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Department of Business & Industry

Division of Insurance

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Network Adequacy

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Division of Insurance

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What Is Network Adequacy?

- Measures whether a network plan has sufficient providers to meet member needs

Very generally, network adequacy is a measure of whether a network plan has sufficient providers to meet member needs.

Associated issues include network directories and surprise billing.

Network adequacy is not a new concept—what is new is that carriers in the individual and small group markets are now required to meet certain criteria in order to sell their plans.

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Background

- Patient Protection and Affordable Care Act
  - 45 C.F.R. § 156.230
    - Network adequacy standards
  - 45 C.F.R. § 156.235
    - Essential community providers
- Exchange
- AB 425 (2013) – NRS 687B.490

Under federal law, qualified health plans are required to meet network adequacy standards established by the Centers for Medicare and Medicaid Services (CMS). This includes:

- a network that is sufficient in number and types of providers to assure all services will be accessible without unreasonable delay
- capacity restrictions
- a provider directory
- essential community providers

Each year, CMS publishes a Letter to Issuers to set forth federal standards. Review for compliance is conducted at the state level. Important to know that the federal network adequacy standards apply to QHPs that are sold through federal Exchanges—the Nevada Exchange is federally facilitated and, therefore, must meet the federal network adequacy standards at a minimum.

Feds have a proposal to address surprise billing, but are waiting to see how states react to the NAIC's Model Law on Network Adequacy, which includes a provision for surprise billing.

In 2011, the Division became involved with network adequacy for QHPs through its role in helping the Silver State Health Insurance Exchange.

In 2013, the Legislature transferred the responsibility of network adequacy for HMOs from the Board of Health to the Division of Insurance, and expanded network adequacy to apply

to PPOs. In addition to DOI's charge to determine network adequacy, NRS 687B.490 also states that DOI has 90 days from the date a network plan is submitted to make a network adequacy determination.

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The Regulation

- Division's expertise
- Research
- Outreach
- Discussions
- Workshops
- Hearings

There were many factors at play in developing network adequacy requirements. These factors include preemption risk, metrics, time and distance standards, access plans, effects of enforcement, surprise billing, directories, and regulatory processing. Additionally, there is a time component. DOI laid out the estimated timeline (Ex. 2), which is extremely tight.

The Division's expertise is insurance. In gearing up to begin the rulemaking process, DOI talked to carriers, providers, health care experts, and other state regulators. DOI considered network adequacy rules that exist in other states. DOI reviewed experiences of Medicaid, as well as reports and papers by National Committee for Quality Assurance, National Association of Insurance Commissioners, URAC, and the National Conference of State Legislatures. DOI published an Issue Brief on Network Adequacy and Solicitation of Comments. DOI also looked at data from other sources, such as the NAIC Managed Care Plan Network Adequacy Model Act.

This regulation had to be crafted in a way that would not set carriers up to fail. If requirements cannot be achieved in rural communities, carriers could decide not to sell in the rurals, which would have a considerable impact on consumers in rural Nevada.

Based on everything researched and learned, DOI issued Bulletin 14-005 (Ex. 4) to provide guidance to carriers until the regulations became final.

With regard to R049-14, there were lots of ideas, opinions, concerns, and frustrations. In November 2015, despite several iterations of the regulation having been circulated with

stakeholders, it became clear that there was still frustration. Assemblyman Oscarson convened a meeting of interested parties in December 2015 to work through some of the frustrations. As a result, DOI decided to approach the regulation from a different angle. DOI would like to thank Assemblyman Oscarson for his commitment and assistance to making sure that this regulation worked for stakeholders.

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R049-14

- March 28, 2016
  - Adopted by Commissioner
- April 4, 2016
  - Passed by Legislative Commission
- April 4, 2016
  - Filed with Secretary of State
- Effective date

- After extensive research and outreach around the state to consumers, providers, and carriers,
- After considering federal standards and state mandates,
- After 6 public workshops, 3 hearings, and over 60 comments both in support and opposition of the regulation,
- After a meeting with Assemblyman Oscarson and some interested providers, associations, and carriers, and
- After much compromise,

R049-14 was promulgated. (Ex. 1)

This regulation satisfies concerns raised by most of the participants. DOI believes it can arrive at reasonable, fair, and timely annual network adequacy requirements each year in a way that is open, transparent, and inclusive. R049-14 establishes the foundation needed to move forward.

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Key Concepts

- Applicability
- Advisory Council
- Recommendation
- Standards
- Requirements
- Timing
- Hearing Provisions
- Federal Approval
- Directories
- Application (Justifications)
- Notice to Commissioner
- Corrective Action Plan
- Consequences

- The regulation applies to individual and small employer group markets—includes PPO and HMO plans both on and off exchange
  - There are exemptions (e.g., for a carrier with fewer than 1,000 covered lives in the preceding calendar year or 1,250 lives anticipated in the next year, and grandfathered plans)

- The federal standards and state mandates are the minimum required in all plans;

- The regulation creates an Advisory Council to make recommendations to the Commissioner;

- The Commissioner issues the requirements, which will go through the full rulemaking process each Fall;

- In the following February, CMS will issue its final standards;

- Timing is not ideal, but this regulation makes it possible for interested parties and the public to participate in the Advisory Council meetings and makes it possible to have hearings while still giving carriers a little time to build their networks based on the requirements.

- The feds can weigh in on network adequacy for QHPs; because Nevada has chosen to make network adequacy requirements applicable to individual and small employer

group network plans, if the feds find that Nevada's network adequacy requirements do not meet their standards, then they could preempt Nevada's requirements for QHPs, which, in turn, would affect all other network plans.

- Requires directories to be updated monthly, including identifying specifically which providers are no longer in the network. Directories include telehealth providers.

- Carriers must submit annual applications addressing the network adequacy component. There may be times when a carrier, from the onset, cannot strictly meet network adequacy requirements (e.g., insufficient number of providers in the county). With their application, carriers can submit a justification and access plan indicating how members can get access in spite of the plan's inability to meet requirement.

- If a network becomes deficient after the plan received approval, a carrier is required to provide notices to the Commissioner: within 3 business days of the network failure; AND within 10 business days a written description of the cause, the impact, and the summary of measures to bring the network plan into compliance.

- Within 60 days, a carrier must submit a Corrective Action Plan.

- During the period when a change in network has been identified, a carrier must ensure that members are able to obtain services with prior authorization at no greater cost within the network or out of network, or through other arrangements approved by the Commissioner. There is an emergency services provision.

- If a network plan other than a QHP is still inadequate, the carrier must submit a statement of network capacity that meets certain conditions of the ACA (guaranteed availability). If the network plan cannot meet network adequacy requirements, then the carrier cannot sell that plan for the remainder of the year.

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Network Adequacy Advisory Council

- Nine members appointed by the Commissioner
- Fair representation of the interests of carriers, providers and consumers
- Meeting open to the public
- Council makes recommendation to Commissioner by September 15 of each year

The Council had to be big enough to represent the various interests
Representation must be fair to ensure no one interest controls
Meetings are open to the public
The Council must meet at least 3 times and make a recommendation by Sep. 15 each year.

