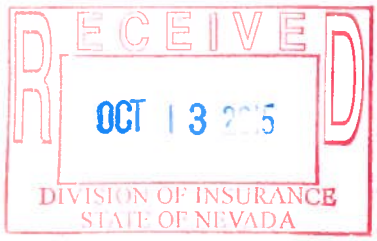

October 12, 2015

Ms. Amy L. Parks, Esq.
Acting Insurance Commissioner
1818 East College Parkway
Suite 103
Carson City, NV 89706

Dear Acting Commissioner Parks:

On behalf of the Nevada Psychiatric Association (NPA), I would like to express my appreciation for the opportunity to provide these comments to the Division of Insurance (DOI) in regard to R049-14 (July 23, 2015 draft). The proposed regulations establish adequacy of network requirements for individual and small employer group plans and impact nearly 216,500 covered lives as of March 31, 2015 (most recent data available from DOI). These comments are in addition to the letter submitted by the Nevada State Medical Association to which the NPA is a co-signer.

Mental illness and substance abuse are frequent in our population. 18.19% of adults in the United States suffer from a mental illness. 8.46% have a substance abuse problem and 3.77 % report serious thoughts of suicide. Nevada is ranked 49th in terms of highest prevalence of mental illness and lowest rates of access to care. Our source for this information is a report entitled *Parity or Disparity: The State of Mental Health in America,* which was published this year by Mental Health America (founded in 1909).

NPA strongly urges the DOI to consider the following two recommendations to help ensure that mental health services provided by psychiatrists are incorporated into the establishment of network adequacy standards.

FEDERAL PARITY LAWS

Treatment of mental illness and substance abuse must be covered as per federal parity laws and carriers must demonstrate that they are doing so. NPA suggests that this requirement is included in two ways. First, add a reference in section 3 of the regulation that the network established and maintained by the carrier must be in accordance with federal parity laws. Second, add a statement to the "Network Adequacy Declaration Document" (Attachment A) that the "Carrier affirms that it will maintain a network that is compliant with federal mental health parity laws."

PSYCHIATRY AS A MEDICAL SPECIALTY

Psychiatry must be considered a medical specialty in the proposed regulation. Psychiatry was listed in the July 15, 2014 draft of the regulation (Attachment B, page 2) and was subsequently removed as a specialty in more recent drafts. In its place, "specialties and categories of health care" are referenced in section 4 of the current draft. According to the network adequacy standards established for the 2015 transitional year and outlined in DOI Bulletin 14-005 (Attachment C, page 6), "mental health" and "substance abuse" are listed. Psychiatry is no longer mentioned. It is unclear how the adequacy of the number of psychiatrists in a network plan will be determined given these categories.

As per section 4(3)(a) of the proposed regulation, psychiatry is a specialty on v1.1 of the "2016 Network Adequacy Template" issued by the Centers for Medicare and Medicaid Services (CMS) in June 2015 (Attachment D). Psychiatry is also offered as a certification by member boards within the American Board of Medical Specialties as per section 4(3)(b) of the proposed regulation. http://www.abms.org/member-boards/specialty-subspecialty-certificates/

Since psychiatry meets both of these requirements, it should be specifically referenced as a specialty specifically subject to network adequacy standards.

Thank-you for your time in considering these recommendations. If you have any questions or need additional information, please do not hesitate to contact me or Jeanette Belz at jb@jkbelz.com or 775-329-0119. NPA looks forward to working with you as these regulations work their way through the approval process.

Sincerely,

Lesley R. Dickson, MD
Executive Director and State Legislative Representative
Nevada Psychiatric Association
(702) 349-5378
Lesleyru@aol.com

Attachment A

Network Adequacy Declaration Document

Nevada Division of Insurance
Network Adequacy Declaration Document
Plan Year 2016

1. Name of this network_____.

2. Name all plan networks your company currently has for individual and small group health benefit plans. Identify if they are for plans sold on or off the exchange. Additionally, explain if any of these networks are subsets of the larger network identified in the above question 1.

3. Provide the names of any "National" or "Rental" Networks that are associated with these plans.

4. Carrier affirms that it will comply with Nevada's Network Adequacy laws, regulations and bulletins.

   *If response is **No,** a justification must be provided. Justifications will be reviewed by the Nevada Division of Insurance on a case-by-case basis in review of this form.*

   ☐ Yes ☐ No

5. Carrier affirms that it will maintain a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay. This includes providers that specialize in mental health and substance abuse services for all plans except dental plans.

   *If response is **No,** a justification must be provided. Justifications will be reviewed by the Nevada Division of Insurance on a case-by-case basis in review of this form.*

   ☐ Yes ☐ No

6. Carrier affirms that network data provided is representative of signed contracts in place, and that all data submitted is accurate and current as of the date of filing.

   *If response is **No**, a justification must be provided. Justifications will be reviewed by the Nevada Division of Insurance on a case-by-case basis in review of this form.*

   ☐ Yes ☐ No

7. Carrier affirms that it will maintain current directory links (i.e. provider and drug formulary) and inform the Division of any changes in the URL within 72 hours.

   *If response is **No**, a justification must be provided. Justifications will be reviewed by the Nevada Division of Insurance on a case-by-case basis in review of this form.*

   ☐ Yes ☐ No

8. Does this network comply with the ECP requirements? For plan year 2016, a network must include at least 30% of the available ECPs in each geographic area covered by the network plan with a least one ECP in each category.

