in accordance with the provisions of sections 5 to 44, inclusive, of this act and NRS 681A.150.

3. If the Board fails to submit a suitable reinsurance plan of operation within 120 days after its appointment or if the Commissioner determines in accordance with subsection 2 that the reinsurance plan of operation as submitted is not suitable, the Commissioner may, after notice and a hearing, adopt and carry out a temporary reinsurance plan of operation which is effective only until the approval of a reinsurance plan of operation submitted by the Board.

4. Before approving a reinsurance plan of operation submitted by the Board, the Commissioner may amend the plan if he or she determines that such an amendment is necessary to ensure that the plan is suitable pursuant to subsection 2.

5. A reinsurance plan of operation becomes effective upon the written approval of the Commissioner.

Sec. 31. *A reinsurance plan of operation and a temporary reinsurance plan of operation established pursuant to section 30 of this act must:*

1. Establish procedures for the handling and accounting of the assets of the Reinsurance Program and for an annual fiscal report to be submitted to the Commissioner pursuant to section 41 of this act.

2. Establish procedures for selecting the Administrator and set forth the powers and duties of the Administrator.

3. Establish procedures for determining the reinsurance payment parameters of the Reinsurance Program pursuant to section 34 of this act.

4. Establish procedures for the determination of any assessments to be charged to eligible contributors.

5. Establish procedures for collecting any assessments from eligible contributors. Any assessment collected must be deposited in the Nevada Reinsurance Program Account created by section

39 of this act for the purpose of paying claims and administrative expenses incurred by the Reinsurance Program.

6. Establish procedures for collecting any state or federal funds. Any funds collected must be deposited in the Nevada Reinsurance Program Account for the purpose of paying claims and administrative expenses incurred by the Reinsurance Program.

7. Establish regular times and places for meetings of the Board in connection with the operation of the Reinsurance Program that comply with section 27 of this act.

8. Establish data and information requirements for:

(a) The submission of requests for reinsurance payments by eligible health carriers;

(b) The processes for notification of eligible health carriers regarding reinsurance payments; and

(c) Issuing reinsurance payments.

9. Establish procedures for:

(a) Keeping records of all financial transactions;

(b) Submitting to the Commissioner and making available to the public the report required pursuant to section 41 of this act; and

(c) The submission of aggregated data by the Administrator to the Commissioner for preparation of any reports required under the terms of the appropriation of state or federal funds.

10. Provide for any additional matters necessary to carry out and administer the Reinsurance Program.

Sec. 32. *1. The Reinsurance Program must collect or access data from an eligible health carrier that are necessary to determine reinsurance payments, according to the data requirements pursuant to subsection 3 of section 37 of this act.*

2. All funds received by or appropriated to the Reinsurance Program must be properly accounted for, in accordance with the reinsurance plan of operation.

3. The Board shall not use any funds appropriated to the Reinsurance Program for:

(a) Staff retreats;

(b) Promotional giveaways;

(c) Executive compensation that the Commissioner deems excessive;

(d) Promotion of federal or state legislative or regulatory change; or

(e) Any other purpose not established in the approved reinsurance plan of operation.

4. For each benefit year, the Reinsurance Program must notify eligible health carriers of any reinsurance payments. Such

reinsurance payments must be made not later than June 30 of the year following the applicable benefit year.

5. On a quarterly basis during the benefit year, the Reinsurance Program must provide each eligible health carrier with the total amount of requests for reinsurance payments the Reinsurance Program has received from eligible health carriers during the applicable quarter of the benefit year.

Sec. 33. *1. The Commissioner shall approve annually reinsurance payment parameters for the Reinsurance Program that:*

(a) Manage the Reinsurance Program within available financial resources and take into account any federal and state funding, appropriations or assessments that are available for use by the Reinsurance Program;

(b) Stabilize or reduce premium rates in the individual market;

(c) Increase participation in the individual market;

(d) Improve access to health care providers and health care services for those in the individual market;

(e) Mitigate the impact that high-risk individuals have on premium rates in the individual market; and

(f) Reflect any adjustments needed to comply with any requirements for the approval of federal or state funds.

2. The Board shall set annually the attachment point for the Reinsurance Program for the benefit year at an amount not exceeding the reinsurance cap.

3. The Board shall set annually the coinsurance rate for the Reinsurance Program for the benefit year at a rate between 50 percent and 80 percent.