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Commissioner's Requirements

- Consider recommendation of Council
- Determine requirements for relevant plan year by October 15 each year
- Promulgate regulation for the requirements each year
- In February/March after the Commissioner promulgates regulation for requirements, if CMS standards change or if requirements are not accepted by CMS, Commissioner must revise and promulgate regulation again

It is essential to have all affected parties engage in the discussions regarding network adequacy to help the Commissioner understand the various perspectives on the issue.

- Consider recommendation of Council
- Determine requirements for relevant plan year by October 15 each year
- Each Fall, the requirements go through the full rulemaking process
- In February/March after the Commissioner promulgates regulation for requirements, if CMS standards change or if requirements are not accepted by CMS, Commissioner must revise and promulgate regulation again

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What to Expect for 2017

- Network adequacy reviews
  - 2017 Letter to Issuers
  - Default to CMS standards with State mandates
- Advisory Council set up
  - Invitation to apply
  - Facilitator to run meetings
  - Orientation and guidance manual
  - Meetings start in 2016 for PY 2018

Right now, DOI is preparing to do network adequacy reviews for plans that will be sold in the next open enrollment period.

- CMS published the letter to issuers in late February
- For 2017 plans, the floor for network adequacy is the CMS standards in the 2017 Letter to Issuers and State mandates

DOI is also doing the work to get the Advisory Council set up

- Invitation to apply has been issued (Ex. 3)
- An informal solicitation was issued to contract a Facilitator to run meetings
- DOI staff is working on an Orientation and guidance manual to give Advisory Council members the information requisite to network adequacy
- Meetings will start in June 2016 for PY 2018

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PY 2017 DOI Review Timeline

- May 2nd Network Plan applications due
- May 13th DOI communicates deficiencies to carrier
- May 27th Carrier submits revised network plans to correct deficiencies
- June 10th DOI communicates remaining deficiencies to carrier, if necessary
- June 24th Carrier submits revised network plans to correct remaining deficiencies
- July 8th DOI communicates remaining deficiencies to carrier, if necessary
- July 29th DOI makes final determinations

This is the timeline for DOI's review of network adequacy for PY 2017. During this process, the Advisory Council will meet to start meetings for PY 2018.

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PY 2017 Network Adequacy Standards

Type	Specialty	Metro		Micro		Rural		CEAC	
		Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)	Max Time (Mins)	Max Distance (Miles)
Provider	Primary Care	15	10	30	20	40	30	70	60
	Endocrinology	60	40	100	75	110	90	145	130
	Infectious Diseases	60	40	100	75	110	90	145	130
	Mental Health	45	30	60	45	75	60	110	100
	Oncology - Medical/Surgical	45	30	60	45	75	60	110	100
	Oncology - Radiation/Radiology	60	40	100	75	110	90	145	130
	Rheumatology	60	40	100	75	110	90	145	130
Facility	Hospitals	45	30	80	60	75	60	110	100
	Outpatient Dialysis	45	30	80	60	90	75	125	110

These are the time and distance standards for PY 2017, which are set out in the 2017 CMS Letter to Issuers. These standards apply to counties depending on the county designation.

CEAC = counties with extreme access criteria (medically underserved counties)

Source – Federally Facilitated Marketplace (CMS)

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Nevada County Designations

Rank	Population Density	County / Population	Designation
1	351.5/sq mi	Carson City, NV / 55,274	Metro
2	242.1/sq mi	Clark, NV / 1,951,269	Metro
3	64.4/sq mi	Washoe, NV / 421,407	Metro
4	63.7/sq mi	Douglas, NV / 46,997	Micro
5	25.7/sq mi	Lyon, NV / 51,980	Micro
6	15.2/sq mi	Storey, NV / 4,010	Rural
7	5.0/sq mi	Churchill, NV / 24,877	CEAC
8	2.8/sq mi	Elko, NV / 48,818	CEAC
9	2.4/sq mi	Nye, NV / 43,946	CEAC
10	1.7/sq mi	Humboldt, NV / 16,528	CEAC
11	1.3/sq mi	Mineral, NV / 4,772	CEAC
12	1.1/sq mi	White Pine, NV / 10,030	CEAC
13	1.1/sq mi	Pershing, NV / 6,753	CEAC
14	1.0/sq mi	Lander, NV / 5,775	CEAC
15	0.5/sq mi	Lincoln, NV / 5,345	CEAC
16	0.5/sq mi	Eureka, NV / 1,987	CEAC
17	0.2/sq mi	Esmeralda, NV / 783	CEAC

This slide shows the county designations. Many Nevada counties fall within the CEAC designation.

Source – DOI and CMS

CEAC = counties with extreme access criteria

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Conclusion

- Competing Priorities
- Passionate Stakeholders
- Tight Deadlines
- Federal Involvement

A couple of things that I'd like to point out that were part of the discussion in promulgating R049-14:

- The effects of the regulation will not be immediate--the Council's work this year will affect network plans for PY 2018
- The regulation does not deal with surprise billing because it is not within DOI's jurisdiction.
- Directory requirements will begin during open enrollment of this year (Nov 1)

With network adequacy, DOI faces competing priorities, passionate stakeholders, very tight deadlines, and federal involvement. DOI has worked hard to make R049-14 viable and reasonable; it was a compromise that allows us to now start down the road of addressing network adequacy in Nevada.

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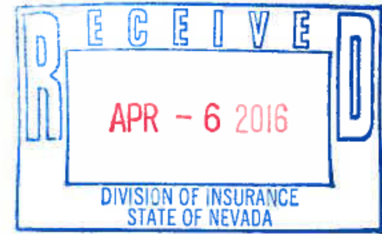
April 4, 2016



Sue Dummar
Executive Secretary
Division of Insurance
1818 East College Parkway, Suite 103
Carson City, Nevada 89706-7986

Re: LCB File No. R049-14

Dear Ms. Dummar:

Regulation R049-14 adopted by the Commissioner of Insurance has been filed today with the Secretary of State pursuant to NRS 233B.067 or 233B.0675, as appropriate. As provided in NRS 233B.070, this regulation becomes effective upon filing, unless otherwise indicated.

Enclosed are two copies of the regulation bearing the stamp of the Secretary of State which indicates that it has been filed. One copy is for your records and the other is for delivery to the State Library and Archives Administrator pursuant to subsection 6 of NRS 233B.070.

Sincerely,

Eric W. Robbins
Deputy Legislative Counsel

Brenda J. Erdoes
Legislative Counsel

EWR/slj
Enclosure

SECRETARY OF STATE FILING DATA	Form For Filing Administrative Regulations	FOR EMERGENCY REGULATIONS ONLY
NEVADA SECRETARY OF STATE 2016 APR 4 PM 12 38 RECEIVED CARSON CITY NV	Agency Dept of Business and Industry Division of Insurance R049-14	Effective date ____ Expiration date ____ Governor's signature

Classification: ☐ PROPOSED ☑ ADOPTED BY AGENCY ☐ EMERGENCY

Brief description of action Regulation concerning the adequacy of a network plan.