   *If response is **No**, a justification must be provided. Justifications will be reviewed by the Nevada Division of Insurance on a case-by-case basis in review of this form.*

	Yes		No

9. Provide a list of the plans (HIOS Plan ID) that have access to this network.

10. What provision(s) are in place if provider services are not available in-network?

11. Is Telehealth being utilized? If yes, provide a list of Telehealth services.

Signature	Date
Print Name	Title/Position

Email: _____

Telephone# _____

Attachment B

R049-14 – July 15, 2014 Draft

PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R049-14

DRAFT PROPOSED AMENDMENT

July 15, 2014

EXPLANATION – Matter in (1) ***blue bold italics*** is new language in the original regulation; (2) ***green bold italic underlining*** is new language proposed in this amendment; (3) ~~red strikethrough~~ is deleted language in the original regulation; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original regulation that is proposed to be retained in this amendment; and (6) **green bold underlining** is newly added transitory language.

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 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.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 13, inclusive, of this regulation.

Sec. 2. ***1. A carrier who applies to the Commissioner for the issuance of a network plan must establish that the network plan has an adequate number of providers in ~~[each category]~~ certain specialties and categories of health care necessary to serve its members in each geographic service area covered by the network plan.***

2. The ~~[categories]~~ specialties of health care necessary to serve members pursuant to subsection 1 are:

(a) Cardiology;

(b) Dermatology;

(c) ~~[Emergency medicine;~~

~~(d)]~~ Gastroenterology;

~~[(e)]~~ (d) Hematology and oncology;

~~[(f)]~~ (e) Internal medicine, general practice and family practice;

~~[(g) Mental health;~~

~~(h)]~~ (f) Nephrology;

~~[(i)]~~ (g) Obstetrics and gynecology;

~~[(j)]~~ (h) Ophthalmology;

~~[(k)]~~ (i) Orthopedics, including, without limitation, general orthopedic surgery, hand surgery and neurosurgery;

~~[(l)]~~ (j) Otolaryngology;

~~[(m)]~~ (k) Pediatrics, not including pediatric dentistry;

~~[(n)]~~ (l) Except as otherwise provided in subsection ~~[3]~~ 4, pediatric dentistry;

~~[(o)]~~ (m) Psychiatry;

(n) Pulmonology;

~~[(p) Substance abuse;~~

~~(q) Surgery, including, without limitation, general, cardiovascular, cardiothoracic, vascular and colorectal;~~

~~(r) Urgent care;]~~ and

~~[(s)]~~ (o) Urology.

3. The categories of health care necessary to serve members pursuant to subsection 1 are:

(a) Emergency medicine, including, without limitation, access to hospital emergency rooms, trauma care, ground ambulance services and, as appropriate, air ambulance services;

(b) Mental health, including, without limitation, substance abuse services;

(c) Surgery, including, without limitation, general, cardiovascular, cardiothoracic, vascular and colorectal as well as related services such as facilities, anesthesia and radiology; and

(d) Urgent care.

4. If a network plan does not offer coverage for the pediatric dental essential health benefits ~~[coverage]~~ pursuant to 42 U.S.C. § 18022(b)(4)(F), the carrier is not required to establish that the network plan has an adequate number of providers of pediatric dentistry pursuant to paragraph ~~[(n)]~~ (l) of subsection 2.

Sec. 3. *1. A carrier who applies to the Commissioner for the issuance of a network plan must establish that the providers of health care with whom the organization has contracted to provide services within the network plan are located so that the members of the network plan may obtain health care without unreasonable travel. Except as otherwise permitted in section 8 of this regulation, the providers of health care used by the network plan to meet the requirements of this regulation must be located within the applicable geographic service area.*

2. On or before ~~[April 1]~~ January 5, but no earlier than January 1, of each year, the Commissioner will make available a preliminary list of the minimum number of providers and maximum travel distance or time, by county, for each specialty and category of health care necessary to serve members within network plans. Interested parties may submit comments concerning the preliminary list to the Commissioner no later than January 20 of the applicable year.

3. On or before January 30, but no earlier than January 21, of each year, the Commissioner will make available a final list of the minimum number of providers and maximum travel distance or time, by county, for each specialty and category of health care necessary to serve members within network plans. 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.]~~ 4. A carrier shall ensure that nonemergency services are available and accessible during normal business hours and that emergency services are available at any time.

5. As used in this section, "unreasonable travel" means a travel time or distance in excess of the standard promulgated by the Commissioner pursuant to subsection 3 of this section which has not been determined adequate pursuant to section 8 of this regulation.

Sec. 3.5. *A carrier applying for the issuance of a network plan shall submit sufficient data to the Commissioner to establish that the proposed network plan has the capacity to adequately serve the anticipated number of enrollees in the network plan.*

Sec. 4. *1. A carrier who applies to the Commissioner for the issuance of a network plan 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 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]~~ At least ~~[20]~~ 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. As used in this section, "essential community provider" has the meaning ascribed to it in 45 C.F.R. § 156.235(c).

Sec. 5. *1. A carrier who applies to the Commissioner for the issuance of a network plan 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.*

2. A member described in subsection 1 must be able to obtain covered services from the Indian Health Service at no greater cost to the member than if the service were obtained from a provider or facility that is part of the network plan.

3. 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 service were obtained from a provider or facility that is part of the network plan.

4. Carriers are not responsible for credentialing providers and facilities 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. 6. *A carrier ~~[which is a health maintenance organization]~~ issued a certificate of authority pursuant to chapter 695C of NRS that who applies to the Commissioner for the issuance of a network plan must ensure that:*

1. Each member of the network plan has access to his or her primary care physician through on-call procedures after normal business hours;

2. Each provider of health care with whom the ~~[health maintenance organization]~~ carrier has contracted to provide services maintains health care records for the members of the network plan which are accessible, only as required for the diagnosis and treatment of the member, to other professionals within the ~~[health maintenance organization]~~ network plan's contracted network. Nothing in this section shall be construed to impinge upon a provider of health care's responsibility to maintain health care records consistent with all applicable state and federal laws;

3. The ~~[health maintenance organization]~~ carrier provides a health care professional who is primarily responsible for coordinating the overall health care services offered to members of its network plan; and

4. The ~~[health maintenance organization]~~ carrier has established a quality assurance program required pursuant to NAC 695C.400.

