NOTICE OF WORKSHOP TO SOLICIT COMMENTS ON PROPOSED REGULATIONS

The State of Nevada, Department of Business and Industry, Division of Insurance ("Division"), is proposing the adoption, amendment or repeal of regulations pertaining to chapter(s) 687B.490 of the Nevada Administrative Code ("NAC"). A workshop has been set for **9:00 a.m. on July 23, 2015**, at the following locations:

Legislative Building
401 South Carson Street, Room 2135
Carson City, Nevada 89701

Interested persons may also participate through a simultaneous videoconference conducted at:

Grant Sawyer Building
555 East Washington Avenue, Room 4412E
Las Vegas, Nevada 89101

The purpose of the workshop is to solicit comments from interested persons on the following general topics that may be addressed in the proposed regulation(s); and to assist in determining whether the proposed regulation is likely to impose a direct and significant burden upon a small business or directly restricts the formation, operation or expansion of a small business. Please submit any written comments no later than **July 16, 2015**.

LCB File No. R049-14. Network Adequacy.
A regulation relating to insurance; establishing certain requirements relating to the adequacy of a network plan issued by a carrier; authorizing the Commissioner of Insurance to determine whether a network plan is adequate under certain circumstances; requiring a carrier whose network plan is deemed or determined to be adequate to notify the Commissioner of any significant change to its network and take certain actions to correct any deficiency that results; providing for the availability of a network plan to persons outside of the approved service area in certain circumstances; and providing other matters properly relating thereto.

The workshop will address and discuss amendments to regulations, LCB File No. R049-14, as amended and dated June 3, 2015, addressing network adequacy of health plans sold in Nevada. The Division held its last proceeding in this matter on November 12, 2014. The Division has, through the 2015 Legislative Session, addressed, modified and restructured the regulations, taking into account comments, concerns and questions. The pending regulations, LCB File No. R049-14, as amended and dated June 3, 2015, will be subject to legal review by the Legislative Counsel Bureau. A final adoption hearing open to the public will be scheduled following any revisions by the Legislative Counsel Bureau. The changes do not modify or alter the effect of the change on small businesses as determined by the small business impact statement.

A copy of all materials relating to the proposal(s) may be obtained at the workshop or by visiting the Division's Internet Web site at http://doi.nv.gov/ or by contacting the Division, 1818 East

College Parkway, Suite 103, Carson City, Nevada 89706, (775) 687-0700. A reasonable fee for copying may be charged. Members of the public who would like additional information about the proposed regulation may contact Mark Krueger, Insurance Counsel, at (775) 687-0783, or via e-mail to mkrueger@doi.nv.gov.

Notice of the workshop was provided via electronic means to all persons on the agency's e-mail list for noticing of administrative regulations. This Notice of Workshop to Solicit Comments on Proposed Regulations was posted to the agency's Internet Web site at http://doi.nv.gov/, the Nevada Legislature's Internet Web site at http://www.leg.state.nv.us, and 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

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

Churchill County Library
553 South Main Street
Fallon, Nevada 89406

Clark County District Library
833 Las Vegas Boulevard North
Las Vegas, Nevada 89101

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

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 Library
P.O. Box 2151
Reno, Nevada 89505-2151

White Pine County Library
950 Campton Street
Ely, Nevada 89301

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

Members of the public who are disabled and require special accommodations or assistance at the workshop are requested to notify the Commissioner's secretary in writing to icommish@doi.nv.gov, or at 1818 East College Parkway, Suite 103, Carson City, Nevada 89706, or by calling (775) 687-0700, no later than five (5) working days prior to the hearing.

DATED this 29th day of June, 2015.

SCOTT J. KIPPER
Commissioner of Insurance

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
(775) 687-0700 • Fax (775) 687-0787
Website: doi.nv.gov
E-mail: insinfo@doi.nv.gov

PUBLIC REGULATION WORKSHOP

JULY 23, 2015 - 9:00 A.M.

In Carson City:
The Legislative Building
401 S. Carson St., Room 2135
Carson City, Nevada 89701

Videoconferenced to Las Vegas:
The Grant Sawyer Building
555 E. Washington Ave., Room 4412E
Las Vegas, Nevada 89101

AGENDA

1. Call to Order.

2. Public comment.

3. (FOR POSSIBLE ACTION) Discussion and possible action on the status and amendments to regulations, LCB File No. R049-14, as amended and dated June 3, 2015, addressing network adequacy of health plans sold in Nevada. The Division held its last proceeding in this matter on November 12, 2014. The Division has, through the 2015 Legislative Session, addressed, modified and restructured the regulations taking into account comments, concerns and questions. The pending regulations, LCB File No. R049-14, as amended and dated June 3, 2015, will be subject to legal review by the Legislative Counsel Bureau. A final adoption hearing open to the public will be scheduled following any revisions by the Legislative Counsel Bureau.

