ADOPTED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R132-24

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

AUTHORITY: § 1, NRS 679B.130 and 685A.210; §§ 2 and 3, NRS 679B.130, 679B.430 and 686B.160; §§ 4 and 6, NRS 679B.130, 686B.100 and 686B.110; §§ 5 and 9, NRS 679B.130 and 686B.100; § 7, NRS 679B.130 and 686B.1775; § 8, NRS 679B.130 and 687B.430; § 10, NRS 679B.130, 694C.170 and 694C.400; § 11, NRS 679B.130.

A REGULATION relating to insurance; removing certain obsolete requirements; revising the period of time in which certain insurers must submit data necessary to produce fast track reports; revising certain requirements for the filing of an increase or decrease in rates for professional liability insurance for certain practitioners; revising the conditions under which the Commissioner of Insurance will accept an individual risk premium modification plan; removing provisions requiring certain profitability reports to be certified by an officer of the insurer; revising procedures for the filing of final rates or loss cost multipliers for policies of industrial insurance; revising requirements for certain filings concerning policies to supplement Medicare; revising the conditions that a schedule-rating plan submitted by an insurer who provides certain professional liability insurance must meet for the Commissioner to accept such a plan; removing the requirement for certain annual audits of a captive insurer to include a statement which certifies that certain requirements have been met; repealing various provisions relating to reports and information that an insurer is required to submit to or file with the Commissioner; repealing provisions relating to the use of electronic means to pay certain fees; repealing the definition of "emergency" for purposes of certain provisions relating to contracts of insurance for home protection; 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. (NRS 679B.130)

Before the enactment of Senate Bill No. 209 (S.B. 209) of the 2017 Legislative Session, existing law authorized the Commissioner to enter into a multi-state agreement to preserve the ability of this State to collect premium tax on multi-state risks. (NRS 685A.185, as that section existed before July 1, 2017) S.B. 209 repealed the authorization of the Commissioner to enter into such agreements. (Section 13 of Senate Bill No. 209, chapter 560, Statute of Nevada 2017, at page 4008) **Section 1** of this regulation removes certain obsolete requirements set forth in existing regulations relating to such agreements.

Existing law requires the Commissioner to adopt regulations requiring each insurer authorized to transact casualty or property insurance in this State to record and report certain information. (NRS 679B.430) Existing regulations require each insurer licensed to transact the business of property and casualty insurance to annually file with the Commissioner an insurance expense exhibit containing certain information. The information in the exhibit is required to be filed pursuant to the specifications of the National Association of Insurance Commissioners for filing an annual statement on diskette. (NAC 686B.351) **Section 2** of this regulation revises that requirement to instead require the information in the exhibit to be filed pursuant to the specifications of the National Association of Insurance Commissioners for filing an annual statement, rather than the specifications for filing such a statement on diskette.

Existing law authorizes the Commissioner to: (1) promulgate or approve reasonable rules providing statistical plans for use thereafter by all insurers in the recording and reporting of loss and expense experience; and (2) designate one or more rate service organizations to assist the Commissioner in gathering such experience and making compilations thereof. (NRS 686B.160) Existing regulations require selected insurers to submit certain data necessary to produce fast track reports within 45 days after the end of the calendar year. (NAC 686B.371) **Section 3** of this regulation requires such data to instead be submitted within 45 days after the end of the calendar quarter.

Existing law requires each authorized insurer and certain rate service organizations to file with the Commissioner all of the following made by it for use in this State: (1) rates and proposed increases thereto; (2) forms of policies to which the rates apply; (3) supplementary rate information; and (4) changes and amendments thereof. (NRS 686B.070) Existing law requires the Commissioner to, by regulation, specify the documents or any other information which must be included in a proposal to increase or decrease a rate. (NRS 686B.110) Existing regulations require a filing for an increase or decrease in rates for professional liability insurance for certain licensed practitioners to include, among other information, a profitability report that: (1) includes the statistical test used to justify the proposed differences in rates by territory or an explanation as to why such a test is not provided; and (2) is certified by an officer of the insurer as to its accuracy. **Section 4** of this regulation removes such requirements for a profitability report and instead requires such a filing to justify any proposed differences in rates by territory, including any relevant data specific to this State, and calculations supporting such differences.