Sec. 7. *A carrier who applies to the Commissioner for the issuance of a network plan must establish a system to collect data related to the health care services provided to members of the network plan.*

Sec. 7.5. *A carrier applying for the issuance of a network plan shall submit all required data, in a form to be determined by the Commissioner:*

1. For plans made available for sale to individuals, no later than April 1 of the calendar year immediately preceding the calendar year in which the plan is to be made available for sale.

2. For plans made available for sale to small groups, 60 days prior to the filing of plan rates.

Sec. 8. *1. If a carrier applies to the Commissioner for the issuance of a network plan that meets the requirements of sections 2 to ~~[7]~~ 7.5, inclusive, of this regulation, the network plan is deemed to be adequate.*

2. If a network plan is not deemed to be adequate pursuant to subsection 1, a carrier may request that the Commissioner determine whether the network plan is adequate. To determine whether a network plan is adequate, the Commissioner may consider:

(a) The relative availability of health care providers or facilities in the geographic service area covered by the network plan, including, without limitation, the operating hours of available health care providers or facilities;

(b) The willingness of providers or facilities in the geographic service area covered by the network plan to contract with the carrier under reasonable terms and conditions;

(c) The system for the delivery of care to be furnished by the providers or facilities in the geographic service area covered by the network plan; ~~[and]~~

(d) The clinical safety of the providers or facilities in the geographic service area covered by the network plan ~~[.]~~ ;

(e) The use of telemedicine or telehealth services to supplement or provide an alternative to in-person care; and

(f) The availability of health care providers or facilities located outside of the network plan's geographic service area but within the reasonable travel standards promulgated by the Commissioner pursuant to section 3 of this regulation.

3. The Commissioner will not determine that a network plan is adequate pursuant to subsection 2 if the network plan fails to meet the requirements of section [4 or] 5 of this regulation.

4. The Commissioner may determine that a network plan which fails to meet the requirements of section 2 [or 3] to 4, inclusive, of this regulation is adequate pursuant to subsection 2. If such a network plan is determined to be inadequate, the Commissioner will notify the carrier of the requirements of sections 2 [and 3] to 4, inclusive, of this regulation which the network plan:

(a) Satisfies; and

(b) Does not satisfy.

5. [For each requirement of sections 2 and 3 of this regulation which a carrier has been notified by the Commissioner pursuant to subsection 4 that its network plan does not satisfy, the carrier shall:

(a) Ensure, through referral by the primary care provider or otherwise, that each covered person may obtain covered services 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 or facilities; or

(b) Make other arrangements acceptable to the Commissioner.]

For the purpose of this section, the term "reasonable" includes, but is not limited to, the reimbursement rate requested by the provider or facility in relation to similarly situated providers or facilities within the same geographic service area.

6. For the purpose of this section, the term "clinical safety" means the documented history of consumer complaints and administrative, civil, and criminal complaints filed against the providers or facilities within the geographic service area covered by the network plan with any agency of proper jurisdiction.

Sec. 9. *A carrier whose network plan is deemed or determined to be adequate pursuant to section 8 of this regulation 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.*

Sec. 10. *1. A carrier whose network plan is deemed or determined to be adequate pursuant to section 8 of this regulation shall update its provider directory no less frequently than every 30 days. Any updates to a provider directory shall clearly indicate those providers joining and leaving the network plan's network.*

2. A carrier with a significant change to its network pursuant to section 12 of this regulation shall update its provider directory within 24 hours of the effective date of the significant change in network. Any updates to a provider directory shall clearly indicate those providers joining and leaving the network plan's network.

3. The provider directory and each update thereto must be posted to the Internet website maintained by the carrier and filed with the Division within ~~[24]~~ 72 hours after the update is made in accordance with the System for Electronic Rate and Form Filing developed and implemented by the National Association of Insurance Commissioners.

Sec. 11. ~~*1. Each carrier whose network plan is deemed or determined to be adequate pursuant to section 8 of this regulation shall attest that its network or networks meet the requirements of sections 2 to 13, inclusive, of this regulation:*~~

~~*(a) For a health benefit plan for individuals available for sale during the open enrollment period described in NRS 686B.080, by January 1 of the calendar year in which the coverage is to be effective.*~~

~~*(b) For a health benefit plan for individuals not available for sale during the open enrollment period described in NRS 686B.080, at least 30 days before the health benefit plan is made available for purchase by any individual.*~~

~~*(c) For a health benefit plan for small employers, at least 30 days before the health benefit plan is made available for purchase by any small employer.*~~

~~*2. Each carrier shall renew its attestation on or before January 1 of each subsequent calendar year.*~~

~~*3. The attestation must be made on a form prescribed by the Commissioner and signed by an officer of the carrier issuing the health benefit plan.*~~

~~*4. Each attestation must be accompanied by an Access Plan Cover Sheet Template specified by the Centers for Medicare and Medicaid Services and filed in accordance with the System for Electronic Rate and Form Filing developed and implemented by the National Association of Insurance Commissioners.*~~

Sec. 12. *1. A carrier whose network plan is deemed or determined to be adequate pursuant to section 8 of this regulation shall notify the Commissioner within* *the earlier of:*

(a) ~~*[30]*~~ *3 days after the effective date of any significant change to its network* ~~*[.]*~~ *;or*

(b) 10 days after the date the carrier receives knowledge of any significant change to its network.

