ADOPTED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R049-14

Effective April 4, 2016

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

AUTHORITY: §§1-9 and 12-18, NRS 679B.130 and 687B.490, as amended by section 28 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 636; §§10 and 11, NRS 679B.130, 679B.160 and 687B.490, as amended by section 28 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 636; §19, NRS 679B.130, 695C.130 and 695C.275.

A REGULATION relating to insurance; adopting by reference certain standards for determining the adequacy of a network plan issued by a carrier; establishing the Network Adequacy Advisory Council to make recommendations concerning additional standards for determining the adequacy of such a network plan; requiring a carrier who applies for approval to issue a network plan to submit certain data and documentation to the Commissioner of Insurance; requiring a carrier to take certain actions in response to a change to its network that results in the network not meeting applicable standards of adequacy; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law authorizes the Commissioner of Insurance to adopt reasonable regulations for the administration of the Nevada Insurance Code and as required to ensure compliance with federal law relating to insurance. (NRS 679B.130) Existing law also requires: (1) a carrier that offers coverage in the group or individual insurance market to demonstrate the capacity to deliver services adequately before making any network plan available for sale; and (2) the Commissioner to promulgate regulations concerning the organizational arrangements of the network plan and the procedure established for the network plan to develop, compile, evaluate and report certain statistics relating to its services. (NRS 687B.490, as amended by section 28 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 636)

Under federal law, a health insurance exchange is a governmental agency or nonprofit entity established by a state that makes health plans that meet certain requirements available to persons and small employers in the state. (42 U.S.C. §§18031, 18032) **Section 9** of this regulation: (1) adopts by reference certain standards prescribed by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services for determining the adequacy of a network plan offered on a health insurance exchange; and (2) provides that those standards are the standards for determining the adequacy of any network plan offered for sale in

this State, including a plan that is not offered on a health insurance exchange. **Section 9** also provides that if a new version of those standards is issued, the Commissioner will determine whether existing requirements concerning network adequacy conform with the new version of those standards. If the Commissioner determines that existing requirements do not conform with the new version of those standards, **section 9** provides that the Commissioner will hold a hearing concerning possible amendments to existing requirements.

Section 10 of this regulation establishes the Network Adequacy Advisory Council and requires the Council to hold at least three annual meetings. **Section 11** of this regulation: (1) requires the Council to propose to the Commissioner recommendations for additional or alternative standards for determining the adequacy of a network plan; and (2) prescribes the content of the recommendations. **Section 12** of this regulation requires each carrier or other person or entity who applies for approval to issue a network plan to submit to the Commissioner with its annual rate filing sufficient data and documentation to establish that the proposed network plan meets the standards for network adequacy prescribed in regulation.

Section 13 of this regulation requires a carrier to update its directory of providers of health care at least once each month and within 5 business days after a change in a network plan that results in the network plan not meeting the standards for adequacy prescribed in regulation. **Section 14** of this regulation requires a carrier to: (1) notify the Commissioner of any such change to its network plan within 3 business days; and (2) provide to the Commissioner within 10 business days a description of the cause and impact of the change and a summary of the measures that the carrier will take to bring the network plan into compliance with the standards. **Section 15** of this regulation requires a carrier to: (1) submit to the Commissioner for approval a corrective action plan to bring the network plan into compliance with the standards; and (2) take certain actions to ensure that covered persons have access to covered services after such a change. **Section 16** of this regulation allows the Commissioner to determine that a network plan is inadequate pursuant to existing law if the Commissioner does not approve a corrective action plan and the network plan fails to comply with the standards. **Section 17** of this regulation excludes a network plan issued by certain smaller carriers from the requirements of **sections 12-16** of this regulation. **Section 18** of this regulation excludes certain other plans from the provisions of this regulation. **Section 19** of this regulation repeals provisions that: (1) require a health maintenance organization or a provider-sponsored organization to define the geographic area it intends to serve and prescribe requirements concerning that geographic area; and (2) require each applicant for a certificate of authority to submit a list of providers in its health care plan.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 18, inclusive, of this regulation.