Authority citation other than 233B NRS 679B.130, 679B.160, 687B.490, and 695C.130(2).

Notice date 2/1/2016 and 3/2/2016 **Date of Adoption by Agency** 3/28/2016

Hearing date 3/16/2016

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.

LEGISLATIVE REVIEW OF ADOPTED REGULATIONS
INFORMATIONAL STATEMENT AS REQUIRED BY NRS 233B.066

LCB FILE NO. R049-14

The following statement is submitted by the Division of Insurance ("Division") for adopted amendments to Nevada Administrative Code ("NAC") Chapter 687B, and repeal of NAC 695C.160 and 695C.200.

1. **A clear and concise explanation of the need for the adopted regulation.**

   Nevada Revised Statute 687B.490 requires the Commissioner of Insurance to adopt regulations to 1) ensure insurance carriers that offer coverage in the small group or individual market demonstrate the capacity to deliver services adequately before making any network plan available for sale, 2) address organizational arrangements of network plans and, 3) address the procedure by which network plans will develop, compile, evaluate and report certain information relating to services. See NRS 687B.490(1) and (2). This regulation establishes an advisory council and a public forum where interested persons may participate in the process used to arrive at annual network adequacy requirements.

2. **A description of how public comment was solicited, a summary of public response, and an explanation of how other interested persons may obtain a copy of the summary.**

   (a) A description of how public comment was solicited:

   Public comment was solicited by e-mailing the regulation, notices of workshops, notices of intent to act upon the regulation, and small business impact statement to persons on the Division's mailing list who requested notification of proposed regulations. These documents were also made available through the Division's website (http://doi.nv.gov/), mailed to the main library for each county in Nevada, distributed by the office of Assemblyman James Oscarson to interested persons, and posted at the following locations:

Department of Business and Industry
Division of Insurance
1818 East College Parkway, Suite 103
Carson City, Nevada 89706

Department of Business and Industry
Division of Insurance
2501 East Sahara Avenue, Suite 302
Las Vegas, Nevada 89104

Legislative Building
401 South Carson Street
Carson City, Nevada 89701

Grant Sawyer Building
555 East Washington Avenue
Las Vegas, Nevada 89101

Blasdel Building
209 East Musser Street
Carson City, Nevada 89701

Capitol Building
101 North Carson Street
Carson City, Nevada 89701

Nevada Department of Employment,
Training and Rehabilitation
2800 E. Saint Louis Avenue
Las Vegas, Nevada 89104

The Division distributed drafts of the regulation with each proposed change, from the initial announcement of the proposed regulation in June 2014 until the adoption hearing held on March 22, 2016. Public comment was also solicited at workshops held on July 1, 2014; July 15, 2014; August 12, 2014; September 25, 2014; July 23, 2015, January 28, 2016, and at hearings held on November 12, 2014, October 20, 2015, and March 16, 2016, which was recessed and reconvened on March 22, 2016. The workshops and hearings took place at the offices of the Division, 1818 East College Parkway, Carson City, Nevada 89706, with simultaneous videoconferencing to the Bradley Building, 2501 East Sahara Avenue, Las Vegas, Nevada 89104, with the exception of the workshop held on July 23, 2015, which was held at the Legislative Building, 401 South Carson Street, Room 2135, Carson City, Nevada 89701, with simultaneous videoconferencing to the Grant Sawyer Building, 555 East Washington Avenue, Room 4412E, Las Vegas, Nevada 89101.

(b) A summary of the public response:

During the six workshops and three hearings listed above, the Division received both oral and written comments from various interested persons about specific aspects of the regulation. Public comment centered mainly in the following areas:

(1) Material (significant) change in a network plan resulting in a need to reexamine its adequacy: Some commenters were concerned that the definition of material change was unclear and left too much room for variation. Others wanted a high number, such as a 20% change, to trigger a reexamination, while others wanted something less than 10%. Concern was also expressed about certain time requirements for notifying the Commissioner, consumers, and updating provider directories about changes in the network.

(2) Time/Distance Standards and Geographic Service Regions: Some commenters advocated large service areas so that residents would have more providers available within the area, while others suggested that large areas would increase the time and distance for residents to access care from providers within the area.

(3) Specialists, Subspecialists, and Categories of Health Care: Some commenters wanted data collected and measured for nearly all specialties included in a network plan, while others wanted very few so that the task of creating an adequate network would be feasible. Those wanting data collected and measured for fewer specialties stressed the lack of specialists and subspecialists in Nevada, particularly in the rural areas.

(4) Provider Directories: Certain timelines and methods for updating carrier provider directories prompted several comments about the logistics of compliance for some carriers.

(5) Mental Health: There were many comments about the need to ensure that mental health parity is addressed in the standards. Commenters expressed concern that there are not enough mental health providers available to meet the needs of consumers.

(6) Appeal Process: Some commenters expressed a need for an appeal process for a provider that is denied membership or is terminated from a carrier's network. Some commenters suggested that network plan designs might try to control costs by including more low cost providers rather than considering the level of services provided.

(7) Commissioner's Network Advisory Council: In December 2015, the concept of creating a Commissioner's "Network Adequacy Advisory Council" pursuant to the regulation was introduced. The proposed regulation presented at the workshop held on January 28, 2016, included provisions for this advisory council. Comments were received regarding the makeup of the council, terms of service of council members, replacement of council members, and criteria to be used by the council in making a recommendation to the Commissioner.

(c) An explanation of how other interested persons may obtain a copy of the summary:

A copy of the summary may be obtained by contacting Cliff King, Chief Insurance Examiner, Life and Health Section, at (775) 687-0700 or cking@doi.nv.gov. This summary will also be made available by e-mail request to insinfo@doi.nv.gov, as well as posted on the Division's website: www.doi.nv.gov

3. **The number of persons who:**

(a)	**Attended each hearing:**	November 12, 2014: 36 March 16, 2016: 21	October 20, 2015: 29 March 22, 2016: 21
(b)	**Testified at each hearing:**	November 12, 2014: 8 March 16, 2016: 7	October 20, 2015: 3 March 22, 2016: 1

(c) Submitted to the agency written statements:

27 persons submitted 71 comments

4. **A list of names and contact information, including telephone number, business address, business telephone number, electronic mail address, and name of entity or organization represented, for each person identified above in #3 (b) and (c), as provided to the agency:**

See Exhibit 1.

5. **A description of how comment was solicited from affected businesses, a summary of their response, and an explanation of how other interested persons may obtain a copy of the summary.**

Comments were solicited from affected businesses in the same manner as they were solicited from the public. Please see the description, summary and explanation provided above in response to question #2.

6. **If, after consideration of public comment, the regulation was adopted without changing any part of the proposed regulation, provide a summary of the reasons for adopting the regulation without change.**

Not applicable. The regulation was revised several times before adoption.

7. **(a) The estimated economic effect of the adopted regulation on the business which it is to regulate:**

(1) Both adverse and beneficial effects:

Adverse – Carriers may have to cover certain additional costs of provider services during a period when a network plan fails to meet adequacy requirements.