2. If a significant change in a carrier's network results in a deficiency in the network, the notification must include a corrective action plan to resolve the deficiency within 60 days of the effective date of the significant change to the network.

3. If a significant change in a carrier's network results in a deficiency in the network with respect to any category of provider or facility, the carrier shall, during the period the corrective action plan is being implemented and with respect to that category of provider or facility:

(a) Ensure through referral by the primary care provider or otherwise that each covered person may obtain the covered service for which there is a deficiency from a provider or facility within reasonable proximity of the covered person at no greater cost share to the covered person than if the service were obtained from network providers or facilities; or

(b) Make other arrangements acceptable to the Commissioner.

4. If the network is still deficient at the end of the time period for the corrective action plan[:

~~(a) For a health benefit plan made available for purchase through the Silver State Health Insurance Exchange, the health benefit plan will be declared deficient pursuant to 42 U.S.C. § 18031(e)(1) and decertified pursuant to 45 C.F.R. § 156.290.~~

~~(b) For any other health benefit plan,]~~ the health benefit plan shall submit a statement of network capacity to the Commissioner pursuant to 42 U.S.C. § 300gg-1(c).

5. As used in this section, "significant change" in a network is any change or combination of changes taking effect within 30 days of each other that affects network capacity in any

single specialty or category of health care necessary to serve members as defined in section 2 of this regulation, by more than 10 percent.

Sec. 13. *1. A carrier whose network plan is deemed or determined to be adequate pursuant to section 8 of this regulation may, upon the approval of the Commissioner, make health benefit plans using that network plan available to persons outside of the approved geographic service area.*

2. A health benefit plan made available outside of the approved geographic service area pursuant to subsection 1:

(a) Must include a disclaimer, the content and placement of which must be approved by the Commissioner, notifying potential enrollees located outside of the approved geographic service area that the network plan may not provide contracted physicians or facilities within the enrollee's approved geographic service area; and

(b) Is subject to all relevant state and federal laws regarding guaranteed availability of coverage.

Sec. 14. *Any carrier submitting a network plan for approval pursuant to paragraph 1 of section 7.5 of this regulation which consists, in whole or in part, of contracts with physicians or facilities whose services have been obtained through an intermediary (often referred to as a "rental network") shall be apportioned a pro-rata share, calculated using anticipated number of covered lives, of the cost of determining the adequacy and/or capacity of all network plans submitted pursuant to that paragraph which also consist, in whole or in part, of contracts with physicians or facilities whose services have been obtained through the same intermediary.*

Sec. 15. *1. The provisions of sections 2 through 14, inclusive, of this regulation do not apply to a network plan issued by an insurer that:*

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

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

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

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

3. A network plan exempt pursuant to subsection 2 that exceeds 1,250 covered lives in any calendar year to which the exemption applies shall submit a statement of network capacity to the Commissioner pursuant to 42 U.S.C. § 300gg-1(c).

Attachment C

DOI Bulletin 14-005

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

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
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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.

SCOTT J. KIPPER
Commissioner of Insurance

DRAFT

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.

Attachment D

Centers for Medicare and Medicaid Services (CMS)

Individual Provider (MD/DO) Specialty Types
2016 Network Adequacy Template
v1.1

Instructions for populating the Specialty/Facility Types without using the drop-down menu

The lists below show the specialty/facility & pharmacy types that can be entered in the Network Adequacy template. Column B shows the available specialty types that can be entered for Individual Provider (MD/DO). Column C shows the available types that can be entered for Facility, Pharmacy, and Other Non-MD/DOs. If you would like to enter more than 1 specialty/facility type for a record, please comma separate each type. For example if you would like to assign 001 General Practice and 002 Family Medicine specialty types to a provider, please enter the the types as "001 General Practice, 002 Family Medicine". Entering multiple specialty/facility types using any other convention will result in a validation error. The same comma separation technique can be used to assign multiple Network IDs to the same provider. For example, an issuer in Virginia with 3 Network IDs could assign network 1 and network 3 to the same provider by entering "VAN001, VAN003".

Individual Provider (MD/DO) Specialty Types	Facility, Pharmacy, and Other Non-MD/DO Specialty Types
001 General Practice	Pharmacy
002 Family Medicine	040 General Acute Care Hospital
003 Internal Medicine	041 Cardiac Surgery Program
004 Geriatrics	042 Cardiac Catheterization Services
005 Primary Care – Physician Assistant	043 Critical Care Services - Intensive Care Units (ICU)
006 Primary Care – Nurse Practitioner	044 Outpatient Dialysis
007 Allergy and Immunology	045 Surgical Services (Ambulatory Surgical Centers and Outpatient Hospital)
008 Cardiovascular Disease	046 Skilled Nursing Facilities
010 Chiropracty	047 Diagnostic Radiology (free-standing; hospital outpatient; ambulatory health facilities with Dx Radiology)
011 Dermatology	048 Mammography
012 Endocrinology	049 Physical Therapy (individual physical therapists providing care in Free-standing; hospital outpatient and ambulatory health care facilities)
013 ENT/Otolaryngology	050 Occupational Therapist
014 Gastroenterology	051 Speech Therapy
015 General Surgery	052 Inpatient Psychiatry (Free-standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital)
016 Gynecology (OB/GYN)	054 Orthotics and Prosthetics
017 Infectious Diseases	055 Home Health
018 Nephrology	056 Durable Medical Equipment
019 Neurology	057 Ambulatory Health Care Facilities - Infusion Therapy/Oncology/Radiology
020 Neurological Surgery	061 Heart Transplant Program
021 Medical Oncology & Surgical Oncology	062 Heart/Lung Transplant Program
022 Radiation Oncology	064 Kidney Transplant Program
023 Ophthalmology	065 Liver Transplant Program
025 Orthopedic Surgery	066 Lung Transplant Program