4. Public comment.

5. Adjournment.

STATE OF NEVADA
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INSURANCE

Determination of Necessity of Small Business Impact Statement
R049-14

A regulation pertaining to the adequacy of provider networks offered by certain health benefit plans.

Effective for plans issued or renewed on or after January 1, 2015

1. BACKGROUND

Prior to January 1, 2014 the Nevada State Board of Health was required to determine the adequacy of provider networks for health maintenance organizations (HMOs) in the state. HMOs traditionally offer a very limited benefit, or no benefit, when the insured uses a provider outside of the network of approved providers. Preferred provider organizations (PPOs) traditionally allow insureds to seek care from a provider outside of the network of preferred providers in exchange for a lower payment contribution by the insurer. As a result of this difference, PPOs have not previously had a standard for network adequacy.

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, as amended, collectively known as the Affordable Care Act (ACA) mandates that all health insurance sold through an exchange, without regard to its status as an HMO or PPO or otherwise, be certified as a qualified health plan (QHP). Part of the QHP certification process entails a determination of network adequacy and the authority for such (per the ACA) is vested in the state exchange, here the Silver State Health Insurance Exchange (SSHIX), unless otherwise authorized in state law.

Given this potentially bifurcated system (HMO network adequacy by the Board of Health, all other by the SSHIX) and the already fragmented QHP certification process (with the Division of Insurance conducting rate and form review) it was decided that the Board of Health and SSHIX would abdicate their authority over network adequacy to the Division of Insurance (DOI). The DOI determined that conducting network adequacy market-wide, without regard to status as a QHP, would ensure a uniform system of insurance regulation and consumer protection. Assembly Bill 425, which accomplished the goal of transferring authority over provider networks to the DOI, was advanced, passed and signed during the 77th (2013) Legislative Session. This proposed regulation seeks to enact rules building upon the framework contained within that legislation.

2. DOES THE PROPOSED REGULATION IMPOSE A DIRECT AND SIGNIFICANT ECONOMIC BURDEN UPON A SMALL BUSINESS OR DIRECTLY RESTRICT THE FORMATION, OPERATION OR EXPANSION OF A SMALL BUSINESS? (NRS 233B.0608.1)(circle one)

☐ NO ☑ YES

3. HOW WAS THAT CONCLUSION REACHED? (NRS 233B.0608.3)

Upon review of the topic and content of the proposed regulation, Division of Insurance staff determined that there was a high probability that the regulation would affect small business. The Division of Insurance sent a brief survey to businesses identified as being directly regulated by the proposed

regulation. At least one survey recipient responded affirmatively to being both a small business (as defined in NRS 233B.0382) and significantly burdened or restricted by the proposed regulation.

I, Scott J. Kipper, Commissioner of Insurance for the State of Nevada, certify that, to the best of my knowledge or belief, a concerted effort was made to determine the impact of the proposed regulation on small businesses and that the information contained in the statement above is accurate. (NRS 233B.0608.3)

02 June 2014
(DATE)

SCOTT J. KIPPER
Commissioner of Insurance

Small Business Impact Statement
R049-14

4. DESCRIPTION OF SOLICITATION

The DOI identified thirteen businesses as potentially being directly affected by the proposed regulation. A survey was drafted and sent to representatives of the companies via email on Thursday, April 24. The survey requested respondents self-identify as a statutory small business and provide feedback concerning the effects of the proposed regulation on business and the potential methods to alleviate the impact of the proposed regulation. Response was requested by the close of business on Friday, May 2.

5. SUMMARY OF COMMENTS RECEIVED FROM SMALL BUSINESSES (NRS 233B.0609.1.a)

Comment: One commenter questioned whether the proposed regulation was applicable only to qualified health plans (QHPs). The commenter noted that the Division's issue brief dated Feb. 7, 2014 indicated that the Affordable Care Act (ACA) network reforms only apply to QHPs and guidance issued by the Centers for Medicare & Medicaid Services (CMS) on May 13, 2013 indicated that standards related to essential community providers only apply to QHP networks.