Existing regulations set forth conditions under which the Commissioner will accept a schedule-rating plan submitted by an insurer who provides policies of professional liability insurance covering the liability of certain licensed practitioners for a breach of professional duty toward a patient. (NAC 690B.540) **Section 9** of this regulation removes from those conditions of acceptance the requirement that the schedule rating applies only to policies which develop certain premiums.

Existing regulations set forth conditions under which the Commissioner will accept an individual risk premium modification plan. (NAC 686B.610) **Section 5** of this regulation removes from those conditions for acceptance the requirements that: (1) the schedule rating applies only to risks which develop certain premiums; and (2) no risk be modified except after inspection of the property.

Existing regulations require an insurer or group of insurers that is insuring more than 2,000 vehicles principally kept in this State to include with all filings for an increase or decrease in rates a profitability report. (NAC 686B.720) **Section 6** of this regulation removes a requirement that the profitability report be certified by an officer of the insurer as to its accuracy.

Existing law requires each insurer authorized to provide industrial insurance to file with the Commissioner all the rates, supplementary rate information, supporting data and changes and amendments thereof, except any information filed by the Advisory Organization, which the insurer intends to use in this State. (NRS 686B.1775) Existing regulations provide procedures for an insurer to follow when filing such rates, including a requirement for an insurer to use the current loss cost multipliers filed by the Advisory Organization in accordance with the anniversary rating date rule in the manuals of rating rules approved by the Commissioner. (NAC 686B.843) **Section 7** of this regulation instead requires the insurer to use the current loss costs filed by the Advisory Organization and approved by the Commissioner.

Existing regulations prohibit an issuer from using or changing the premium rates for a policy to supplement Medicare or a certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Commissioner. (NAC 687B.229) Existing regulations require each issuer providing a policy to supplement Medicare or a certificate in this State, on or before May 31 of each year, to file with the Division of Insurance of the Department of Business and Industry its rates, rating schedule and supporting documentation. (NAC 687B.230) **Section 8** of this regulation removes the requirement that an issuer file its rates, rating schedule and supporting documentation on or before May 31 of each year. **Section 8** additionally requires supporting documentation to demonstrate that expected claims in relation to premiums comply with the aggregate benefit requirements when combined with actual experience as of the date of filing. **Section 11** of this regulation repeals provisions requiring an issuer, on or before May 31 of each year, to report to the Commissioner certain information relating to residents in this State for whom the issuer has in force more than one policy to supplement Medicare or certificate. (NAC 687B.283)

Existing regulations require, with certain exceptions, a captive insurer to have an annual audit conducted by an independent certified public accountant and file the audit with the Commissioner each year. (NAC 694C.210) **Section 10** of this regulation removes a requirement that the annual audit include a statement prepared by the independent certified public accountant who conducted the audit certifying that all financial requirements established by law, the articles of incorporation, the bylaws and the business plan of the captive insurer have been met.

Existing regulations require an insurer who submits a form for an insurance policy, rate, rider or endorsement or a broker who submits a memorandum of open lines insurance or brokers affidavit of surplus line insurance to the Commissioner to complete and submit with that form a copy of the Commissioner's form for assessing fees. (NAC 680B.010) **Section 11** repeals that requirement. **Section 11** additionally repeals provisions authorizing any fees required to be paid for filing forms with the Commissioner to be paid in accordance with the program adopted by the State Treasurer that provides for the electronic payment of money owed. (NAC 680B.095)

Existing regulations require each health maintenance organization which receives a certificate of authority, on or before March 1 of each year, to file with the Commissioner the quality and performance indicators selected by the Commissioner for the immediately preceding calendar year. (NAC 695C.275) **Section 11** repeals that requirement.