026 Physical Medicine & Rehabilitation	067 Pancreas Transplant Program
027 Plastic Surgery	000 OTHER
028 Podiatry	
029 Psychiatry	
030 Pulmonology	
031 Rheumatology	
033 Urology	
034 Vascular Surgery	
035 Cardiothoracic Surgery	
101 Pediatrics - Routine/Primary Care	
102 Licensed Clinical Social Workers	
103 Psychology	
000 OTHER	
Dental - General	
Dental - Orthodontist	
Dental - Periodontist	
Dental - Endodontist	

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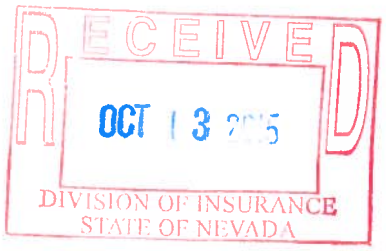

October 13, 2015

Kim Everett
Nevada Division of Insurance
1818 E College Parkway, Suite 103
Carson City, NV 89706

Attention: RO-49-14 – July 23, 2015 version

Dear Ms. Everett:

Thank you for the opportunity to provide comments on the proposed network adequacy regulation. We are pleased to provide the following additional comments to the above pending regulation. We do continue to raise concerns about the proposed definition of material change, provider directory updates, 72 hour notice requirements and requirements to indicate providers who have left a health plan's network.

Section 2, subsection 11: Material Change Definition

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.

The proposed definition of material change does not take into account the different business models under which health plans and providers contract with each other. This proposed definition would be especially problematic for contracts between health plans and hospital corporations or other contracting arrangements with provider groups where the contract is not at the individual provider level. We urge the Division to consider the many types of contracting arrangements and take those into account when defining material change in order to avoid any unintended consequences of applying this provision to large provider systems.

Another area where this definition could be especially problematic is with respect to provider specialties. As we saw with network adequacy reviews this year, the Centers for Medicare and Medicaid Services (CMS) has been including very sub-specialized care, such as Infectious Disease, Rheumatology, Endocrinology, in its network adequacy reviews for Qualified Health Plans (QHP) and sending deficiency notices for some of these highly specialized provider types. Many of these provider specialties will not have a large number of providers in rural areas, if any. They would tend to be located around urban areas and/or medical centers. If they do have some providers in rural areas, the volume may not be significant and so the lack of participation for any one could have a material impact on the participation percentage. If a similar review is

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utilized by the Division, we are concerned that the proposed definition in conjunction with proposed time and distance standards would create a framework where notices of material change would be required in circumstances where the material change is beyond the health plans' control and result in unnecessary notifications and/or apply in circumstances for which this provision is not intended.

Section 4: Time & Distance Standards

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 ~~[30]~~, 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.

We continue to have concerns with this section including the time frame for stakeholder comments and the Division's consideration of comments as well as the issues that may arise in rural areas given the time and distance standards.

With regard to Section 4, subsections 1 & 2, this section indicates that sometime between December 1st and the first Tuesday in January, the Division will issue a preliminary list of the number of providers, time and distance standards. Interested parties then have until January 20th to comment and the Division must issue the final list no later than January 31st. We are concerned that ten (10) days is not enough time for the Division to take all interested party comments into consideration prior to issuance of the final list and this will jeopardize the Division's ability to provide meaningful action and response.

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Section 10: Provider Directories

Sec. 10. *1. A carrier shall update its health care provider directory at least once a month. Updates [Any updates] to a health care provider directory shall indicate those health care providers which have left the network plan or are no longer [have joined the network plan since the directory was last updated and those health care providers that are not] accepting new patients. A carrier is not responsible for failing to update its health care provider directory each month with information that providers are contractually obligated to provide but fail to provide to the carrier.*

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

(a) Update its health care provider directory within 3 business days [72 hours] 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 joined the network plan since the health care directory was last updated;(2)] That have left the network plan since the health care directory was last updated; and

(2) [(3)] 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 3 business days [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.

We appreciate the removal of the requirement for health plans to indicate when a provider has joined the network as this would create administrative challenges and be burdensome to manage this information.

We remain equally concerned with the proposed requirement that provider directories indicate when a provider has left the network. The requirement that health plans "clearly indicate" providers that have left the network plan since the last directory update not only requires health plans to manage information on providers with whom they no longer have any contractual agreements, it also presents information to consumers which may be misleading.

Additionally, since the information must be indicated for providers that have left the network since the last update of the directory, the information will require additional resources and management, as well as require funding for system build-outs and implementation. Providers leave health plan networks for a variety of reasons including circumstances beyond health plans' control such as disciplinary action,

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retirement, change in location, death, etc. Providers may also leave a health plan's network and rejoin the network at a later time. There are even situations when the participation status is disrupted for a minimal period of time, often due to protracted contract negotiations. We urge the Division to remove this requirement for the above stated reasons.

Additionally, given our concerns with the definition of material change and how frequently that provision may be triggered if the Division does not take into consideration contractual business models, we also have concerns with the requirement to notify members of a material change within 3 business days. The frequency in which the requirement to notify members is triggered will create a lot of unnecessary communication from health plans to members. Additionally, the requirement does not afford the opportunity for the requisite internal work to produce such a notification, including, but not limited to, membership extract reports for targeted mailings, notification draft and review, coordination with any external vendors that may be used for such a mailing, etc.

We also have concerns with the requirement to update provider directories within 3 business days of the effective date of the material change in the network plan. We suggest that provider updates be made within seven (7) business days of the effective date of the material change.