Sec. 34. *1. Beginning with the 2021 benefit year, the Board shall annually propose to the Commissioner the reinsurance payment parameters for the next benefit year by January 15 of the year immediately preceding the next benefit year.*

2. The Commissioner shall approve or reject the reinsurance payment parameters within 30 days after the proposal of the Board.

3. If the Commissioner fails to approve or reject the reinsurance payment parameters within 30 days after the proposal of the Board, the reinsurance payment parameters proposed by the Board are final and will be effective for the next benefit year.

Sec. 35. *1. Notwithstanding the provisions of sections 33 and 34 of this act, and subject to subsection 2, the reinsurance payment parameters for the 2020 benefit year are:*

(a) An attachment point of $60,000;

(b) A coinsurance rate of 60 percent; and

(c) A reinsurance cap of $300,000.

2. The Board may alter the reinsurance payment parameters to the extent necessary to secure approval of state or federal funds.

Sec. 36. *1. Each reinsurance payment must be calculated with respect to costs incurred by an eligible health carrier to cover the claims and benefits filed by an individual enrolled during the benefit year.*

2. If the costs incurred by an eligible health carrier pursuant to subsection 1 do not exceed the attachment point, the reinsurance payment is $0.

3. If the costs incurred by an eligible health carrier pursuant to subsection 1 exceed the attachment point, the reinsurance payment must be calculated as the product of the:

(a) Coinsurance rate; and

(b) Lesser of:

(1) The costs incurred by an eligible health carrier pursuant to subsection 1 minus the attachment point; or

(2) The reinsurance cap minus the attachment point.

4. The Board shall ensure that reinsurance payments made to eligible health carriers do not exceed the total amount paid of an eligible claim by the eligible health carrier.

5. As used in this section, "total amount paid of an eligible claim" means, as of the time the data is submitted or made accessible under subsection 3 of section 37, the dollar amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, copayment or federal or state subsidy.

Sec. 37. *1. An eligible health carrier may request reinsurance payments from the Reinsurance Program after the requirements of this section and section 32 are met.*

2. An eligible health carrier must make requests for reinsurance payments in accordance with any requirements that are:

(a) Established by the Board; and

(b) Reflected in the reinsurance plan of operation.

3. All submitted claims, working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the Commissioner or any other person in the course of a health care examination made pursuant to this chapter are confidential, are not subject to subpoena and may not be made public by the Commissioner or any other person, except as necessary for a hearing or as provided by NRS 239.0115. A person to whom such information is given must agree in writing before receiving the information to provide to the information the same confidential treatment as required by this section, unless the prior written consent of the insurer to which it pertains has been

obtained. In addition, no waiver of confidentiality or privilege with respect to any document, material or information occurs as a result of disclosure to the Commissioner pursuant to this section.

4. An eligible health carrier must provide the Reinsurance Program with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program pursuant to 42 U.S.C. § 18063, or any other appropriate data collection mechanism chosen by the Board and approved by the Commissioner. Eligible health carriers must submit an attestation to the Board asserting compliance with the:

(a) Applicable dedicated data environments;

(b) Data requirements;

(c) Establishment and usage of identification numbers for the enrolled individuals with such identification numbers being masked; and

(d) Data submission deadlines.

5. An eligible health carrier must provide the access described in subsection 4 for the applicable benefit year by April 30 of the year after the applicable benefit year.

6. An eligible health carrier must maintain documents and records, whether paper, electronic or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least 6 years from the date of request. An eligible health carrier must also make such documents and records available upon request of the Commissioner for the purposes of verification, investigation, audit or other review of the requests for reinsurance payments.

7. An eligible health carrier may be audited by the Reinsurance Program to assess the compliance of the eligible health carrier with the requirements of this section. The eligible health carrier must ensure that its contractors, subcontractors and agents cooperate with any audit authorized by this section. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this section, the eligible health carrier may provide a response to the proposed finding within 30 days of notification of the proposed finding. Within 30 days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier shall provide a written corrective action plan to the Reinsurance Program for approval. After the corrective action plan is approved by the Reinsurance Program, the eligible health carrier shall:

(a) Implement the approved corrective action plan within the timeframe stipulated in the approved corrective action plan; and