Beneficial – Carriers will now be able to participate in a more active way, via the advisory council, in the development of network adequacy requirements. This should help them better forecast service needs and design the plan accordingly to minimize events that might cause the network to fail to meet adequacy requirements during the relevant plan year.

(2) Both immediate and long-term effects:

Immediate – Depending on whether the final network adequacy requirements issued by the Commissioner each year include specialties, types and standards not previously required in network plans, the carriers may have to add additional healthcare providers to their current network plan designs.

Long-Term Effects – Once carriers establish the relevant number and types of healthcare providers necessary to meet the network adequacy requirements, the impact on carriers will be better known. Data will be gathered by the Division through its annual review of performance of a carrier's network plan. This data can then be studied to better predict long term effects of certain network adequacy requirements.

(b) The estimated economic effect of the adopted regulation on the public:

(1) Both adverse and beneficial effects:

Adverse – Although network adequacy requirements will be issued each year, this does not guarantee that every healthcare provider sought by a policyholder will always be an "in-network" provider. As a result, the policyholder may still be responsible for paying some additional amounts out-of-pocket for an "out-of-network" provider.

Beneficial – It is anticipated that the network adequacy requirements issued each year will generally provide a more broad base of "in network" healthcare providers and access thereto. Timely updates to the carriers' provider directories will also provide policyholders with

more current information about the network status of a particular provider.

(2) Both immediate and long-term effects:

Immediate – By providing a more broad base of "in network" healthcare providers and access thereto, policyholders should experience lower out-of-pocket costs.

Long-Term Effects – By providing a more broad base of "in network" healthcare providers and access thereto, policyholders should experience lower out-of-pocket costs.

8. **The estimated cost to the agency for enforcement of the adopted regulation.**

Initially, there may be a slight increased cost to the Division to enforce the regulation in order to provide guidance to the advisory council by way of a contracted independent professional facilitator. Such a facilitator will be helpful to the advisory council concerning organizing and focusing discussion topics, as well as providing guidance on process to come to a recommendation to submit to the Commissioner. The cost of the facilitator is currently being built into the Division's budget.

9. **A description of any regulations of other state or government agencies which the proposed regulation overlaps or duplicates and a statement explaining why the duplication or overlapping is necessary. If the regulation overlaps or duplicates a federal regulation, the name of the regulating federal agency.**

The regulation does not duplicate or overlap other state or federal regulations.

10. **If the regulation includes provisions that are more stringent than a federal regulation which regulates the same activity, a summary of those provisions.**

There are currently no federal regulations that regulate the same activity for all network plans in the individual and small group markets.

11. **If the regulation establishes a new fee or increases an existing fee, the total annual amount the agency expects to collect and the manner in which the money will be used.**

The regulation does not create a new fee.

March 22, 2016 Hearing – Person who testified:

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Jack Kim	United Healthcare	P.O. Box 15645 Las Vegas, NV 89114-5645	702-240-8890	Jack.Kim@uhc.com

March 16, 2016 Hearing – Persons who testified:

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Jeannette Belz	Nevada Psychiatric Association	10580 N. McCarran Blvd, #115-222 Reno, NV 89503	775-329-0119	jb@jkbelz.com
Scott Heinze	Prominence Health Plan	1510 Meadow Wood Lane Reno, NV 89502	775-770-9327	Scott.heinze@uhsinc.com
James Wadhams, Esq.	Fennemore Craig Jones Vargas	300 S. Fourth Street Suite 1400 Las Vegas, NV 89101	702-692-8000	jwadhams@fclaw.com
Keith Lee, Esq.	Nevada Association of Health Plans	1941 Rolling Brook Reno, NC 89519	775-829-1400	Not legible
Joan Hall	Nevada Rural Hospital Partners	4600 Kietzke Lane Suite I-209 Reno, NV 89502	775-827-4770	joan@nrhp.org
Catherine O'Mara	Nevada State Medical Association	Not given	775-742-6170	Catherine@nevadadoctors.org
Bill Welch	Nevada Hospital Association	5190 Neil Rd. Ste. 400 Reno, NV 89502	775-827-0184	bill@nvha.net

October 20, 2015 Hearing – Persons who testified:

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Jeannette Belz	Nevada Psychiatric Association	10580 N. McCarran Blvd, #115-222 Reno, NV 89503	775-329-0119	jb@jkbelz.com
David Brewster	American Academy of Dermatology Association	1445 New York Ave. NW Washington, D.C.	202-340-2875	dbrewster@aad.org
Sara Partida	Nevada State Medical Association	631 N. Stephanie St., Ste. 202 Henderson, NV	Not furnished	sara@theperkinsco.com

November 12, 2014 Hearing – Persons who testified:

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Jack Kim	United Healthcare	P.O. Box 15645 Las Vegas, NV 89114-5645	702-240-8890	Jack.Kim@uhc.com
Stacy Woodbury	Nevada State Medical Association	3660 Baker Lane, #101 Reno, NV 89509	775-825-6788	stacy@nsmadocs.org
Kristin Viswanathan	Biotechnology Industry Organization (BIO)	1201 Maryland Ave SW Washington, D.C. 20024	Not furnished	kviswanathan@bio.org
Bill Welch	Nevada Hospital Association	5250 Neil Road, Suite 302 Reno, NV 89502	775-827-0184	bill@nvha.net
David Brewster	American Academy of Dermatology Association	1445 New York Ave. NW Washington, D.C.	202-340-2875	dbrewster@aad.org
Joan Hall	Nevada Rural Hospital Partners	4600 Kietzke Lane Suite I-209 Reno, NV 89502	775-827-4770	joan@nrhp.org
James Wadhams, Esq.	Fennemore Craig Jones Vargas	300 S. Fourth Street Suite 1400 Las Vegas, NV 89101	702-692-8000	jwadhams@fclaw.com
Linda Ash-Jackson	Hometown Health	830 Harvard Way Reno, NV 89502	775-982-3000	Not given

Persons who provided written statements:

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Grace Campbell	AHIP (America's Health Insurance Plans)	601 Pennsylvania Ave, NW South Building Suite Five Hundred Washington, DC 20004	202-778-3200	gcampbell@ahip.org
Katie Ryan Lisa Farnan	Dignity Health/ St. Rose Dominican	3001 St. Rose Pkwy. Henderson, NV 89052	702-616-5000	Katie.ryan@dignityhealth.org Not given
Chris Ferrari	Ferrari Public Affairs	4741 Caughlin Parkway, Suite 2 Reno, NV 89519	702-574-8781	chris@ferraripa.com
Dwight Hansen Bill Welch	Nevada Hospital Association (NHA)	5190 Neil Rd. Ste. 400 Reno, NV 89502	775-827-0184	Not given