Existing regulations require: (1) an insurer, on or before April 1 of each year, to report certain information relating to long-term care insurance to the Commissioner using form NDOI-947; and (2) an insurer or other entity selling or issuing benefits for long-term care insurance to maintain a record of all rescissions of its long-term insurance contracts or certificates in this State or any other State and, on or before March 1 of each year, furnish such information using

form NDOI-929 or a similar form approved by the Commissioner. (NAC 687B.057, 687B.069) **Section 11** repeals those requirements.

Existing law: (1) requires a contract of insurance for home protection to specify certain information including that, except in an emergency, services will be initiated by or under the direction of the insurer within 48 hours after the conclusion of an investigation of a claim; and (2) authorizes the Commissioner to adopt regulations to define the term "emergency" for the purposes of such a requirement. (NRS 690B.160) **Section 11** repeals the definition of "emergency" set forth in existing regulations for such purposes. (NAC 690B.400)

Section 1. NAC 685A.420 is hereby amended to read as follows:

685A.420 For the purpose of determining the tax payable to the Commissioner pursuant to NRS 685A.180 **,** ~~[~~**:**

~~1. For a multi-state risk:~~

~~(a) If the Commissioner has entered into a multi-state agreement pursuant to NRS 685A.185, a broker shall use the allocation formulas and filing procedures established pursuant to the multi-state agreement to determine the allocation to this State of premiums as to persons, property, subjects or risks in this State insured under policies and contracts covering persons, property, subjects or risks located or resident in more than one state.~~

~~(b) If the Commissioner has not entered into a multi-state agreement pursuant to NRS 685A.185, a broker shall file premium taxes through the Surplus Lines Information Portal, or a successor system, of the nonprofit organization of surplus lines brokers formed pursuant to NRS 685A.075 for all risks for which Nevada is the home state of the insured.~~

~~2. For a risk with exposure located solely in Nevada,~~**]** a broker shall file premium taxes through the Surplus Lines Information Portal, or a successor system, of the nonprofit organization of surplus lines brokers formed pursuant to NRS 685A.075.

Sec. 2. NAC 686B.351 is hereby amended to read as follows:

686B.351 As a condition of doing business in this State, each insurer licensed to transact the business of property and casualty insurance must, in addition to any other reports required, report to the Commissioner financial data for the preceding year as follows:

1. An insurance expense exhibit must be filed with the Commissioner on or before April 1 of each year, or on a later date, if appropriate. The exhibit must provide information from across the country on the insurer's expenses for the previous calendar year. The exhibit must be in the form prescribed by the National Association of Insurance Commissioners. Information from the insurer's insurance expense exhibit shall be deemed to be filed with the Commissioner if it is filed at the Central Office of the National Association of Insurance Commissioners, 1100 Walnut Street, Suite ~~[1500,]~~ ***1000,*** Kansas City, Missouri 64106-2197, on or before April 1 of each year. The information must be filed pursuant to the specifications of the National Association of Insurance Commissioners for filing information for an annual statement **.** ~~[on diskette.]~~

2. Other schedules or supplements must be filed as required by the Commissioner. Any additional National Association of Insurance Commissioners' schedule required by the Commissioner must be in the form prescribed by the National Association of Insurance Commissioners.

Sec. 3. NAC 686B.371 is hereby amended to read as follows:

686B.371 Data necessary to produce fast track reports must be submitted to the statistical agents by selected insurers within 45 days after the end of the calendar ~~[year.]~~ ***quarter.*** The data must be submitted as follows:

1. Fast track quarterly premium and loss data must be submitted for the following types of insurance:

(a) Private passenger liability.

(b) Private passenger physical damage.

(c) Commercial motor vehicle liability.

(d) Commercial motor vehicle physical damage.

(e) Homeowners.

(f) Dwelling fire.

(g) Dwelling allied lines.

(h) Commercial fire.

(i) Commercial allied lines.

(j) Farm business.

(k) Commercial multiple peril.

(l) Liability other than motor vehicle.

(m) Medical malpractice.

2. Claim cost and claim severity data must be included for the following types of insurance:

(a) Private passenger comprehensive.