1 *(b) Provide the Reinsurance Program with written*
2 *documentation of the corrective action once taken.*
3 **Sec. 38.** *1. The Board and the Administrator shall develop*
4 *procedures to ensure the confidentiality of all data submitted by*
5 *members in accordance with the requirements of the Reinsurance*
6 *Program.*
7 *2. The procedures must ensure that all submitted claims,*
8 *working papers, recorded information, documents and copies*
9 *thereof produced by, obtained by or disclosed to the Commissioner*
10 *or any other person in the course of an examination made*
11 *pursuant to this chapter are confidential and subject to the*
12 *provisions of subsection 3 of section 37 of this act.*
13 *3. Nothing in this act precludes the Administrator or the*
14 *Commissioner from sharing aggregated data submitted by*
15 *companies in accordance with the requirements of the*
16 *Reinsurance Program.*
17 **Sec. 39.** *1. The Nevada Reinsurance Program Account is*
18 *hereby created in the State General Fund.*
19 *2. The State Treasurer shall administer the Nevada*
20 *Reinsurance Program Account and shall deposit into the Nevada*
21 *Reinsurance Program Account all receipts from assessments and*
22 *federal or state funds collected for the purpose of paying*
23 *administrative expenses of the Reinsurance Program.*
24 *3. The State Treasurer shall, upon authorization from the*
25 *Board, make expenditures from the Nevada Reinsurance Program*
26 *Account to:*
27 *(a) Operate and administer the Reinsurance Program; and*
28 *(b) Make reinsurance payments to eligible health carriers.*
29 *4. The operational and administrative costs and reinsurance*
30 *payments of the Reinsurance Program must be funded using the*
31 *following amounts deposited in the Nevada Reinsurance Program*
32 *Account in the following order:*
33 *(a) Any federal funding available;*
34 *(b) Any state funding available; and*
35 *(c) Any amounts assessed to eligible contributors.*
36 **Sec. 40.** *The Board shall keep accurate accounting for each*
37 *benefit year of all:*
38 *1. Funds received by or appropriated to the Reinsurance*
39 *Program;*
40 *2. Requests for reinsurance payments received from eligible*
41 *health carriers;*
42 *3. Reinsurance payments made to eligible health carriers;*
43 *and*
44 *4. Administrative and operational expenses incurred by the*
45 *Reinsurance Program.*

Sec. 41. *1. The Board shall submit to the Commissioner and make available to the public a report summarizing the operations of the Reinsurance Program for each benefit year, in a form approved by the Commissioner, by November 1 of the year following the applicable benefit year or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later.*

2. The report required pursuant to subsection 1 must, at a minimum, include the following information for the benefit year that is the subject of the report:

(a) Funds deposited in the Nevada Reinsurance Program Account;

(b) Requests for reinsurance payments received from eligible health carriers;

(c) Reinsurance payments made to eligible health carriers; and

(d) Administrative and operational expenses incurred for the Reinsurance Program.

Sec. 42. *1. The Board shall hire and cooperate with an independent certified public accountant that is licensed to do business in Nevada to perform an audit of the Reinsurance Program for each benefit year, in accordance with generally accepted auditing standards. The audit must, at a minimum:*

(a) Assess compliance with the requirements of sections 5 to 44, inclusive, of this act; and

(b) Identify any material weaknesses or significant deficiencies of the Reinsurance Program and address manners in which to correct any such material weaknesses or deficiencies.

2. The Board, after receiving the completed audit pursuant to subsection 1, shall:

(a) Provide the Commissioner with the results of the audit;

(b) Identify to the Commissioner any material weakness or significant deficiency identified in the audit and address in writing to the Commissioner how the Board intends to correct any such material weakness or significant deficiency; and

(c) Make public the results of the audit, including, without limitation, any material weakness or significant deficiency and how the Board intends to correct the material weakness or significant deficiency.