Sec. 2. ***As used in sections 2 to 18, inclusive, of this regulation, unless the context otherwise requires, the words and terms defined in sections 3 to 8, inclusive, of this regulation have the meanings ascribed to them in those sections.***

Sec. 3. *"Carrier" means an insurer that makes a network plan available for sale in this State pursuant to NRS 687B.490.*

Sec. 4. *"Council" means the Network Adequacy Advisory Council established by section 10 of this regulation.*

Sec. 5. *"Covered person" means a policyholder, subscriber, enrollee or other person participating in a network plan.*

Sec. 6. *"Network plan" has the meaning ascribed to it in NRS 689B.570.*

Sec. 7. *"Provider of health care" has the meaning ascribed to it in NRS 695G.070.*

Sec. 8. *"Qualified health plan" has the meaning ascribed to it in NRS 695I.080.*

Sec. 9. *1. For the purpose of determining the adequacy of a network plan made available for sale in this State, the Commissioner hereby adopts by reference the standards contained in the 2017 Letter to Issuers in the Federally-facilitated Marketplaces issued by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. A copy of the letter may be obtained free of charge at the Internet address https://www.cms.gov/CCIIO/resources/regulations-and-guidance/.*

2. Upon the issuance of a new Letter to Issuers in the Federally-facilitated Marketplaces, the Commissioner will determine whether the requirements of sections 2 to 18, inclusive, of this regulation, including, without limitation, the standards adopted by reference in subsection 1, conform with any similar standards prescribed in the new Letter to Issuers in the Federally-facilitated Marketplaces. If the Commissioner determines that the requirements of sections 2 to 18, inclusive, of this regulation do not conform with any similar standards prescribed in the new Letter to Issuers in the Federally-facilitated Marketplaces, the Commissioner will hold a public hearing concerning possible amendments to sections 2 to 18, inclusive, of this

regulation and give notice of that hearing in accordance with NRS 233B.060 at least 30 days before the date of the hearing.

Sec. 10. *1. The Network Adequacy Advisory Council is hereby established.*

2. The Council consists of nine members appointed by the Commissioner. The members of the Council will be chosen to ensure fair representation of the interests of carriers, providers of health care and consumers of health care. The members of the Council serve at the pleasure of the Commissioner and without compensation.

3. If a vacancy occurs in the membership of the Council, the Commissioner will appoint a qualified person to fill the vacancy. The person appointed to fill the vacancy must represent interests similar to those represented by the member who is being replaced.

4. The Council shall meet at least three times each year. The first meeting of the Council must take place not later than June 15 of each year. Written notice of each meeting of the Council must be given as provided in NRS 241.020, as amended by section 4 of Senate Bill No. 70, chapter 226, Statutes of Nevada 2015, at page 1056, except that the notice must be given at least 5 working days before the meeting.

Sec. 11. *1. The Council shall consider the standards adopted by reference in section 9 of this regulation and any other requirements of sections 2 to 18, inclusive, of this regulation and may recommend additional or alternative standards for determining whether a network plan is adequate.*

2. The recommendations proposed by the Council to the Commissioner:

(a) Must include quantifiable metrics commonly used in the health care industry to measure the adequacy of a network plan;

(b) Must include, without limitation, recommendations for standards to determine the adequacy of a network plan with regard to the number of providers of health care that:

(1) Practice in a specialty or are facilities that appear on the Essential Community Providers/Network Adequacy Template issued by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services and available at the Internet address https://www.cms.gov/CCIIO/programs-and-initiatives/health-insurance-marketplaces/qhp.html free of charge, which is hereby adopted by reference; and

(2) Are necessary to provide the coverage required by law, including, without limitation, the provisions of NRS 689A.0435, 689C.1655, 695C.1717 and 695G.1645;

(c) May propose standards to determine the adequacy of a network plan with regard to types of providers of health care other than those described in paragraph (b); and

(d) May, if a sufficient number of essential community providers, as defined in 45 C.F.R. § 156.235(c), are available and willing to enter into an agreement with a carrier to participate in network plans, propose requiring a network plan to include a greater number of such providers than the number of providers of health care of that type that a network plan is required to include pursuant to the standards adopted by reference in section 9 of this regulation and any other requirements of sections 2 to 18, inclusive, of this regulation.