(b) Private passenger collision.

(c) Private passenger bodily injury liability.

(d) Private passenger property damage liability.

(e) Private passenger personal injury protection, if applicable.

Sec. 4. NAC 686B.501 is hereby amended to read as follows:

686B.501 1. A filing for an increase or decrease in rates for professional liability insurance for practitioners licensed pursuant to chapters 630 to 640, inclusive, of NRS must:

(a) Include a profitability report in the form prescribed by the Commissioner;

(b) Identify the largest theoretical rate increase proposed by the filing; ~~[and]~~

(c) Identify the components of the rate increase ~~[~~.

~~2. The profitability report required by subsection 1 must:~~

~~(a) Include the statistical test, including, if applicable, the "students t" test, used to justify the]~~ ***; and***

(d) Justify any proposed differences in rates by territory, ~~[or, if a statistical test is not provided, an explanation as to the reason why a test was not provided;]~~ ***including any relevant data specific to this State,*** and

~~[(b) Be certified by an officer of the insurer as to its accuracy.~~

~~3.]~~ ***calculations supporting such differences.***

2. The Division's actuary may specify, where reserve charges are coded to a specific year, the years in which accidents have occurred, commonly referred to as "calendar accident years," that the insurer must include in the profitability report.

~~[4.]~~ ***3.*** Unless otherwise required by the Commissioner, if an insurer has previously submitted a profitability report, the new report must include updated numbers for all calendar accident years in the previous report and all subsequent years in which accidents have occurred for a maximum reporting period of 10 years.

~~[5.]~~ ***4.*** The insurer and the Division's actuary may agree to use the data from the fiscal year in which accidents have occurred, commonly referred to as "fiscal accident year," as the basis for profitability reports.

Sec. 5. NAC 686B.610 is hereby amended to read as follows:

686B.610 1. For the purposes of this section, "schedule rating" means application of judgment credits and debits to the risk rate or premium charge which has been developed through the use of base rate or class rate modified by:

(a) Package discounts where applicable; and

(b) Any other approved rating plan which does not duplicate credits or debits.

2. The Commissioner will accept individual risk premium modification plans if:

(a) Schedule-rating factors apply only to individual risk characteristics which reflect potential hazards.

(b) ~~[Schedule rating applies only to risks which develop at least $500 annual premium or $1,500 3-year prepaid premium. When schedule credits are being applied, the resulting premium must be $500 or more for 1 year, or $1,500 or more for 3 years.~~

~~(c)]~~ The schedule-rating plan ~~[must provide]~~ ***provides*** for debits and credits, and is subject to maximum total debits or credits of 25 percent.

~~[(d) No risk may be modified except after inspection of the property.]~~

(c) The insurer ~~[shall retain]~~ ***retains*** adequate supporting data, including copies of inspection reports, which may be inspected by the Division.

3. Each filing of an individual risk premium modification plan must be accompanied by a statement by the filing official affirming that the filing conforms to the provisions of this section.

4. This section does not apply to automobile liability, automobile physical damage, general liability, medical malpractice liability, burglary, glass, fidelity or boiler and machinery rating plans.

Sec. 6. NAC 686B.720 is hereby amended to read as follows:

686B.720 1. An insurer or group of insurers that is insuring more than 2,000 vehicles principally kept in this State must include a profitability report with all filings for an increase or decrease in rates.

2. A profitability report must be in the form required by the Division . ~~[and certified by an officer of the insurer as to its accuracy.]~~

3. The Division's actuary may specify, where reserve charges are coded to a specific year, the years in which accidents have occurred, commonly referred to as "calendar accident years," that the insurer must include in the profitability report.

4. Unless otherwise required by the Commissioner, if an insurer has previously submitted a profitability report, the new report must include updated numbers for all calendar accident years in the previous report and all subsequent years in which accidents have occurred for a maximum reporting period of 10 years.

5. The insurer and the Division's actuary may agree to use the data from the fiscal year in which accidents occurred, commonly referred to as "fiscal accident year," as the basis for the profitability reports.