Sec. 43. *The Commissioner shall:*

1. Approve the selection of the Administrator made by the Board pursuant to subsection 2 of section 31 of this act and approve the Board's contract with the Administrator;

2. Contract with the Federal Government or another unit of State Government to ensure coordination of the Reinsurance Program with other governmental programs;

3. Undertake, directly or through contracts with other persons, studies or demonstration programs to develop awareness of the benefits of this chapter; and

4. Formulate general policy and adopt regulations that are reasonably necessary to administer this chapter.

Sec. 44. *In a rate filing submitted pursuant to NRS 686B.070, an eligible health carrier is required to identify, in a form approved by the Commissioner, the impact of reinsurance payments on the:*

1. Costs of projected claims; and

2. Development of rates.

Sec. 45. *1. The Commissioner may apply to the Secretary of Health and Human Services pursuant to 42 U.S.C. § 18052 for a waiver for state innovation of applicable provisions of the Patient Protection and Affordable Care Act, Public Law 111-148, with respect to health insurance coverage in this State for a plan year beginning on or after January 1, 2020.*

2. The Commissioner may implement a state plan that meets the waiver requirements in a manner consistent with state and federal law and as approved by the Secretary of Health and Human Services.

Sec. 46. NRS 686B.010 is hereby amended to read as follows:

686B.010 1. The Legislature intends that NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** be liberally construed to achieve the purposes stated in subsection 2, which constitute an aid and guide to interpretation but not an independent source of power.

2. The purposes of NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** are to:

(a) Protect policyholders and the public against the adverse effects of excessive, inadequate or unfairly discriminatory rates;

(b) Encourage, as the most effective way to produce rates that conform to the standards of paragraph (a), independent action by and reasonable price competition among insurers;

(c) Provide formal regulatory controls for use if independent action and price competition fail;

(d) Authorize cooperative action among insurers in the rate-making process, and to regulate such cooperation in order to prevent practices that tend to bring about monopoly or to lessen or destroy competition;

(e) Encourage the most efficient and economic marketing practices; and

(f) Regulate the business of insurance in a manner that will preclude application of federal antitrust laws.

Sec. 47. NRS 686B.020 is hereby amended to read as follows:

686B.020 As used in NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act,*** unless the context otherwise requires:

1. "Advisory organization," except as limited by NRS 686B.1752, means any person or organization which is controlled by or composed of two or more insurers and which engages in activities related to rate making. For the purposes of this subsection, two or more insurers with common ownership or operating in this State under common ownership constitute a single insurer. An advisory organization does not include:

(a) A joint underwriting association;

(b) An actuarial or legal consultant; or

(c) An employee or manager of an insurer.

2. "Market segment" means any line or kind of insurance or, if it is described in general terms, any subdivision thereof or any class of risks or combination of classes.

3. "Rate service organization" means any person, other than an employee of an insurer, who assists insurers in rate making or filing by:

(a) Collecting, compiling and furnishing loss or expense statistics;

(b) Recommending, making or filing rates or supplementary rate information; or

(c) Advising about rate questions, except as an attorney giving legal advice.

4. "Supplementary rate information" includes any manual or plan of rates, statistical plan, classification, rating schedule, minimum premium, policy fee, rating rule, rule of underwriting relating to rates and any other information prescribed by regulation of the Commissioner.

Sec. 48. NRS 686B.030 is hereby amended to read as follows:

686B.030 1. Except as otherwise provided in subsection 2 and NRS 686B.125, the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** apply to all kinds and lines of direct insurance written on risks or operations in this State by any insurer authorized to do business in this State, except:

(a) Ocean marine insurance;

(b) Contracts issued by fraternal benefit societies;

(c) Life insurance and credit life insurance;

(d) Variable and fixed annuities;

(e) Credit accident and health insurance;

(f) Property insurance for business and commercial risks;

(g) Casualty insurance for business and commercial risks other than insurance covering the liability of a practitioner licensed pursuant to chapters 630 to 640, inclusive, of NRS;

(h) Surety insurance;
(i) Health insurance offered through a group health plan maintained by a large employer; and
(j) Credit involuntary unemployment insurance.
2. The exclusions set forth in paragraphs (f) and (g) of subsection 1 extend only to issues related to the determination or approval of premium rates.

Sec. 49. NRS 686B.040 is hereby amended to read as follows:
686B.040 1. Except as otherwise provided in subsection 2, the Commissioner may by rule exempt any person or class of persons or any market segment from any or all of the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** if and to the extent that the Commissioner finds their application unnecessary to achieve the purposes of those sections.
2. The Commissioner may not, by rule or otherwise, exempt an insurer from the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** with regard to insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of the practitioner's professional duty toward a patient.