We appreciate the opportunity to continue to provide our perspective on this regulation. If you have any questions, please feel free to contact me at (775) 827-0880 or via email at Tracey.Woods@Anthem.com.

Sincerely,

Tracey Woods
Government Relations Director, Sr.
Anthem, Inc.

are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message and any attachment thereto.

Nevada Patient Access Coalition
702-371-5577

October 13, 2015

The Honorable Amy L. Parks, Acting Commissioner
Nevada Division of Insurance
Office of the Commissioner
1818 E. College Parkway
Carson City, NV 89706

Comments sent by e-mail to: insinfo@doi.nv.gov and sletourneau@doi.nv.gov

Re: Proposed Regulation for LCB File NO. R049-14: Network Adequacy

Acting Commissioner Parks:

The Nevada Patient Access Coalition is concerned that the proposed regulation does not address the needs of people who live in rural Nevada or those who require specialized care. The proposed regulations do not define reasonable or maximum travel. As written, it is possible that one may have health coverage but, in practical terms because of the time and/or distance involved, no access to care.

The Nevada Patient Access Coalition is very supportive that the proposed regulations mandate that the health care provider directory be posted to an internet website accessible to the general public. This provides transparency so that those who are not part of the plan are able to view the health care provider directory (Section 9.3). We ask that this portion of the proposed regulation remain as written.

In conclusion, the Nevada Patient Access Coalition has concerns regarding the access to care for those in rural areas or those in need of specialized care. Thank you very much for the opportunity to express our viewpoint.

Sincerely,
Nevada Patient Access Coalition Members:

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

America's Health Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org

May 12, 2014

Mr. Adam Plain,
Insurance Regulation Liaison
Nevada Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, NV 89706

Re: Network Adequacy Proposed Rules

Dear Mr. Plain,

I write today on behalf of America's Health Insurance Plans (AHIP) to provide comments in response to the proposed regulations issued by the Nevada Division of Insurance (Division) on network adequacy.

AHIP is the national trade association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs. Health plans have been committed to providing consumers with affordable products that offer robust networks of quality, cost-efficient providers.

First, we would like to raise our concerns regarding this rulemaking process. We have always respected and shared a good relationship with the Division, and we are disheartened that the network adequacy rulemaking process is not being undertaken in the same open and collaborative manner as in the past. It was our understanding that after commenting on the network adequacy issue brief, there would be stakeholder meetings prior to the introduction of proposed rules. We received very short notice about the listening sessions held two weeks ago and received no notice that proposed rules were being published. We continue to hope that for a collaborative stakeholder discussion with the Division as we move through this important rulemaking effort. With this in mind, we offer the following additional comments.

The Affordable Care Act (ACA) Exchange Rule *(45 C.F.R. § 156.230(a)(2))* established network adequacy requirements for qualified health plans (QHPs) and in April 2013, the Nevada health benefit exchange (Exchange) board approved network adequacy standards for QHPs that meet the federal ACA requirements. [1] Stakeholders including AHIP and members were heavily

[1] Network Adequacy Standards Approved by the Silver State Health Insurance Exchange Board. April 24, 2013. Available at: http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Meetings/04A%20-%20Final%20Exchange%20Network%20Adequacy%20Standards.pdf

involved in the development of the Nevada Exchange standards for QHPs and were assured that pending network adequacy rules developed by the Division would be similar to the Exchange network adequacy requirements, which they are not, which can create unnecessary challenges for health plans and confusion for consumers During the Exchange network adequacy standards discussion it was agreed at that time that applying similar standards both inside and outside the Exchange would provide a level-playing field and common understanding for providers, health plans and patient advocates of what standards were applied.

In addition, specific network adequacy standards are required in order to meet National Committee for Quality Assurance (NCQA) and URAC accreditation for health plans both inside and outside of exchanges. With these existing structures in place, we urge the Division to utilize the existing state and federal standards for network adequacy rather than creating unnecessary new or potentially conflicting requirements.

Nevada faces a number of challenges related to the rural environment in large portions of the state, which is reflected in the CMS designation of ten of Nevada's 17 counties as "counties with extreme access considerations." Compounded by the severe shortage of providers in many areas of the state, it is imperative that the state find new network access solutions without returning to outdated methods like travel and wait times and number of providers per person. Requiring carriers to contract with providers solely due to their proximity to enrollees threatens higher costs for consumers as providers can demand high reimbursement rates if they are one of the few providers in a geographic area. These old approaches do not provide high quality, high value care for consumers and will not resolve the access issues in Nevada.

Health plans have, and continue to take, a leadership role in addressing gaps in provider networks and also gaps in quality of care. We encourage the Division to consider in their network standards some of the efforts undertaken by health plans regarding delivery system reforms and new alternative provider payment models including telemedicine, patient centered medical homes, accountable care organizations (ACOs), "Centers of Excellence", and single case reimbursement of providers to help fill these gaps in coverage. These innovative alternatives can be applied to various plan structures and various consumer needs, whether urban or rural and are more cost effective than requiring plans to contract with every provider in an area – some of whom may not meet the plan's credentialing or quality standards.

AHIP is concerned that these rules intend to have the Division publish minimum number of providers and travel and distance requirements every year by April 1. Building provider networks is a lengthy and arduous process that involves months of planning and negotiations. With filings being due shortly after April 1 every year, it does not leave enough time for carriers to adjust to any new requirements published by the Division. We strongly urge the Division to set minimum requirements in regulation without annual adjustments so that carriers can develop meaningful, quality networks based around the established regulatory requirements.