6. The Division's actuary may specify that a profitability report filed by an insurer providing coverage for at least 60,000 vehicles principally kept in this State must include profitability by territory.

Sec. 7. NAC 686B.843 is hereby amended to read as follows:

686B.843 1. For each filing of final rates or loss cost multipliers for policies of industrial insurance made pursuant to NRS 686B.1775, the insurer:

(a) Shall complete and include, without limitation:

(1) If an expense constant applies, Expense Worksheet A, which is prescribed by the Commissioner; or

(2) If an expense constant does not apply, Expense Worksheet B, which is prescribed by the Commissioner.

(b) Shall include, without limitation, reference to the premium discount tables which apply and the rules for applying the discounts.

(c) ~~[Except as otherwise provided in paragraph (d), may]~~ ***May*** continue to use the loss cost multipliers filed until:

(1) The loss cost multipliers are disapproved by the Commissioner; or

(2) The insurer submits a new filing to replace the loss cost multipliers previously filed.

(d) Unless the Commissioner has explicitly approved otherwise, shall use the current loss ~~[cost multipliers]~~ ***costs*** filed by the Advisory Organization ~~[in accordance with the anniversary rating date rule in the manuals of rating rules]~~ ***and*** approved by the Commissioner pursuant to NRS 686B.177.

2. As used in this section, "expense constant" means a premium charged to each policy of industrial insurance regardless of the size of the policy.

Sec. 8. 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 ***and supporting documentation*** 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.

3. In addition to the requirement set forth in subsection 2:

(a) 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. On or before May 31 of each year, each issuer providing a policy to supplement Medicare or a certificate in this State shall file 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]~~

(b) Supporting documentation must:

~~[(a)]~~ ***(1)*** 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)]~~ ***(2)*** 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. 9. NAC 690B.540 is hereby amended to read as follows:

690B.540 1. For the purposes of this section, "schedule rating" means the application of judgment credits and debits to the risk rate or premium charge which has been developed

through the use of base rate or class rate modified by any other approved rating plan which does not duplicate credits or debits.

2. The Commissioner will accept a schedule-rating plan submitted by an insurer who provides policies of professional liability insurance covering the liability of a practitioner licensed pursuant to chapters 630 to 640, inclusive, of NRS for a breach of professional duty toward a patient if:

(a) The schedule-rating factors apply only to individual risk characteristics which reflect potential hazards.

(b) ~~[The schedule rating applies only to policies which develop at least a $2,500 annual premium or a $7,500 3-year prepaid premium. When schedule credits or debits are being applied, the resulting premium must be $2,500 or more for 1 year, or $7,500 or more for 3 years.~~

~~(c)]~~ The schedule-rating plan provides for credits and debits.

~~[(d)]~~ ***(c)*** The schedule-rating plan is subject to a maximum total credit or debit of 25 percent for the policy of professional liability insurance and 40 percent for any individual practitioner who is covered under the policy.

3. An insurer who files a schedule-rating plan pursuant to this section shall retain adequate supporting data for the credits and debits applicable to each risk included in the schedule-rating plan and shall make such records available for inspection by the Division upon request.

4. Each filing of a schedule-rating plan with the Division must be accompanied by a statement by the filing official affirming that the filing conforms to the provisions of this section.

Sec. 10. NAC 694C.210 is hereby amended to read as follows:

694C.210 1. Except as otherwise provided in subsection 2 or 7, a captive insurer shall have an annual audit by an independent certified public accountant who is authorized by the

Commissioner to conduct the audit. The captive insurer shall file the audited financial report with the Commissioner on or before June 30 for the year ending on the immediately preceding December 31.

2. Unless exempted pursuant to subsection 7 or NAC 680A.172, 680A.199 or 680A.205, a state-chartered risk retention group shall have an annual audit pursuant to NAC 680A.172 to 680A.211, inclusive. Unless the Commissioner grants an extension pursuant to subsection 5 or NAC 680A.177, a state-chartered risk retention group shall file the audited financial report with the Commissioner on or before June 1 for the year ending on the immediately preceding December 31.