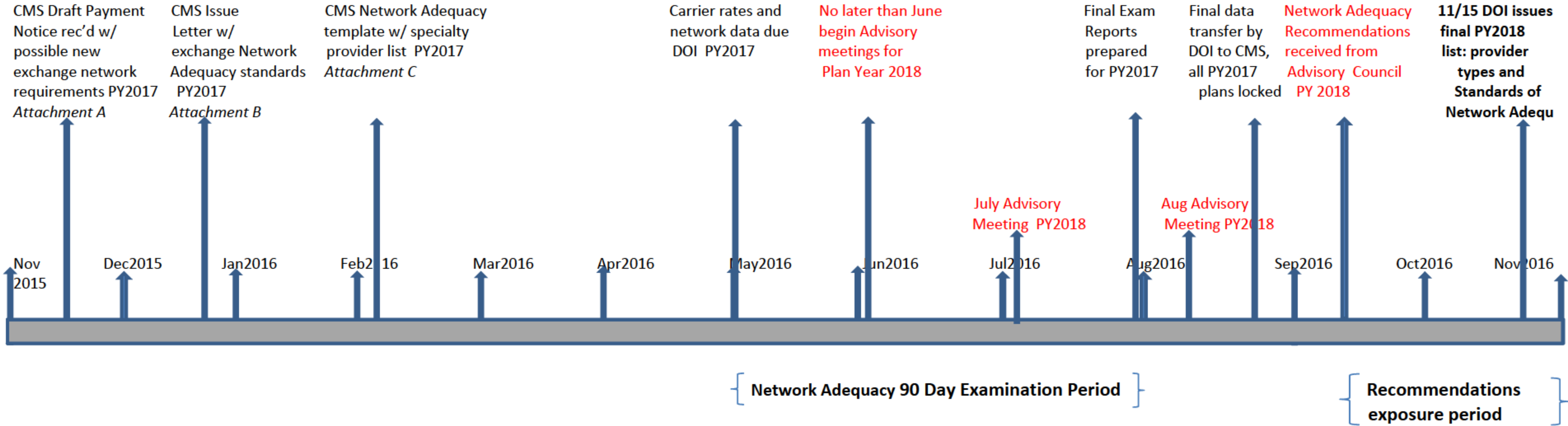
Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Mitchell Forman Stacy Woodbury Veronica Sutherland Abdi Raissi Adam Rovit Dodge Slagle Lesley Dickson Dean Polce Ross Golding Charles Price Michael Edwards Bret Frey Keith Brill Karen Massey Tomas Hinojosa Isaac Hearne	Nevada State Medical Association (NSMA)	3660 Baker Lane #101 Reno, NV 89509	775-825-6788	Not given
Jeremy Van Haselen	DaVita HealthCare Partners	2000 16th Street Denver, CO 80202	303-876-6000	Not given
Air Methods Government Relations	Air Methods	7211 S. Peoria Englewood, CO 80112	303-792-7400	Ruthie.hubka@airmethods.com
Jack Kim	Health Plan of Nevada	2724 N. Tenaya Way Las Vegas, NV 89128	702-240-8890	Not given
Gregory Skuta Daniel Briceland Cindy Bradford Michael Repka	American Academy of Ophthalmology (AAO)	Suite 400 20 F Street, NW Washington, DC 20001-6701	202-737-6662	Not given
James Madara, MD	American Medical Association (AMA)	330 N. Wabash Ave. Suite 39300 Chicago, IL 60611-5885	312-464-5000	Not given
Tracey Woods	Anthem Blue Cross and Blue Shield	9133 W. Russell Road Las Vegas, NV 89148	Not given	Tracey.Woods@anthem.com
Elisa Cafferata	Nevada Advocates for Planned Parenthood Affiliates, Inc. (NAPPA)	550 W. Plumb Lane, c/o UPS Mail #B-104 Reno, NV 89509	775-412-2087	ecafferata@NevadaAdvocates.org
Not given	American Academy of Dermatology and AAD Association	Not given	Not given	Not given

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Tom McCoy	American Cancer Society Cancer Action Network	691 Sierra Rose Drive Suite A Reno, NV 89511	775-828-2206	Tom.mccoy@cancer.org
Erin Estey Hertzog	Biotechnology Industry Organization (BIO)	1201 Maryland Avenue SW Suite 900 Washington DC 20024	202-962-9200	ehertzog@bio.org
George Hruza Lisle Thielbar	American Society for Dermatologic Surgery Association (ASDSA)	Not given	847-956-9126	Not given lthielbar@asds.net
Brett Coldiron Mark Lebwohl	American Academy of Dermatology (AADA)	1445 New York Ave., NW Suite 800 Washington, DC 20005-2134	202-842-3555	Not given
Ty Windfeldt	Hometown Health	830 Harvard Way Reno, NV 89502	775-982-3000	Not given
Saul Levin	American Psychiatric Association	1000 Wilson Blvd. Suite 1825 Arlington, VA 22209	703-907-7300	Not given
Lawrence LaMotte Emily Hovermale	Immune Deficiency Foundation (IDF)	40 West Chesapeake Ave. Suite 308 Towson, MD 21204	800-296-4433	Not given ehovermale@primaryimmune.org
Not given	Nevada Hospital Association (NHA)	Not given	Not given	Not given
Joan Hall	Nevada Rural Hospital Partners	4600 Kietzke Lane Suite I-209 Reno, NV 89502	775-827-4770	joan@nrhp.org
Scott Heinze	Prominence Health Plan	1510 Meadow Wood Lane Reno, NV 89502	775-770-9327	Scott.heinze@uhsinc.com
Linda Cooper	AETNA	Not given	Not given	CooperL3@aetna.com
Barry Ziman	Hospital Based Physician Specialties	1350 I Street, NW Suite 590 Washington, DC 20005	800-392-9994 ext. 7117	bziman@cap.org
Isaac Hearne	Nevada Academy of Ophthalmology (NAO)	20 F. Street, NW Suite 400 Washington, DC 20001-6700	202-737-6662	Not given

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Karen Sartell	Nevada Patient Access Coalition Members as follows: Arthritis Foundation, Pacific Region American Academy of Pain Management Colors of Lupus Nevada National MS Society National Patient Advocate Foundation Power of Pain Foundation US Pain Foundation	Not given	702-371-5577	k.sartell@sncrf.org
Rev. Diane Drach-Mienel	Religious Alliance in Nevada	Not given	Not given	Not given
John Albertini	American College of Mohs Surgery	Not given	Not given	Not given

Nevada Division of Insurance

Network Adequacy Timeline - Example



THE STATE OF NEVADA,
DEPARTMENT OF BUSINESS AND INDUSTRY,
DIVISION OF INSURANCE
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NOTICE TO SUBMIT APPLICATIONS FOR MEMBERSHIP ON COMMISSIONER'S NETWORK ADEQUACY ADVISORY COUNCIL

DEADLINE TO SUBMIT APPLICATIONS: 5:00 PM, MAY 16, 2016

Nevada Revised Statute ("NRS") 687B.490 places on the Commissioner of Insurance ("Commissioner") the responsibility of determining each year the adequacy of health insurance carriers' provider networks offered in small employer group and individual health benefit plans. On April 4, 2016, R049-14, otherwise known as the Network Adequacy Regulation, was finally adopted and became a part of the Nevada Administrative Code. See attached Regulation. R049-14 sets forth, among other things, the process by which the Commissioner will, each year, establish and issue the requirements that must be met by a carrier to show that its network is adequate ("Network Adequacy Requirements"). R049-14 provides for the creation of the Network Adequacy Advisory Council ("Council"). The nine-member Council will be tasked with making a recommendation to the Commissioner, for her consideration, as to what the Network Adequacy Requirements should be for the relevant plan year. The Commissioner will appoint the Council members such that there will be a fair representation of carriers, providers of health care, and consumers or consumer groups on the Council. Council members will serve at the pleasure of the Commissioner and without compensation. In performing their duties on the Council, members are not considered employees of the State. The Council must meet at least three times each year. The first meeting of the Council must take place no later than June 15th of each year, including 2016, and the Council must submit its final recommendation to the Commissioner no later than September 15th of each year. Each meeting of the Council will be a public meeting.