These proposed rules require carriers to allow for covered services to be provided to an enrollee by a non-contracted provider when a provider is not available in network. And the provision of such services must not cost the enrollee more than if services were provided in network. This approach sets an expectation that may lead to payment via billed charges for arrangements made with non-contracted providers. This has significant harmful implications for health carriers in the provider contracting process. It may inadvertently lead certain providers to not contract if they believe that they can obtain billed charges for such services by remaining non-contracted. This works against stable access in the network and also will lead to higher health care costs and premiums.

AHIP believes that any new network adequacy requirements should not be more extensive than are currently required by state, federal, and private sector standards that are already providing sufficient network adequacy protections for consumers. Standards related to Essential Community Providers (ECPs) are a category of providers established for QHPs offered under the Exchange and should not be broadly applied throughout the market. AHIP recommends that compliance for ECPs align with CMS's final Issuer Letter[2] to minimize confusion of the ECP contracting and availability standards and reduce the burden of tracking each type of ECP that would have a different contracting standard. In addition, we request that these rules specify that these provisions require a carrier to make a good faith effort to contract with the ECPs in each service area.

While we appreciate and support the need for patients to have access to their providers, we oppose requiring a health carrier to ensure that a member has access to their primary care provider after normal business hours. In most practices, a health care provider enlists a telephone service to assist in triaging after hours care or may instruct patients to seek emergent care at the nearest emergency facility. Carriers are not privy to the scheduling practices of providers or their availability and suggest that the availability standard be changed so that a carrier must provide a member access to a primary care provider through on call procedures, but not necessarily their own personal primary care provider.

Under section 7, these rules require health carriers to collect data related to the health care services provided to members. However, health carriers are not necessarily aware of the services provided to enrollees. Health carriers receive reimbursement and diagnostic codes through the claims process which do not include complete clinical data that would be contained in an electronic medical record. We are uncertain as to the value of collection of claims data and do not believe that network adequacy regulations are the appropriate venue for this type of data

[2] "2015 Letter to Issuers in the Federally-facilitated Marketplaces (FFM)." CMS. 14 March 2014. Available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf

collection activity. This type of data may be better collected from the hospitals and providers actually providing the health care services. This is a much broader discussion that should be arranged with a broad range of stakeholders and removed from these rules.

Finally, we believe these rules should not apply to dental, supplemental, or other HIPAA-excepted benefits insurers. It is important to clarify that these network adequacy requirements apply only to comprehensive, major medical plans. To the extent that the Division desires to construct network adequacy standards for stand-alone pediatric dental plans being offered as part of the essential health benefits package, the Division should begin discussions with stakeholders to construct a common sense approach to dental access.

Health plans have been creating new and innovative provider service models that are changing the way health care is delivered while improving the provider network landscape. Network adequacy requirements should provide flexibility for health care plans to build innovative, high-quality, high-value networks that meet the needs of the population served by the health care plan. Health plan innovations such as telemedicine, increased utilization of urgent care centers instead of emergency rooms, and value-based purchasing all necessitate flexibility when looking at how an adequate network is determined. Organizations such as NCQA and URAC understand how these, and other innovative network designs are beneficial to consumers and are working with health plans to have their network adequacy metrics account for these new service delivery models. The Division should consider these new models as an important part of network development and network adequacy standards. Strict network adequacy requirements that limit the ability for health plans to innovate and adapt to the needs of the consumers in the future will only harm consumers.

Establishing high-value provider networks is one way health plans can help preserve benefits and mitigate the cost impact on beneficiaries as health care reform brings new benefits, but also new costs. Health plans contract with hospitals and physicians that have met standards to ensure that patients have access to high-quality and effective care. By developing networks of doctors and hospitals that provide cost-effective **and** high-quality care, health plans are helping to ensure consumers receive the best value for their health care dollars. Health plans also use tiered networks of providers and facilities based on specific performance metrics including cost efficiency and measures of quality. Tiered networks provide cost saving benefits for consumers to utilize the higher-performing tiers and incentivize providers to improve their performance.

As a result of the high-value provider networks health plans have implemented, premiums in the new Exchanges are lower than they would be without these network changes. According to the U.S. Department of Health and Human Services (HHS), individuals purchasing coverage in the new Exchanges will have "significant choice and lower than expected premiums." A recent McKinsey analysis shows that policies with high-value networks resulted in premiums that were

26 percent lower than comparable options with broader networks.[3] Additionally, a recent Kaiser Family Foundation poll found that most people who purchase their own insurance favor narrow networks with lower costs.[4] We are including with these comments a copy of the AHIP Issue Brief on Value-Based Provider Networks which includes additional data on how innovation is being used in the composition of provider networks to not only meet consumer needs, but to improve quality and lower costs.

In addition to the general comments above, we also request that the proposed rule language be amended to allow carriers 45 days to update their provider directory. This will help ensure that updates are as accurate and as timely as they can be, thus providing the most value to enrollees. Alternately, we propose that a SERFF filing only be required if there is a significant change to the provider network. Further, we request these rules allow health insurers to post what information they may get from providers, with the full acknowledgement that some information may be missing if the provider does not report that information to the health plan.

AHIP will continue to work to promote and provide a transparent, value-based health care system. Collaboration with the Division, health care providers, and other stakeholders is critical to the overall goal of achieving an affordable and broad choice of health care options to Nevadans. We appreciate the opportunity to provide comments and look forward to continued discussions with you on this important issue. . If you have any questions, please do not hesitate to contact me at gcampbell@ahip.org (**425-223-5686**).

Sincerely,

Grace Campbell

Grace Campbell
Regional Director

Enclosure

[3]McKinsey Center for U.S. Health System Reform/McKinsey Advanced Healthcare Analytics analysis of publicly available rate filings and carrier information; AHA database
[4] Kaiser Family Foundation. *Health Tracking Poll: February 2014.* Available at http://kaiserfamilyfoundation.files.wordpress.com/2014/02/8555-t-wo-hni-qs.pdf.