3. The Commissioner will deem the annual audit conducted pursuant to this section to be a part of the annual report of financial condition of the captive insurer which is filed pursuant to NRS 694C.400.

4. The annual audit required by this section must include:

(a) ~~[A statement, prepared by the independent certified public accountant who conducted the audit, certifying that all financial requirements established by law, the articles of incorporation, the bylaws and the business plan of the captive insurer have been met.~~

~~(b)]~~ The opinion of the independent certified public accountant who conducted the audit which states that the financial statements of the captive insurer were examined in accordance with generally accepted auditing standards, as determined by the American Institute of Certified Public Accountants and included in the publication *AICPA Professional Standards*, which is adopted by reference in NAC 694C.090. The opinion must:

(1) Cover all years presented in the audit;

(2) Be addressed to the captive insurer on stationery of the accountant; and

(3) Include the address of the accountant issuing the opinion, original manual signatures and the date on which the opinion was issued.

~~[(c)]~~ ***(b)*** A report of an evaluation of the internal controls of the captive insurer relating to:

(1) The methods and procedures used in the securing of assets; and

(2) The reliability of the financial records of the captive insurer, including, without limitation, the controls for the system of authorization and approval, and the separation of duties.

~~[(d)]~~ ***(c)*** A letter from the independent certified public accountant which includes:

(1) A statement that the accountant is independent with respect to the captive insurer and that he or she conforms to the standards of his or her profession as set forth in the *AICPA Professional Standards*, published by the American Institute of Certified Public Accountants, and adopted by reference in NAC 694C.090, and the pronouncements of the Financial Accounting Standards Board;

(2) A general description of the background and experience of the staff of the accountant engaged in the audit, including the experience of the staff in auditing captive insurers and other insurance companies;

(3) A statement that the accountant understands that the audited annual report and his or her opinions thereon will be filed with the Commissioner pursuant to subsection 1;

(4) A statement that the accountant will comply with NAC 694C.230 and consents and agrees to make his or her work papers available for review by the Commissioner or a designee thereof; and

(5) A statement that the accountant is properly licensed by the appropriate state licensing authority and is a member in good standing of the American Institute of Certified Public Accountants.

~~[(c)]~~ ***(d)*** Financial statements, including:

(1) A balance sheet;

(2) A statement of gain or loss from operations;

(3) A statement of changes in financial position;

(4) A statement of changes in paid-up capital, gross paid-in contributed surplus and unassigned money or assets; and

(5) Notes to financial statements required by generally accepted accounting principles, or as required by any other comprehensive basis of accounting in use by the captive insurer and approved by the Commissioner, including:

(I) A reconciliation of differences, if any, between the audited financial report and the report filed with the Commissioner pursuant to NRS 694C.400, with a written description of the nature of these differences;

(II) A summary of ownership and relationships of the company and all affiliated corporations or companies insured by the captive insurer; and

(III) A narrative explanation of all material transactions and balances with the captive insurer.

~~[(f)]~~ ***(e)*** An annual actuarial certification of loss reserves and loss expense reserves which includes an opinion of the adequacy of the loss reserves and loss expense reserves of the captive insurer, in a format acceptable to the Commissioner. The person who certifies the adequacy of the reserves must be approved by the Commissioner and must be a Fellow of the Casualty Actuarial Society, a Fellow of the Society of Actuaries, a member in good standing of the American Academy of Actuaries or a person who has otherwise demonstrated competence in the

evaluation of loss reserves to the Commissioner. The annual actuarial certification must be in such form as the Commissioner determines appropriate.

5. Upon a showing of good cause by the captive insurer and subject to the provisions of NRS 694C.390 and 694C.400, the Commissioner may grant a reasonable extension of the filing date for the annual audit required by this section. Such a request for extension must be submitted to the Commissioner in writing not less than 10 days before the date on which the audited financial report is due and must contain sufficient details to permit the Commissioner to make an informed decision with respect to the requested extension.