Sec. 50. NRS 686B.080 is hereby amended to read as follows:
686B.080 1. Except as otherwise provided in subsections 2 to 5, inclusive, each filing and any supporting information filed under NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** must, as soon as filed, be open to public inspection at any reasonable time. Copies may be obtained by any person on request and upon payment of a reasonable charge therefor.
2. All rates for health benefit plans available for purchase by individuals and small employers are considered proprietary and constitute trade secrets, and are not subject to disclosure by the Commissioner to persons outside the Division except as agreed to by the carrier or as ordered by a court of competent jurisdiction.
3. The provisions of subsection 2 expire annually on the date 30 days before open enrollment.
4. Except in cases of violations of NRS 689A.010 to 689A.740, inclusive, or 689C.015 to 689C.355, inclusive, the unified rate review template and rate filing documentation used by carriers servicing the individual and small employer markets are considered proprietary and constitute a trade secret, and are not subject to disclosure by the Commissioner to persons outside the Division except as agreed to by the carrier or as ordered by a court of competent jurisdiction.
5. An insurer providing blanket health insurance in accordance with the provisions of chapter 689B of NRS shall make all information concerning rates available to the Commissioner upon

request. Such information is considered proprietary and constitutes a trade secret and is not subject to disclosure by the Commissioner to persons outside the Division except as agreed by the insurer or as ordered by a court of competent jurisdiction.

6. For the purposes of this section:

(a) "Open enrollment" has the meaning ascribed to it in 45 C.F.R. § 147.104(b)(1)(ii).

(b) "Rate filing documentation" and "unified rate review template" have the meanings ascribed to them in 45 C.F.R. § 154.215.

Sec. 51. NRS 686B.110 is hereby amended to read as follows:

686B.110 1. Except as otherwise provided in NRS 686B.112, the Commissioner shall consider each proposed increase or decrease in the rate of any kind or line of insurance or subdivision thereof filed with the Commissioner pursuant to subsection 1 of NRS 686B.070. If the Commissioner finds that a proposed increase will result in a rate which is not in compliance with NRS 686B.050 or subsection 3 of NRS 686B.070, the Commissioner shall disapprove the proposal. The Commissioner shall approve or disapprove each proposal no later than 30 days after it is determined by the Commissioner to be complete pursuant to subsection 6. If the Commissioner fails to approve or disapprove the proposal within that period, the proposal shall be deemed approved.

2. If the Commissioner disapproves a proposed increase or decrease in any rate pursuant to subsection 1, the Commissioner shall send a written notice of disapproval to the insurer or the rate service organization that filed the proposal. The notice must set forth the reasons the proposal is not in compliance with NRS 686B.050 or subsection 3 of NRS 686B.070 and must be sent to the insurer or the rate service organization not more than 30 days after the Commissioner determines that the proposal is complete pursuant to subsection 6.

3. Upon receipt of a written notice of disapproval from the Commissioner pursuant to subsection 2 or 6, the insurer or rate service organization may request that the Commissioner reconsider the proposed increase or decrease. The request for reconsideration must be received by the Commissioner not more than 30 days after the insurer or rate service organization receives the written notice of disapproval from the Commissioner, except that if the insurer or rate service organization requests, in writing, an extension of 30 additional days in which to request a reconsideration, the Commissioner shall grant the extension. A request for reconsideration submitted pursuant to this subsection may include, without limitation, any documents or other information for review by the Commissioner in reconsidering the proposal. The

Commissioner shall approve or disapprove the proposal upon reconsideration not later than 30 days after receipt of the request for reconsideration and shall notify the insurer or rate service organization of his or her approval or disapproval.

4. Whenever an insurer has no legally effective rates as a result of the Commissioner's disapproval of rates or other act, the Commissioner shall on request specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by the Commissioner. When new rates become legally effective, the Commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis must not be required.

5. If the Commissioner disapproves a proposed rate pursuant to subsection 1 or subsection 6 or upon reconsideration pursuant to subsection 3 and an insurer requests a hearing to determine the validity of the action of the Commissioner, the insurer has the burden of showing compliance with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive ~~[.]~~ ***, and section 45 of this act.*** Any such hearing must be held:

(a) Within 30 days after the request for a hearing has been submitted to the Commissioner; or

(b) Within a period agreed upon by the insurer and the Commissioner.

➥ If the hearing is not held within the period specified in paragraph (a) or (b), or if the Commissioner fails to issue an order concerning the proposed rate for which the hearing is held within 45 days after the hearing, the proposed rate shall be deemed approved.