If you wish to be considered by the Commissioner for appointment to the Council, please submit your application with the information listed below to the Commissioner **no later than 5:00 pm, May 16, 2016**. Please send your application to:

Nevada Division of Insurance
Attention: Tracy Zehner
1818 E. College Parkway
Suite 103
Carson City, Nevada 89706

or by e-mail to: tzehner@doi.nv.gov

The Application should include the following documents and information:

- **Cover Letter**: with contact information (including county of residence), reasons why you want to be on the Council and why you believe you should be chosen,

what interest you propose to represent and why, a brief description of your experience dealing with health insurance related matters.

- **Resume**: listing and describing current employment, employment history, education, any other helpful information such as public service work, volunteer work, awards, professional licenses, etc.

- **List of References**: including the references' contact information.

- **Endorsements/Recommendations**: from any of the interest group(s) you propose to represent.

Questions concerning the application process should be directed to Kimberly Everett, at (775) 687-0735 or keverett@doi.nv.gov.

A copy of this notice will be on file at the State Library, 100 North Stewart Street, Carson City, Nevada, for inspection by members of the public during business hours. Additional copies of the notice will be available at the offices of the Division, 1818 East College Parkway, Suite 103, Carson City, Nevada 89706, and 2501 East Sahara Avenue, Suite 302, Las Vegas, Nevada 89104, and in all counties in which an office of the agency is not maintained, at the main public library, for inspection and copying by members of the public during business hours. Copies of this notice will be mailed to members of the public upon request. This Notice was provided via electronic means to all persons on the agency's e-mail list for administrative regulations, posted to the agency's Internet Web site at **http://doi.nv.gov/**, and provided to or posted at the following locations:

Department of Business and Industry
Division of Insurance
1818 East College Parkway, Suite 103
Carson City, Nevada 89706

Department of Business and Industry
Division of Insurance
2501 East Sahara Avenue, Suite 302
Las Vegas, Nevada 89104

Legislative Building
401 South Carson Street
Carson City, Nevada 89701

Grant Sawyer Building
555 East Washington Avenue
Las Vegas, Nevada 89101

Blasdel Building
209 East Musser Street
Carson City, Nevada 89701

Capitol Building Main Floor
101 North Carson Street
Carson City, Nevada 89701

Nevada Department of Employment,
Training and Rehabilitation
2800 E. Saint Louis Ave.
Las Vegas, NV 89104

Nevada State Library & Archives
100 North Stewart Street
Carson City, Nevada 89701

Carson City Library
900 North Roop Street
Carson City, Nevada 89701

Churchill County Library
553 South Main Street
Fallon, Nevada 89406

Douglas County Library
P.O. Box 337
Minden, Nevada 89423

Elko County Library
720 Court Street
Elko, Nevada 89801

Esmeralda County Library
P.O. Box 430
Goldfield, Nevada 89013

Eureka Branch Library
P.O. Box 293
Eureka, Nevada 89316

Humboldt County Library
85 East 5th Street
Winnemucca, Nevada 89445

Lander County Library
P.O. Box 141
Battle Mountain, Nevada 89820

Las Vegas-Clark County Library District
7060 W. Windmill Lane
Las Vegas, NV 89113

Lincoln County Library
P.O. Box 330
Pioche, Nevada 89043-0330

Lyon County Library
20 Nevin Way
Yerington, Nevada 89447

Mineral County Public Library
P.O. Box 1390
Hawthorne, Nevada 89415

Pershing County Library
P.O. Box 781
Lovelock, Nevada 89419

Storey County Clerk
P.O. Drawer D
Virginia City, Nevada 89440

Tonopah Public Library
P.O. Box 449
Tonopah, Nevada 89049

Washoe County/Downtown Reno Library
P.O. Box 2151
Reno, Nevada 89505-2151

White Pine County Library
950 Campton Street
Ely, Nevada 89301

BRIAN SANDOVAL
Governor

STATE OF NEVADA

BRUCE H. BRESLOW
Director

SCOTT J. KIPPER
Commissioner

DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE
1818 East College Pkwy., Suite 103
Carson City, Nevada 89706
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Website: doi.nv.gov
E-mail: insinfo@doi.nv.gov

Bulletin 14-005

June 30, 2014

Network Adequacy Standards for Certain Health Benefit Plans - 2015 Transitional Year

Nevada Revised Statute ("NRS") 687B.490 vests in the Commissioner of Insurance ("Commissioner") the authority to determine the adequacy of provider networks to be used by network plans made available for sale in this State. A permanent regulation, filed with the Legislative Counsel Bureau as proposed regulation R049-14, is being deliberated to interpret and clarify the provisions of NRS 687B.490. The Commissioner recognizes that proposed regulation R049-14 may still be several weeks or months away from adoption and, when adopted, may deviate significantly from its present form. The Commissioner also recognizes that insurance carriers offering health benefit plans utilizing a network plan will possibly be required to submit their plans and rates for approval prior to the adoption of proposed regulation R049-14.

To resolve this potential timing disparity, the Commissioner is declaring calendar year 2015 to be a "transitional" year with regards to network adequacy. Insurance carriers will not be expected to retroactively meet the requirements of proposed regulation R049-14 when it is adopted. Instead, the Commissioner intends to use the enclosed standards when evaluating the adequacy of provider networks in 2015 calendar year plans.

Bulletin 14-005 and the enclosed standards are intended to apply to all health benefit plans in the individual and small group markets, as defined in NRS 689A and 689C, respectively, utilizing a network plan and issued or renewed on or after January 1, 2015.

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Commissioner of Insurance

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Network Adequacy Standards

Section I. A carrier that offers health coverage through a network plan shall use best efforts to maintain each plan provider network in a manner that is sufficient in numbers and types of health care providers, including providers that specialize in mental health and substance abuse services, to assure that all health care services to covered persons will be accessible without unreasonable delay. Each covered person shall have adequate choice among each type of health care provider. In the case of emergency services, covered persons shall have access 24 hours a day, 7 days a week. A carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health care services to covered persons. Provider directories shall be updated on-line and filed with the Division of Insurance in SERFF no less than every 60 days.