Response: Nevada Revised Statute (NRS) 687B.490 grants authority to the Division of Insurance to determine the adequacy of all network plans in Nevada without regard to their status as a QHP.

Comment: One commenter suggested that the proposed regulation be limited to apply only to QHPs.

Response: NRS 687B.490 applies to all network plans without regard to the status as a QHP. The Division believes that it is in the best interest of consumers to apply network adequacy standards to all network plans available in the state.

Comment: One commenter suggested that the proposed regulation be clarified to indicate that it does not apply to policies classified as "grandfathered" under the ACA.

Response: NRS 687B.490, requiring the Commissioner to determine the adequacy of network plans, is applicable to a network plan before it is "available for sale in this State." Grandfathered plans, by definition, are not available for sale and thus are not subject to the requirements of this proposed

regulation. The Division would note that grandfathered plans may be subject to other network adequacy requirements, e.g. NRS 695C or 695G, if the grandfathered plan was subject to those requirements prior to the efficacy of NRS 687B.490.

Comment: One commenter noted that, as used in sections 8 and 12 of the proposed regulation, the phrase "no greater cost to the covered person than if the service were obtained from network providers or facilities" may be ambiguous. The commenter was unsure if the phrase required out-of-network claims to be paid without regard to a contracted rate or a usual and customary allowance.

Response: The DOI agrees that the language in section 8, subsection 5 is ambiguous and requires amendment. The language in question would appear to permit a carrier using a network plan to bypass the requirement to have an initial adequate network by using referral or other methods to ensure care for covered services. This is not the intent of the DOI and section 8, subsection 5 will be amended to better reflect that intent.

The DOI believes that the language in question is appropriate for section 12, subsection 3, permitting a carrier using a network plan to supplement an inadequate network through referral or other methods while a corrective action plan is being implemented.

Comment: One commenter suggested that sections 8 and 12 of the proposed regulation be amended to indicate that insurance carriers be required to pay the same benefit rate, as opposed to dollar amount, if an adequate network isn't found to exist.

Response: The Division believes that subsection 5 of section 8 may inappropriately burden insurance carriers that have been determined to have an adequate network pursuant to section 8 and may propose it be removed.

Subsection 3 of section 12 was originally applicable to HMOs. The Division recognizes that its application to PPO and other products may not function as intended and will explore other options to accomplish the goal of ensuring care to consumers when a network becomes inadequate.

Comment: One commenter suggested that sections 8 and 12 of the proposed regulation be amended to require an increased payment only if the claim in question is a non-elective emergent service.

Response: The Division believes that subsection 5 of section 8 may inappropriately burden insurance carriers that have been determined to have an adequate network pursuant to section 8 and may propose it be removed.

Subsection 3 of section 12 is intended to ensure that consumers are held harmless when a network plan becomes inadequate during a policy year. The Division recognizes that concern exists relating to elective or non-emergent care but believes that consumers should not be prevented from seeking care or be forced to pay considerably more for care when an insurance carrier and providers cannot

come to an equitable arrangement regarding contracting. However, the Division is willing to explore other methods which may be used to accomplish this goal.

Comment: One commenter suggested that the Commissioner only declare a network to be inadequate in the most egregious situations.

Response: The Division believes that adherence to a defined standard is in the best interests of consumers. The standard should be set so that it provides concrete benefits to consumers without unduly burdening network plans. Setting a standard that is too low obviates the need for a network adequacy standard at all.

Comment: One commenter noted that they employ more than 150 employees and would not meet the appropriate statutory definition of a small employer.

Response: The Division appreciates all feedback from interested parties, even if it falls outside of the scope of this statutory small business impact analysis.

Other interested parties may receive a copy of this summary by contacting the Insurance Regulation Liaison of the Nevada Division of Insurance, Adam Plain, at (775) 687-0783 or aplain@doi.nv.gov.

6. ESTIMATED ECONOMIC EFFECT ON SMALL BUSINESSES THE REGULATION IS TO REGULATE (NRS 233B.0609.1.c)

The Division has insufficient data to determine the existence or estimate the magnitude of any estimated economic effects on small businesses the proposed regulation regulates.

7. METHODS CONSIDERED TO REDUCE IMPACT ON SMALL BUSINESSES (NRS 233B.0609.1.d)

The Division is exploring options to amend the proposed regulation to reduce the actual and perceived burden on small businesses.