6. The Commissioner shall by regulation specify the documents or any other information which must be included in a proposal to increase or decrease a rate submitted to the Commissioner pursuant to subsection 1. Each such proposal shall be deemed complete upon its filing with the Commissioner, unless the Commissioner, within 15 business days after the proposal is filed with the Commissioner, determines that the proposal is incomplete because the proposal does not comply with the regulations adopted by the Commissioner pursuant to this subsection. The Commissioner shall notify the insurer or rate service organization if the Commissioner determines that the proposal is incomplete. The notice must be sent within 15 business days after the proposal is filed with the Commissioner and must set forth the documents or other information that is required to complete the proposal. The Commissioner may disapprove the proposal if the insurer or rate service organization fails to provide the documents or other

information to the Commissioner within 30 days after the insurer or rate service organization receives the notice that the proposal is incomplete. If the Commissioner disapproves the proposal pursuant to this subsection, the Commissioner shall notify the insurer or rate service organization of that fact in writing.

Sec. 52. NRS 686B.112 is hereby amended to read as follows:

686B.112 1. The Commissioner shall consider each proposed increase or decrease in the rate of a health plan issued pursuant to the provisions of chapter 689A, 689B, 689C, 695B, 695C, 695D or 695F of NRS, including, without limitation, long-term care and Medicare supplement plans, filed with the Commissioner pursuant to subsection 1 of NRS 686B.070. If the Commissioner finds that a proposed increase will result in a rate which is not in compliance with NRS 686B.050 or subsection 3 of NRS 686B.070, the Commissioner shall disapprove the proposal. The Commissioner shall approve or disapprove each proposal not later than 60 days after the proposal is determined by the Commissioner to be complete pursuant to subsection 4. If the Commissioner fails to approve or disapprove the proposal within that period, the proposal shall be deemed approved.

2. Whenever an insurer has no legally effective rates as a result of the Commissioner's disapproval of rates or other act, the Commissioner shall on request specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by the Commissioner. When new rates become legally effective, the Commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis must not be required.

3. If the Commissioner disapproves a proposed rate pursuant to subsection 1, and an insurer requests a hearing to determine the validity of the action of the Commissioner, the insurer has the burden of showing compliance with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive [.] ***, and section 45 of this act.*** Any such hearing must be held:

(a) Within 30 days after the request for a hearing has been submitted to the Commissioner; or

(b) Within a period agreed upon by the insurer and the Commissioner.

➥ If the hearing is not held within the period specified in paragraph (a) or (b), or if the Commissioner fails to issue an order concerning the proposed rate for which the hearing is held within 45 days after the hearing, the proposed rate shall be deemed approved.

4. The Commissioner shall by regulation specify the documents or any other information which must be included in a proposal to increase or decrease a rate submitted to the Commissioner pursuant to subsection 1. Each such proposal shall be deemed complete upon its filing with the Commissioner, unless the Commissioner, within 15 business days after the proposal is filed with the Commissioner, determines that the proposal is incomplete because the proposal does not comply with the regulations adopted by the Commissioner pursuant to this subsection.

Sec. 53. NRS 686B.115 is hereby amended to read as follows:

686B.115 1. Any hearing held by the Commissioner to determine whether rates comply with the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** must be open to members of the public.

2. All costs for transcripts prepared pursuant to such a hearing must be paid by the insurer requesting the hearing.

3. At any hearing which is held by the Commissioner to determine whether rates comply with the provisions of NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** and which involves rates for insurance covering the liability of a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS for a breach of the practitioner's professional duty toward a patient, if a person is not otherwise authorized pursuant to this title to become a party to the hearing by intervention, the person is entitled to provide testimony at the hearing if, not later than 2 days before the date set for the hearing, the person files with the Commissioner a written statement which states:

(a) The name and title of the person;

(b) The interest of the person in the hearing; and

(c) A brief summary describing the purpose of the testimony the person will offer at the hearing.

4. If a person provides testimony at a hearing in accordance with subsection 3:

(a) The Commissioner may, if the Commissioner finds it necessary to preserve order, prevent inordinate delay or protect the rights of the parties at the hearing, place reasonable limitations on the duration of the testimony and prohibit the person from providing testimony that is not relevant to the issues raised at the hearing.