Section II. Each carrier shall confirm that its network(s) will meet these requirements by January 1, 2015, and at all times thereafter. A declaration form of compliance with network adequacy standards will be required to be signed by an officer of the company and submitted to the Commissioner of Insurance ("Commissioner") on or before November 14, 2014. *A declaration form can be obtained on the Division of Insurance website.* Each carrier shall submit the "Plans and Benefits Template", "Network Adequacy Template", "Network Template", "ECP Template", "Service Area Template" and "Member Data Call Spreadsheet" for all network plans. The templates and spreadsheet are to be submitted in a SERFF Binder. Validated templates may be submitted under the Templates tab. Unvalidated templates and documents must be submitted under the "Supporting Documents" tab.

A carrier shall use best efforts to provide notice of any significant change in the network to the Commissioner within 45 days of the change taking effect. If the significant change results in a deficiency in the network, the notification must include a corrective action plan by the carrier to resolve the deficiency. Failure to provide such notification may lead to the suspension or termination of the network plan and any accompanying consequences. Additionally, an administrative fine may be assessed for each violation. The carrier shall have the right to appeal the decision and submit a corrective action plan to the Commissioner for consideration.

Section III. In any case where the carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall use best efforts to ensure through referral by the primary care provider, or otherwise, that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the Commissioner.

Section IV. Each carrier shall use best efforts to establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of covered persons. Carriers shall make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits. In determining whether a

carrier has complied with this provision, the Commissioner will give due consideration to the relative availability of health care providers or facilities in each geographic area using standards that are realistic for the community, the delivery system and clinical safety. Relative availability includes the willingness of providers or facilities in the geographic area to contract with the carrier under reasonable terms and conditions.

Section V. The carrier shall disclose to all covered persons that limitations or restrictions to access of participating providers and facilities may arise from the health care service referral and authorization practices of participating providers and facilities. The carrier shall provide instructions to covered persons as to how they can receive details about such practices from their primary care provider or through other formally established processes.

Section VI. A health benefit plan seeking certification or recertification as a Qualified Health Plan shall use best efforts to maintain arrangements that ensure that American Indians and Native Alaskans who are covered persons have access to Indian health care services and facilities that are part of the Indian Health Care System (IHS). Carriers shall ensure that such covered persons may obtain covered services from the IHS at no greater cost to the covered person than if the service were obtained from network providers and facilities. Carriers are not responsible for credentialing providers and facilities that are part of the IHS. A carrier may use the HHS Standard Indian Addendum when contracting with Indian providers. Nothing in this subsection prohibits a carrier from limiting coverage to those health care services that meet the standards for medical necessity, care management, and claims administration, or from limiting payment to that amount payable if the health care service were obtained from a network provider or facility.

Section VII. All health benefit plans shall use best efforts to have a sufficient number and geographic distribution of Essential Community Providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the geographic area. Sufficient number and geographic distribution is defined as at least 30 percent of available ECPs in the plan's geographic area participating in the carrier's provider network with at least one ECP in each category, as defined in Table 2.1 of the "2015 Letter to Issuers in the Federally-facilitated Marketplaces", issued by the Center for Consumer Information and Insurance Oversight on March 14, 2014. A narrative justification must be included as part of the Qualified Health Plan application; or carriers that provide a majority of covered services through employed physicians or a single contracted medical group must have the equivalent number of provider locations in Health Professional Shortage Areas and low-income ZIP codes. You can find a non-exhaustive list of ECPs for Nevada at: https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq

Section VIII. Adequacy of choice may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: Provider-to-covered-person ratios by specialty, primary-care-provider-to-covered-person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or

specialty care. Any exceptions or deviations from the standards identified below (ratios and geographic accessibility) must be approved by Commissioner.

Section IX. Participating Provider Availability and Accessibility Standards

Accessibility standards have been developed to address the fact that population density in the carrier's geographic area varies from one defined market region to another. One set of standards for each type of geographic area (urban, rural, or frontier) will be addressed separately for each category. Each carrier must demonstrate that its network meets the established time and distance requirements. Carriers will be held accountable for meeting the standards described below.

PCP and OBGYN ACCESSIBILITY STANDARDS*

Minimum Number of Providers with Specialties	***Ratio***
Internal Medicine, General Practice and Family Practice	1 provider for every 2,500 covered persons
OBGYN	1 provider for every 2,500 covered persons NOTE: Number of covered persons based on female membership ages 14 and over.
Pediatrics	1 provider for every 2,500 covered persons NOTE: Number of covered persons based on membership ages 18 and under.

Geographic Areas by County	***Maximum Travel, Distance or Time***
URBAN COUNTIES	
Carson City	45 miles or 45 minutes
Clark	45 miles or 45 minutes
Washoe	45 miles or 45 minutes
RURAL COUNTIES	
Douglas	60 miles or 1 hour
Lyon	60 miles or 1 hour
Storey	60 miles or 1 hour
FRONTIER COUNTIES	
Churchill	100 miles or 2 hours
Elko	100 miles or 2 hours
Esmeralda	100 miles or 2 hours
Eureka	100 miles or 2 hours
Humboldt	100 miles or 2 hours
Lander	100 miles or 2 hours
Lincoln	100 miles or 2 hours

Mineral	100 miles or 2 hours
Nye	100 miles or 2 hours
Pershing	100 miles or 2 hours
White Pine	100 miles or 2 hours

*Availability of certain provider types may be limited within each county. Additionally, the availability of certain provider types may also be limited within certain cities/communities within a specific county. Every consideration, including established community patterns of care, will be given by the Commissioner to the relative availability of health care providers or facilities in the geographic area when determining if a carrier meets the above established network adequacy provider to member ratios and the travel standards as measured in distance or time as outlined above.

Telemedicine may be utilized in order to provide accessible care in addition to the above network adequacy ratios and travel standards.

URGENT ACCESSIBILITY STANDARDS*

Minimum Number of Providers with Specialties	***Ratio***
Urgent Care	1 provider for every 5,000 covered persons

Geographic Areas by County	***Maximum Travel, Distance or Time***
URBAN COUNTIES	
Carson City	45 miles or 45 minutes
Clark	45 miles or 45 minutes
Washoe	45 miles or 45 minutes
RURAL COUNTIES	
Douglas	60 miles or 1 hour
Lyon	60 miles or 1 hour
Storey	60 miles or 1 hour
FRONTIER COUNTIES	
Churchill	100 miles or 2 hours
Elko	100 miles or 2 hours
Esmeralda	100 miles or 2 hours
Eureka	100 miles or 2 hours
Humboldt	100 miles or 2 hours
Lander	100 miles or 2 hours
Lincoln	100 miles or 2 hours
Mineral	100 miles or 2 hours
Nye	100 miles or 2 hours
Pershing	100 miles or 2 hours

White Pine	100 miles or 2 hours

*Availability of certain provider types may be limited within each county. Additionally, the availability of certain provider types may also be limited within certain cities/communities within a specific county. Every consideration, including established community patterns of care, will be given by the Commissioner to the relative availability of health care providers or facilities in the geographic area when determining if a carrier meets the above established network adequacy provider to member ratios and the travel standards as measured in distance or time as outlined above.

Telemedicine may be utilized in order to provide accessible care in addition to the above network adequacy ratios and travel standards.

