Bulletin No. 02-009 **September 30, 2002**

HEALTH MAINTENANCE ORGANIZATION (HMO) POINT OF SERVICE (POS) HEALTH PLANS

The purpose of this bulletin is to clarify the procedures and chapters that apply to a Health Maintenance Organization (HMO) seeking permission from the Commissioner to market and sell an HMO Point of Service (POS) health plan in the state of Nevada.

Paragraph (1) of subsection (b) of NRS 679B.150 states that the Commissioner may: "(b) Develop, promulgate and revise as he deems appropriate, standards in each of the several areas of insurance appropriate to be applied to policies sold in the State of Nevada. The standards must seek to ensure that policies are not unjust, unfair, inequitable, unfairly discriminatory, misleading, deceptive, obscure or encourage misrepresentation or misunderstanding of the contract."

The Department of Business and Industry, Division of Insurance (Division) has determined that it is in the best interest of the consumer to allow an HMO to provide a POS health plan. The Division recognizes that the consumer may want the flexibility to see a provider of their choosing by utilizing the managed fee-for-service POS health plan feature in addition to the cost savings offered by utilizing the HMO POS health plan feature.

The managed fee-for-service POS health plan feature may consist of either a plan provider tier, a non-plan provider tier or both. The plan provider tier and non-plan tiers are subject to Chapters 689A, 689B, 689C, 695G of NRS and Chapters 689A, 689B, 689C, 695G of NAC.

The HMO must submit the POS health plan to the Division for prior approval and certify compliance with NRS 689B.061 and NAC 689B.120 to 689B.160, inclusive.

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ALICE A. MOLASKY-ARMAN

Commissioner of Insurance

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