(b) The Commissioner shall consider all relevant testimony provided by the person at the hearing in determining whether the rates comply with the provisions of NRS 686B.010 to 686B.1799, inclusive ~~[.]~~ ***, and section 45 of this act.***

Sec. 54. NRS 686B.130 is hereby amended to read as follows:

686B.130 1. A rate service organization and an advisory organization shall not provide any service relating to the rates of any

insurance subject to NRS 686B.010 to 686B.1799, inclusive, ***and section 45 of this act*** and an insurer shall not utilize the services of an organization for such purposes unless the organization has obtained a license pursuant to NRS 686B.140.

2. A rate service organization and an advisory organization shall not refuse to supply any services for which it is licensed in this state to any insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services.

Sec. 55. NRS 687B.120 is hereby amended to read as follows:

687B.120 1. Except as otherwise provided in subsection 2:

(a) No life or health insurance policy or contract, annuity contract form, policy form, health care plan or plan for dental care, whether individual, group or blanket, including those to be issued by a health maintenance organization, organization for dental care or prepaid limited health service organization, or application form where a written application is required and is to be made a part of the policy or contract, or printed rider or endorsement form or form of renewal certificate, or form of individual certificate or statement of coverage to be issued under group or blanket contracts, or by a health maintenance organization, organization for dental care or prepaid limited health service organization, may be delivered or issued for delivery in this state, unless the form has been filed with and approved by the Commissioner.

(b) As to ***individual policies pursuant to paragraph (d) of subsection 2 of NRS 679B.220 or*** group insurance policies effectuated and delivered outside this state but covering persons resident in this state, the [group] certificates to be delivered or issued for delivery in this state must be filed, for informational purposes only, with the Commissioner at the request of the Commissioner.

2. As to group insurance policies to be issued to a group approved pursuant to NRS 688B.030 or 689B.026, no policies of group insurance may be marketed to a resident or employer of this State unless the policy and any form or certificate to be issued pursuant to the policy has been filed with and approved by the Commissioner.

3. Every filing made pursuant to the provisions of subsection 1 or 2 must be made not less than 45 days in advance of any delivery pursuant to subsection 1 or marketing pursuant to subsection 2. At the expiration of 45 days the form so filed shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by order of the Commissioner. Approval of any such form by the Commissioner constitutes a waiver of any unexpired portion of such waiting period. The Commissioner may extend by not more than an additional 30 days the period within which the

Commissioner may so affirmatively approve or disapprove any such form, by giving notice to the insurer of the extension before expiration of the initial 45-day period. At the expiration of any such period as so extended, and in the absence of prior affirmative approval or disapproval, any such form shall be deemed approved. The Commissioner may at any time, after notice and for cause shown, withdraw any such approval.

4. Any order of the Commissioner disapproving any such form or withdrawing a previous approval must state the grounds therefor and the particulars thereof in such detail as reasonably to inform the insurer thereof. Any such withdrawal of a previously approved form is effective at the expiration of such a period, not less than 30 days after the giving of notice of withdrawal, as the Commissioner in such notice prescribes.

5. The Commissioner may, by order, exempt from the requirements of this section for so long as the Commissioner deems proper any insurance document or form or type thereof specified in the order, to which, in the opinion of the Commissioner, this section may not practicably be applied, or the filing and approval of which are, in the opinion of the Commissioner, not desirable or necessary for the protection of the public.

6. Appeals from orders of the Commissioner disapproving any such form or withdrawing a previous approval may be taken as provided in NRS 679B.310 to 679B.370, inclusive.

Sec. 56. NRS 687B.480 is hereby amended to read as follows:

687B.480 ~~[1.]~~ All health benefit plans must be made available in the manner required by 45 C.F.R. § 147.104.