3. The Council must submit its recommendations to the Commissioner on or before September 15 of each year. On or before October 15 of each year, the Commissioner will determine whether to accept any of the recommendations of the Council and take any action necessary to issue any new requirements for determining the adequacy of a network plan. Any such new requirements will become effective on the second January 1 next ensuing after the adoption of the requirements.

Sec. 12. *1. Each carrier or other person or entity that applies to the Commissioner for approval to issue a network plan pursuant to NRS 687B.490, as amended by section 28 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 636, shall submit to the Commissioner with its annual rate filing sufficient data and documentation to establish that the proposed network plan meets the standards adopted by reference in section 9 of this regulation and any other requirements of sections 2 to 18, inclusive, of this regulation.*

2. The data and documentation submitted to the Commissioner pursuant to subsection 1 must be in a format prescribed by the Commissioner.

Sec. 13. *1. Each carrier shall update its directory of providers of health care at least once each month. Except as otherwise provided in this subsection, each update to the directory must include each provider of health care who, as of the previous month, is no longer in the network plan or has stopped accepting new patients. A carrier shall not be deemed to have violated the provisions of this subsection if a provider of health care fails to provide information to the carrier which the provider of health care is contractually obligated to provide to the carrier.*

2. If a change occurs to the network plan of a carrier that results in the network plan failing to meet the standards adopted by reference in section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation, the carrier must update its directory of providers of health care not later than 5 business days after the effective date of the change and include in the directory a clear description of the change.

3. The directory of providers of health care and each update to the directory must be:

(a) Posted to a publicly available Internet website maintained by the carrier not later than 5 business days after the update is completed;

(b) Posted in a manner that allows a person who is not enrolled in any plan offered by the carrier to view the directory; and

(c) Made available in a printed format to any person upon request.

4. As used in this section:

(a) "Directory of providers of health care" means a list of physicians, hospitals and other professionals and organizations that provide health care services, including, without limitation, through telehealth, as part of a network plan.

(b) "Telehealth" has the meaning ascribed to it in section 3 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 621.

Sec. 14. *A carrier shall:*

1. Within 3 business days after the effective date of a change to a network plan that results in the network plan failing to meet the standards adopted by reference in section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation, notify the Commissioner in writing of the change; and

2. Within 10 business days after the effective date of a change to a network plan that results in the network plan failing to meet the standards adopted by reference in section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation, provide to the Commissioner a written description of the cause of the change, the impact of the change on the network plan and a summary of the measures that the carrier will take to bring the network plan into compliance with those standards and requirements.

Sec. 15. *1. A carrier shall, within 60 days after the effective date of a change to a network plan that results in the network plan failing to meet the standards adopted by reference in section 9 of this regulation or any other requirement of sections 2 to 18, inclusive,*

of this regulation, submit to the Commissioner for approval a written corrective action plan to bring the network plan into compliance with those standards and requirements.

2. Except as otherwise provided in subsection 3, during the period in which the network plan does not meet the standards adopted by reference in section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation, the carrier shall, at no greater cost to the covered person:

(a) Ensure that each covered person affected by the change may obtain any covered service from a qualified provider of health care who is:

(1) Within the network plan; or

(2) Not within the network plan by entering into an agreement with the nonparticipating provider of health care pursuant to NRS 695G.164; or

(b) Make other arrangements approved by the Commissioner to ensure that each covered person affected by the change is able to obtain the covered service.

3. The provisions of subsection 2 do not apply to services received from a nonparticipating provider of health care without the prior authorization of the carrier unless the services received are medically necessary emergency services, as defined in subsection 3 of NRS 695G.170.