6. If an extension for the filing of the audited financial report is granted pursuant to subsection 5, the same extension will be deemed granted for the filing of the Management's Report on Internal Control Over Financial Reporting.

7. Upon a showing of good cause by the captive insurer and subject to the provisions of NRS 694C.390 and 694C.400, the Commissioner may grant an exemption from compliance with any provisions of this section if he or she determines, upon review of an application for exemption that compliance with any or all provisions of this section would constitute a financial or organizational hardship on the captive insurer or that the captive insurer has shown other good cause why such an exemption should be granted. A request for an exemption must be submitted in writing not less than 30 days before the date on which the audited financial report is due and must contain sufficient details to permit the Commissioner to make an informed decision with respect to the requested exemption.

Sec. 11. NAC 680B.010, 680B.095, 687B.057, 687B.069, 687B.283, 690B.400 and 695C.275 are hereby repealed.

TEXT OF REPEALED SECTIONS

680B.010 Submission of form for assessing fees; time for action by Commissioner. (NRS 679B.130)

1. An insurer who submits a form for an insurance policy, rate, rider or endorsement or a broker who submits a memorandum of open lines insurance or brokers affidavit of surplus lines insurance to the Commissioner must complete and submit with that form a copy of the Commissioner's form for assessing fees or the Commissioner will not consider the submission to be complete.

2. If the form being submitted is one upon which the Commissioner by law has a limited time to act, the time for the Commissioner to act does not begin to run until the appropriate filing fee is paid and the submission is complete.

680B.095 Fees: Payment by electronic transfer. (NRS 679B.130, 679B.136) Any fees required to be paid for filing forms with the Commissioner may be paid in accordance with the program adopted by the State Treasurer that provides for the electronic transfer of money for the payment of money owed.

687B.057 Standards of suitability: Annual report to Commissioner. (NRS 679B.130) On or before April 1 of each year, for the preceding calendar year, an insurer shall report 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.

687B.069 Record of rescissions. (NRS 679B.130) An insurer or other entity selling or issuing benefits for long-term care insurance shall maintain a record of all rescissions of its long-term care insurance contracts or certificates in this State or in any other state, except those which the insured voluntarily effectuated, and shall, on or before March 1 of each year, furnish this information to the Commissioner using form NDOI-929, which is available from the Division, or a similar form approved by the Commissioner.

687B.283 Annual reporting of multiple policies or certificates. (NRS 679B.130, 687B.430)

1. On or before 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.

690B.400 "Emergency" defined for NRS 690B.160. (NRS 679B.130, 690B.160) For the purposes of NRS 690B.160, "emergency" means:

1. The loss of plumbing, including the loss of water service and the stoppage or backup of a sewer system;

2. A substantial loss of electrical service;

3. The loss of heating or cooling; or

4. Any other condition within the home that renders the home uninhabitable,

➥ if the structures, components, systems or appliances related thereto are covered by the contract of insurance for home protection.

695C.275 Quality and performance indicators to be included in report of health maintenance organization. (NRS 439.200, 679B.130, 695C.210)

1. On or before March 1 of each year, each health maintenance organization which receives a certificate of authority shall file with the Commissioner the quality and performance indicators selected by the Commissioner for the immediately preceding calendar year. The Commissioner will select the indicators from the reporting set data domains set forth in Technical Specifications for Health Plans, Healthcare Effectiveness Data and Information Set (HEDIS), volume 2, in the form most recently published by the National Committee for Quality Assurance (NCQA), unless the Commissioner gives notice that the most recent revision is not suitable for this State pursuant to subsection 2. Volume 2 of HEDIS may be obtained from the National Committee for Quality Assurance, NCQA, 1100 13th Street N.W., Washington, D.C. 20005, for the price of $355 plus $33 for shipping and handling or by ordering via telephone at (888) 275-7585 or on the Internet at http://store.ncqa.org/.

2. The Commissioner will review each revision of the reporting set data domains set forth in Technical Specifications for Health Plans, Healthcare Effectiveness Data and Information Set (HEDIS), volume 2, to ensure their suitability for this State.