8. ESTIMATED COST OF ENFORCEMENT (NRS 233B.0609.1.e)

The Division anticipates no direct cost to enforce the proposed regulation. NRS 687B.490(6) requires that any expense borne by the Division in determining the adequacy of a network plan be assessed against the insurance carrier applying for the network plan approval.

9. FEE CHANGES (NRS 233B.0609.1.f)

The proposed regulation does not create new fees. NRS 687B.490(6) requires that any expense borne by the Division in determining the adequacy of a network plan be assessed against the insurance carrier applying for the network plan approval. The Division is considering amending the proposed regulation to indicate how costs may be allocated across insurance carriers, if at all, when multiple insurers submit network plans with similar or identical components.

10. DUPLICATIVE PROVISIONS (NRS 233B.0609.1.g)

The proposed regulation is similar in scope to the network adequacy requirements of NRS 695C.080. The division believes that three primary differences exist between the proposed regulation and NRS 695B.080:

1. The proposed regulation is not applicable to grandfathered plans;
2. The proposed regulation is applicable to all network plans and not limited to HMOs; and

3. NRS 695C.080 is applicable to HMOs applying for a certificate of authority whereas the proposed regulation applies to all plans issued by a licensed HMO, specifically plans that may be utilizing a network different than that submitted with the application for the certificate of authority.

11. HOW WAS THE ANALYSIS CONDUCTED? (NRS 233B.0609.1.b)
Division personnel deemed subject matter experts reviewed the responses to the small business impact survey in conjunction with the proposed regulation and guidance from the Centers for Medicare & Medicaid services.

12. REASONS FOR CONCLUSIONS (NRS 233B.0609.1.h)
The analysis of relevant inputs indicated that the proposed regulation was insufficient in many regards. There was concern regarding vague language and general applicability as well as areas omitted due to oversight. The Division has determined that a comprehensive amendment of the proposed regulation is necessary with one goal being the reduction of the impact upon small businesses.

I, Scott J. Kipper, Commissioner of Insurance for the State of Nevada, certify that, to the best of my knowledge or belief, the information contained in the statement above was prepared properly and is accurate. (NRS 233B.0609.2)

02 June 2014
(DATE)

SCOTT J. KIPPER
Commissioner of Insurance

PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R049-14

DRAFT PROPOSED INCLUDING AMENDMENTS

June 3, 2015

EXPLANATION – Matter in (1) ***blue bold italics*** is new language including amendments.

AUTHORITY: §§1-13, NRS 679B.130 and 687B.490.

A REGULATION relating to insurance; establishing certain requirements relating to the adequacy of a network plan issued by a carrier; authorizing the Commissioner of Insurance to determine whether a network plan is adequate under certain circumstances; requiring a carrier whose network plan is deemed or determined to be adequate to notify the Commissioner of any material change to its network and take certain actions to correct any deficiency that results; providing for the availability of a network plan to covered persons outside of the approved service area in certain circumstances; and providing other matters properly relating thereto.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 15, inclusive, of this regulation.

Sec. 2. (Definitions)

1. A "Carrier" means an insurer that makes any network plan available for sale in this State in the small employer group or individual market as contemplated by NRS 687B.490.

2. "CCIIO" means the Center for Consumer Information and Insurance Oversight within the Centers for Medicare and Medicaid Services division within the United States Department of Health and Human Services or its successor.

3. The "Centers for Medicare and Medicaid Services" means the Medicare Centers and Medicaid Services Centers within the Centers for Medicare and Medicaid Services division within the United States Department of Health and Human Services.

4. "Covered Persons" has the meaning ascribed to it in NRS 695G.017.

5. An "essential community provider" has the meaning ascribed to it in 45 C.F.R. § 156.235(c).

6. "Established Patterns of Care" means clinically appropriate referral patterns with expected patient travel to a location for treatment for a particular condition.

7. "Exchange" means the Silver State Health Insurance Exchange as defined by NRS 695I.030.

8. A "geographic service area" has the meaning ascribed to it:

(a) For health benefit plans sold to individuals, in NRS 689A.527; or

(b) For health benefit plans sold to small employers, in NRS 689C.072.

9. "Health Care Providers" has the meaning ascribed to it in NRS 695G.070.

10. "Indian Health Services" means the Indian Health Services division within the United States Department of Health and Human Services which is responsible for providing federal health services to American Indians and Alaska Natives.