EMERGENT ACCESSIBILITY STANDARDS*

Minimum Number of Providers with Specialties	***Ratio***
Emergency Medicine	1 provider for every 5,000 covered persons NOTE: Covered persons shall have access 24 hours a day, seven (7) days a week.

Geographic Areas by County	***Maximum Travel, Distance or Time***
URBAN COUNTIES	
Carson City	30 miles or 30 minutes
Clark	30 miles or 30 minutes
Washoe	30 miles or 30 minutes
RURAL COUNTIES	
Douglas	60 miles or 1 hour
Lyon	60 miles or 1 hour
Storey	60 miles or 1 hour
FRONTIER COUNTIES	
Churchill	75 miles or 1.5 hours
Elko	75 miles or 1.5 hours
Esmeralda	75 miles or 1.5 hours
Eureka	75 miles or 1.5 hours
Humboldt	75 miles or 1.5 hours
Lander	75 miles or 1.5 hours
Lincoln	75 miles or 1.5 hours
Mineral	75 miles or 1.5 hours
Nye	75 miles or 1.5 hours
Pershing	75 miles or 1.5 hours
White Pine	75 miles or 1.5 hours

*Air Ambulance may be medically necessary to provide accessibility without unreasonable delay.

Availability of certain provider types may be limited within each county. Additionally, the availability of certain provider types may also be limited within certain cities/communities within a specific county. Every consideration, including established community patterns of care, will be given by the Commissioner to the relative availability of health care providers or facilities in the geographic area when determining if a carrier meets the above established network adequacy provider to member ratios and the travel standards as measured in distance or time as outlined above.

Telemedicine may be utilized in order to provide accessible care in addition to the above network adequacy ratios and travel standards.

MENTAL HEALTH AND SUBSTANCE ABUSE ACCESSIBILITY STANDARDS*

Minimum Number of Providers with Specialties	***Ratio***
Mental Health	1 provider/facility for every 30,000 covered persons.
Substance Abuse	1 provider/facility for every 30,000 covered persons.

Geographic Areas by County	***Maximum Travel, Distance or Time***
URBAN COUNTIES	
Carson City	30 miles or 30 minutes
Clark	30 miles or 30 minutes
Washoe	30 miles or 30 minutes
RURAL COUNTIES	
Douglas	60 miles or 1 hour
Lyon	60 miles or 1 hour
Storey	60 miles or 1 hour
FRONTIER COUNTIES	
Churchill	90 miles or 1.5 hours
Elko	90 miles or 1.5 hours
Esmeralda	90 miles or 1.5 hours
Eureka	90 miles or 1.5 hours
Humboldt	90 miles or 1.5 hours
Lander	90 miles or 1.5 hours
Lincoln	90 miles or 1.5 hours
Mineral	90 miles or 1.5 hours
Nye	90 miles or 1.5 hours
Pershing	90 miles or 1.5 hours
White Pine	90 miles or 1.5 hours

*Availability of certain provider types may be limited within each county. Additionally, the availability of certain provider types may also be limited within certain cities/communities within a specific county. Every consideration, including established community patterns of care, will be given by the Commissioner to the relative availability of health care providers or facilities in the geographic area when determining if a carrier meets the above established network adequacy provider to member ratios and the travel standards as measured in distance or time as outlined above.

Telemedicine may be utilized in order to provide accessible care in addition to the above network adequacy ratios and travel standards.

SPECIALTY PROVIDERS ACCESSIBILITY STANDARDS*

Minimum Number of Providers with Specialties	***Ratio***
Cardiology	1 provider/facility for every 7,500 covered persons.
Dermatology	1 provider for every 17,500 covered persons.
Gastroenterology	1 provider for every 25,000 covered persons.
Hematology/Oncology	1 provider for every 17,500 covered persons.
Nephrology	1provider for every 10,000 covered persons.
Ophthalmology	1 provider for every 27,500 covered persons.
Orthopedics (General, Hand and Neurosurgery)	1 provider for every 10,000 covered persons.
Otolaryngology	1 provider for every 25,000 covered persons.
Pulmonology	1 provider for every 20,000 covered persons.
Surgery (General, Cardiovascular, Cardiothoracic, Vascular and Colorectal)	1 provider for every 12,500 covered persons.
Urology	1 provider for every 25,000 covered persons.

Geographic Areas by County	*Maximum Travel, Distance or Time*
URBAN COUNTIES	
Carson City	60 miles or 60 minutes
Clark	60 miles or 60 minutes
Washoe	60 miles or 60 minutes
RURAL COUNTIES	
Douglas	90 miles or 1.5 hour
Lyon	90 miles or 1.5 hour
Storey	90 miles or 1.5 hour
FRONTIER COUNTIES	
Churchill	180 miles or 3 hours
Elko	180 miles or 3 hours
Esmeralda	180 miles or 3 hours
Eureka	180 miles or 3 hours
Humboldt	180 miles or 3 hours
Lander	180 miles or 3 hours
Lincoln	180 miles or 3 hours
Mineral	180 miles or 3 hours
Nye	180 miles or 3 hours
Pershing	180 miles or 3 hours
White Pine	180 miles or 3 hours

*Availability of certain provider types may be limited within each county. Additionally, the availability of certain provider types may also be limited within certain cities/communities within a specific county. Every consideration, including established community patterns of care, will be given by the Commissioner to the relative availability of health care providers or facilities in the geographic area when determining if a carrier meets the above established network adequacy provider to member ratios and the travel standards as measured in distance or time as outlined above.

Telemedicine may be utilized in order to provide accessible care to meet the above network adequacy ratios and travel standards.

Section X. Provider Network Adequacy Goals:

- To offer an adequate number and type of contracted or participating providers to meet the health care needs of covered persons.
- To offer a network of participating providers that is geographically accessible to covered persons.
- The number of network providers of different types will vary from one geographic area/county to another. The carrier will contract with sufficient providers of all types necessary to provide a full range of covered services using standards that are realistic for the community, the delivery system and clinical safety.

- Compliance with the distance standards will be achieved if 95 percent of the population of the geographic service area or existing HMO membership is within the distance standards of the providers with whom the carrier contracts.
- The minimum distance standards for PPO insureds will be achieved if 50 percent of the population of the geographic service area or the carrier's enrolled membership is within the distance standards of the providers with whom the carrier contracts.
- The carrier shall provide a wide choice of accessible physicians, facilities and ancillary providers whenever and wherever there is an adequate number of such health care providers practicing in the defined geographic area or county.

Section XI. Provider Network Requirements:

- Be adequate in numbers and types of providers to meet the full range of health care service needs of the enrolled population.
- Include at least one community hospital, where one is available.
- Comply with the Essential Community Provider requirement.
- Use best efforts to include at least 50 percent of the primary care physicians with active staff privileges or hospital admitting privileges or agreements of the contracted community hospital, within each county or multi-county region.
- Include, within each county or multi-county region, enough primary care and specialty care physicians to provide covered persons a choice of physicians.
- A provider directory must be available for publication online and to potential enrollees in hard copy upon request. An HMO/POS provider directory must identify primary care physicians that are not accepting new patients.