Sec. 16. *If a network plan does not meet the standards adopted by reference in section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation and the Commissioner does not approve the corrective action plan submitted pursuant to section 15 of this regulation, the Commissioner may:*

1. For a qualified health plan, determine that the network plan is inadequate pursuant to subsection 5 of NRS 687B.490; or

2. For any network plan other than a qualified health plan, determine that the network plan is inadequate pursuant to subsection 5 of NRS 687B.490 and require the carrier to submit a statement of network capacity to the Commissioner demonstrating that the carrier meets the conditions described in 42 U.S.C. § 300gg-1(c)(1)(B).

Sec. 17. *The provisions of sections 12 to 16, inclusive, of this regulation do not apply during any calendar year to a network plan that:*

1. Is issued by a carrier that has been authorized to transact insurance in this State pursuant to chapter 680A of NRS;

2. Had a statewide enrollment of not more than 1,000 persons during the immediately preceding calendar year;

3. Has an anticipated statewide enrollment of not more than 1,250 persons during the next succeeding calendar year; and

4. Is not a qualified health plan.

Sec. 18. *The provisions of sections 2 to 18, inclusive, of this regulation do not apply to:*

1. A network plan issued pursuant to NRS 422.273 for the purpose of providing services through a Medicaid managed care program on behalf of the Department of Health and Human Services;

2. A network plan issued for a health benefit plan that is regulated pursuant to chapter 689B of NRS and is not available for sale to small employers, as defined in NRS 689C.095;

3. A grandfathered plan, as defined in NRS 679A.094; or

4. A plan issued pursuant to Medicare, as defined in NAC 687B.2028, or a Medicare Advantage plan, as defined in NAC 687B.2034.

Sec. 19. NAC 695C.160 and 695C.200 are hereby repealed.

TEXT OF REPEALED SECTIONS

695C.160 Geographic area of service: Definition. (NRS 679B.130, 695C.130, 695C.275)

1. An organization shall clearly define the geographic area it intends to serve which:

(a) In a county having a population of 100,000 or more, must have a radius of not more than 25 miles between the subscriber or individual enrollee and a primary physician and the hospital used by the organization. This subsection does not apply to services rendered pursuant to Medicaid or Nevada Check Up.

(b) In any other county, must be defined by the organization under a plan for the provision of health care services if the organization receives the written approval of the Division for such a geographic area by:

(1) Demonstrating the availability and accessibility of services to its enrollees, including reasonable access to primary physicians, a hospital and to medically necessary services or services in an emergency; and

(2) Submitting a statement concerning the standards within that community regarding the availability and accessibility of other health care services and demonstrating that the organization will meet the community's standards for such services.

2. As used in this section, "Nevada Check Up" has the meaning ascribed to it in NAC 442.688.

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

1. Each applicant for a certificate of authority shall:

(a) Submit a list of the providers in its health care plan and a description of the type of providers based upon a projected number of enrollees;

(b) Sufficiently describe its list of providers to demonstrate the accessibility and availability of health care to its enrollees; and

(c) Describe a plan for increasing the number of providers based upon increased enrollment.

2. The organization shall notify:

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

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

(c) An enrollee in writing of the disassociation of his or her primary physician from the organization not later than 30 working days after such disassociation.

3. Based upon the current list of providers of an organization, an overall reduction of more than 30 percent in the number of primary physicians in a geographic area of service or a material change in the panel of specialists shall be deemed by the Division to jeopardize the ability of the organization to meet its obligations to its enrollees, and the Division will so notify the organization, and for a health maintenance organization, the Division will also notify the State Board of Health. The organization may rebut this presumption by providing written information to the Division within 14 days after the notice is sent to the organization.

4. The provisions of subsection 3 do not apply if the organization:

(a) Notifies the Division in writing;

(b) Submits information concerning the number of persons enrolled in the organization and the reasons for any reductions; and

(c) Obtains the approval of the Division in advance for the reduction.