11. A "material change" in a network plan is any change, or combination of changes taking effect within 30 days of each other, that:

(a) For specialties or categories of health care with more than 10 providers, affects network plan capacity by more than 10 percent in any single specialty or category of health care for which a benefit is offered;

(b) For specialties or categories of health care with 10 or fewer providers, affects network plan capacity by more than 20 percent in any single specialty or category of health care for which a benefit is offered: or

(c). Does not meet the standards as provided for in section 4 of this regulation.

12. "Medically Necessary Emergency Services" has the meaning ascribed to it in NRS 695G.170.

13. "Telehealth" has the meaning ascribed to it in section 3(3)(c) of AB292 from the 78th (2015) Session.

14. "Unreasonable travel" means a travel distance or time that does not meet the standards as provided for in section 4 of this regulation.

Sec. 3. *A carrier must establish and maintain a network plan that has an adequate number and geographic distribution of contracted providers in each geographic service area covered by the network plan in order to meet anticipated health care needs based upon the benefits offered under the plan.*

Sec. 4. *1. On or before the first Tuesday in January of each year, but no earlier than December 1 of the preceding year, the Commissioner will make available a preliminary list of the minimum number of health care providers and reasonable maximum travel distance or time, by county, for certain specialties and categories of health care. Interested parties may submit comments concerning the preliminary list to the Commissioner no later than January 20 of the applicable year.*

2. On or before January 31, but no earlier than January 21, of each year, the Commissioner will make available a final list of the minimum number of health care providers and reasonable maximum travel distance or time, by county, for certain specialties and

categories of health care. The final list will be applicable to health benefit plans issued or renewed on or after January 1 of the calendar year after the list is issued.

3. Unless otherwise approved in writing by the Commissioner, the specialties and categories of health care providers referenced in subsections 1 and 2 of this section shall be those specialties and categories of health care that:

(a) Appear as options on the Network Adequacy Template issued and periodically updated by the Centers for Medicare and Medicaid Services; and

(b) Are offered as a certification by:

(1) Member Boards within the American Board of Medical Specialties; or

(2) The American Osteopathic Association.

4. A change to either list of specialties and categories of health care in subsection 3 of this section made after the Commissioner issues the final list of the minimum number of health care providers and maximum travel distance or time pursuant to subsection 2 of this section shall not be reflected until the next following calendar year's list of minimum number of health care providers and maximum travel distance or time is issued.

Sec. 5. *A carrier shall, in conjunction with the annual rate and form filing, collect, compile, evaluate, report and submit sufficient data, in a format as determined by the Commissioner, to the Commissioner to establish that the proposed network plan has the capacity to adequately serve the anticipated number of covered persons in the network plan.*

Sec. 6. *1. A carrier must establish that the carrier has a sufficient number and geographic distribution of essential community providers, where available, within the network plan to ensure reasonable and timely access to a broad range of such essential community*

providers for low-income, medically underserved members in each geographic service area covered by the network plan.

2. For the purposes of subsection 1, a network plan that includes:

(a) At least 30 percent of the available essential community providers in each geographic service area covered by the network plan; and

(b) At least one essential community provider from each category in the following list:

(1) 42 U.S.C. § 256b(a)(4)(A);

(2) 42 U.S.C. § 256b(a)(4)(C);

(3) 42 U.S.C. § 256b(a)(4)(D);

(4) 42 U.S.C. § 256b(a)(4)(I); and

(5) 42 U.S.C. § 256b(a)(4)(L), 42 U.S.C. § 256b(a)(4)(M), 42 U.S.C. § 256b(a)(4)(N), or 42 U.S.C. § 256b(a)(4)(O).

shall be deemed sufficient.

3. For the purposes of meeting the 30 percent inclusion requirement in subsection 2, a carrier may use an essential community provider that does not meet the requirements to be included in any of the categories contained in paragraph (b) of subsection 2 so long as the carrier follows the write-in procedure for essential community providers outlined in the most current "Letter to Issuers in the Federally-facilitated Marketplaces", as issued and updated periodically by CCIIO .

4. For the purposes of satisfying paragraph (b)(4) of subsection 2 of this section, a carrier may utilize a letter of agreement with the applicable essential community provider.

Sec. 7. *1. A carrier who offers a network plan on the Exchange must use its best efforts to establish and maintain arrangements to ensure that American Indians and Alaskan Natives who are members within the network plan have access to health care services and facilities that are part of the Indian Health Service at no greater cost to the member than if the services were obtained from a health care provider that is part of the network plan.*

2. Nothing in this section prohibits a health benefit plan from limiting coverage to those health care services that meet its standards for medical necessity, care management and claim administration or from limiting payment to that amount payable if the health care services were obtained from a health care provider that is part of the network plan.