~~[2. In addition to the requirements of subsection 1, any health benefit plan for individuals that is not purchased on the Silver State Health Insurance Exchange established by NRS 695I.210:~~

~~(a) Must be made available for purchase at any time during the calendar year;~~

~~(b) Is subject to a waiting period of not more than 90 days after the date on which the application for coverage was received;~~

~~(c) Is effective upon the first day of the month immediately succeeding the month in which the waiting period expires; and~~

~~(d) Is not retroactive to the date on which the application for coverage was received.]~~

Sec. 57. NRS 687B.500 is hereby amended to read as follows:

687B.500 1. The premium rate charged by a health insurer for health benefit plans offered in the individual or small employer group market may vary with respect to the particular plan or coverage involved based solely on these characteristics:

(a) Whether the plan or coverage applies to an individual or a family;

(b) Geographic rating area;
(c) Tobacco use *; ~~[, except that the rate shall not vary by a ratio of more than 1.5 to 1 for like individuals who vary in tobacco use;]~~ and
(d) Age ~~[, except that the rate must not vary by a ratio of more than 3 to 1 for like individuals of different age who are age 21 years or older and that the variation in rate must be actuarially justified for individuals who are under the age of 21 years,]~~ consistent with the uniform age rating curve established in the Federal Act. For the purpose of identifying the appropriate age adjustment under this paragraph and the age band defined in the Federal Act to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal must be used.
2. The provisions of subsection 1:
(a) Apply to a fraternal benefit society organized under chapter 695A of NRS; and
(b) Do not apply to grandfathered plans.
3. As used in this section, "small employer" has the meaning ascribed to it in NRS 689C.095.

Sec. 58. NRS 690B.330 is hereby amended to read as follows:

690B.330 1. In each rating plan of an insurer that issues a policy of professional liability insurance to a practitioner licensed pursuant to chapter 630 or 633 of NRS, the insurer shall provide for a reduction in the premium for the policy if the practitioner implements a qualified risk management system. The amount of the reduction in the premium must be determined by the Commissioner in accordance with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive ~~[.]~~ ***, and section 45 of this act.***
2. A qualified risk management system must comply with all requirements established by the Commissioner.
3. The Commissioner shall adopt regulations to:
(a) Establish the requirements for a qualified risk management system; and
(b) Carry out the provisions of this section.
4. The provisions of this section apply to all rating plans which an insurer that issues a policy of professional liability insurance to a practitioner licensed pursuant to chapter 630 or 633 of NRS files with the Commissioner on and after the effective date of the regulations adopted by the Commissioner pursuant to this section.

Sec. 59. NRS 690B.360 is hereby amended to read as follows:

690B.360 1. The Commissioner may collect all information which is pertinent to monitoring whether an insurer that issues professional liability insurance for a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS is complying with the

applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive [.] ***, and section 45 of this act.*** Such information may include, without limitation:

(a) The amount of gross premiums collected with regard to each medical specialty;

(b) Information relating to loss ratios;

(c) Information reported pursuant to NRS 690B.260; and

(d) Information reported pursuant to NRS 679B.430 and 679B.440.

2. In addition to the information collected pursuant to subsection 1, the Commissioner may request any additional information from an insurer:

(a) Whose rates and credit utilization are materially different from other insurers in the market for professional liability insurance for a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS in this State;

(b) Whose credit utilization shows a substantial change from the previous year; or

(c) Whose information collected pursuant to subsection 1 indicates a potentially adverse trend.

3. If the Commissioner requests additional information from an insurer pursuant to subsection 2, the Commissioner may:

(a) Determine whether the additional information offers a reasonable explanation for the results described in paragraph (a), (b) or (c) of subsection 2; and

(b) Take any steps permitted by law that are necessary and appropriate to assure the ongoing stability of the market for professional liability insurance for a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS in this State.

4. On an ongoing basis, the Commissioner may analyze and evaluate the information collected pursuant to this section to determine trends in and measure the health of the market for professional liability insurance for a practitioner licensed pursuant to chapter 630, 631, 632 or 633 of NRS in this State.

5. If the Commissioner convenes a hearing pursuant to subsection 1 of NRS 690B.350 and determines that the market for professional liability insurance issued to any class, type or specialty of practitioner licensed pursuant to chapter 630, 631 or 633 of NRS is not competitive and that such insurance is unavailable or unaffordable for a substantial number of such practitioners, the Commissioner shall prepare and submit a report of the Commissioner's findings and recommendations to the Director of the Legislative Counsel Bureau for transmittal to members of the Legislature.

1 **Sec. 60.** The provisions of subsection 1 of NRS 218D.380 do
2 not apply to any provision of this act which adds or revises a
3 requirement to submit a report to the Legislature.
4 **Sec. 61.** 1. This section and sections 1 to 55, inclusive, 58,
5 59 and 60 of this act become effective upon passage and approval.
6 2. Sections 56 and 57 of this act become effective on
7 October 1, 2019.

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