3. Carriers are not responsible for credentialing health care providers that:

(a) Are part of the Indian Health Service; and

(b) Do not have a contract with the carrier to provide services as part of the carrier's network plan.

Sec. 8. *1. In determining whether a network plan is adequate, the Commissioner may, but is not limited to, consider:*

(a) The relative availability of health care providers in the geographic service area covered by the network plan, including, without limitation, the:

(1). Operating hours, or their equivalent, of available health care providers; and/or

(2). Established patterns of care;

(b) The ability of a carrier to enter into a contract with health care providers within the travel standards provided pursuant to section 4 of this regulation;

(c) The system for the delivery of care to be furnished by the health care providers contracted by a carrier in the network plan;

(d) The availability of telehealth services;

(e) The availability of health care providers located outside of the network plan's geographic service area but within the travel standards provided pursuant to section 4 of this regulation; and

(f). The availability of nonemergency services accessible during normal business hours and medically necessary emergency services accessible at any time.

Sec. 9. ***A carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network plans' health care providers to furnish health care services to covered persons.***

Sec. 10. ***1. A carrier shall update its health care provider directory at least once a month. Any updates to a health care provider directory shall indicate those health care providers which have left the network plan or are no longer accepting new patients.***

2. A carrier with a material change to its network plan shall:

(a) Update its health care provider directory within 3 business days of the effective date of the material change in network plan. Any updates to a health care provider directory resulting from a material change to a network plan shall clearly indicate those health care providers:

(1) That have left the network plan since the health care directory was last updated; and

(2) That are not accepting new patients.

(b) Notify affected covered persons that a material change in network plan has occurred. The notice shall inform covered persons of how they may receive more information regarding the material change in network plan. The notice may be sent via electronic mail in instances where the carrier has received affirmative permission from the covered person to communicate in that manner.

3. The health care provider directory and each update thereto must:

(a) Be posted to the Internet website maintained by the carrier within 72 hours after the update is made. The posting shall be made to a page that is accessible without a username and password or otherwise permits covered persons who are not enrolled in any plan offered by the carrier to view the health care provider directory; and

(b) Be made available in a printed format upon request.

Sec. 11. ***1. A carrier shall notify the Commissioner, within 72 hours of the effective date of a material change in its network plan, of:***

(a) The effective date of the material change in its network plan; and

(b) A description of the cause and impact of the material change in its network plan.

Sec. 12. ***1. If a material change in a carrier's network plan results in a deficiency in its network plan, the carrier shall submit a corrective action plan to resolve the deficiency within 60 days after the effective date of the material change in its network plan.***

2. During the period the corrective action plan submitted pursuant to subsection 1 is being implemented, a carrier shall:

(a) Ensure that a covered person affected by the material change may obtain the covered service from a health care provider:

(1) Within the network plan, at no greater cost to the covered person; or

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

(b) Make other arrangements approved by the Commissioner to ensure that a covered person affected by the material change may obtain service.

3. The provisions of subsection 2 are not applicable if the covered person receives care from a non-participating health care provider without receiving prior authorization from the carrier unless the covered person receives medically necessary emergency services.

Sec. 13. *1. If the network plan is deficient at the end of the time period for the corrective action plan as provided for in section 11 the Commissioner may:*

(a) For a network plan containing a health benefit plan made available for purchase on the Exchange, declare the network plan inadequate pursuant to NRS 687B.490, and the health benefit plan will be declared deficient pursuant to 42 U.S.C. § 18031(c)(1) and subject to decertification pursuant to 45 C.F.R. § 156.290; or

(b) For any other network plan, declare the network plan inadequate pursuant to NRS 687B.490, and the carrier shall submit a statement of network capacity to the Commissioner pursuant to 42 U.S.C. § 300gg-1(c).

Sec. 14. *1. The provisions of sections 6, 7, 8, 12 and 13 of this regulation do not apply to a network plan issued by a carrier that:*

(a) Is licensed pursuant to chapter 680A of NRS;

(b) Had a statewide enrollment of 1,000 covered persons or fewer in the prior calendar year; and

(c) Has an anticipated statewide enrollment of 1,250 covered persons or fewer in the next upcoming calendar year.

2. A network plan meeting the requirements of subsection 1 shall be determined to meet the provisions of NRS 687B.490.

Sec. 15. ***The provisions of this regulation do not apply to:***

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

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

3. A grandfathered plan as defined in NRS 679A.094