Dignity Health.
St. Rose Dominican

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June 26, 2014

Insurance Commissioner Scott Kipper
Nevada Division of Insurance
1818 E. College Pkwy., Suite 103
Carson City, NV 89706

Re: Network Adequacy Definition; LCB File No. R049-14

Dear Mr. Kipper:

On behalf of our three hospitals in Nevada, Dignity Health-St. Rose Dominican appreciates the opportunity to submit comments on the proposed network adequacy recommendations. As the nation's fifth-largest health system, Dignity Health is committed to our mission of providing compassionate, high-quality care to all and strongly supports a system of health care that includes choice, proximity and timely access to services. Dignity Health believes there should be a minimum standard for these provisions and that at no time should a health insurance plan be so narrow that it doesn't meet the minimum requirements.

Along with choice, proximity and timely access to health care services, Dignity Health-St. Rose Dominican believes the network adequacy definition should include these three principles:

1) Education of the Consumer – In order for consumer to properly purchase the best health insurance plan for their needs, payers need to provide sufficient information about the plan and the composition of the provider network in order for the consumer to make an educated choice. Health insurance companies should meet a minimum standard for documentation of details related to the plan so that consumers will know what exactly they're purchasing, which providers are in the network and examples of coverage when it comes to in-network and out-of-network coverage.

2) Protection of the Consumer in Emergent Situations – According to EMTALA, all hospitals are required to treat patients during an emergent crisis, whether their services are covered or not by a consumer's health plan. Both the Affordable Care Act (ACA) and state law require health plans to cover emergent care through stabilization, but many times the financial burden of the post-stabilization care is passed onto the consumer by the health insurance companies when attempts are made to transfer the patient to their covered provider and it doesn't happen. This continues to happen despite the fact that many patients don't have a choice in choosing a hospital in an emergent situation. Protecting the consumer from financial burden when seeking emergent care as

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a prudent person should be covered under all health plans.

3) Limitations of Network Changes – The network adequacy definition should also forbid health insurance companies from making severe changes to networks after the open enrollment period has ended. Changes to networks, including the narrowing of networks, creates confusion for consumers, especially those with chronic conditions that rely on their health coverage more than the average consumer, along with higher out-of-pocket costs.

While Dignity Health-St. Rose Dominican fully supports the effort to create the network adequacy definition, we have specific concerns. There are two specific items we would like to add to this proposal:

1) Primary Care Focus – To develop effective partnerships between providers and health plans, comprehensive primary care networks must be in place in order to build alternative network models which promote quality and cost efficiencies. Requirements related to primary care, which includes internal medicine, general practice and family practice are mentioned in section 2(f), but access standards and capacity requirements should be developed to monitor plan compliance. Based on models elsewhere, including California, we are recommending a set of standards which address the following with the suggested metrics:

    a. One (1) primary care physician per 2000 commercial enrollees
    b. One (1) physician, including specialists, per 1200 enrollees
    c. One (1) full time physician extender (physicians assistants and nurse practitioners) per 1000 enrollees
    d. Radius for primary care physicians to member residence should be no further than 10 miles or 30 minutes
    e. Minimum number of physician panels that must be open to new patents.

2) Electronic Health Records –Section 6(2) addresses the maintenance of health records and Section 7 mentions patient data. We believe that any new regulation should encourage the development and implementation of the electronic health record (EHR). This focus supports the ACA and enables health plans and providers to fully coordinate a patient's care across the continuum.

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Dignity Health-St. Rose Dominican appreciates the opportunity to respond to the network adequacy recommendations and hopes our input is helpful as your office proceeds further. If you have any questions, please feel free to contact Katie Ryan, Director of Communications and Public Policy at (702) 616-4847 or at katie.ryan@dignityhealth.org.

Sincerely,

Lisa Farnan
Dignity Health, Nevada Market
Vice President, Managed Care

Katie Ryan
Dignity Health-St. Rose Dominican
Director, Communications and Public Policy

Ferrari
PUBLIC AFFAIRS

July 1, 2014

Department of Business & Industry
Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, NV 89706
Attn: Commissioner Scott Kipper

Dear Commissioner Kipper:

On behalf of our client, DaVita, we appreciate the opportunity to provide comment on LCB File No. R049-14.

In order to remain consistent in advocacy on behalf of DaVita's more than 2,169 patients across twenty-five (25) centers in Nevada, we are hereby re-submitting the comments we submitted to Mr. Adam Plain of the Division on February 28, 2014 following the Division's request for input on Network Adequacy.

End Stage Renal Disease (ESRD) or kidney failure, is the last stage (stage five) of chronic kidney disease (CKD). This stage is reached when an individual's kidneys stop fully functioning and, therefore, cannot sustain life. When one's kidneys fail, a kidney transplant or regular dialysis treatment, performed in-center at least three times per week for about four hours per session is required to sustain life.

It is for this critical reason, that our client has been consistent in requesting clear network adequacy criteria specific to ESRD and further defining "unreasonable delay" in terms of geographic distance or average drive time maximums.

We are requesting drive times in Nevada's metro areas of no more than 30 miles or 30 minutes, and in rural areas, we are urging the Division to work with ESRD patients and providers to establish standards to ensure reasonable patient access to the life-sustaining dialysis treatments provided by our client.

Thank you for your attention to this important matter.

Chris Ferrari, President

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DaVita | HealthCare Partners

February 28, 2014

Nevada Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, NV 89706
Attn: Adam Plain, CPCU AIE AFSB AIAF API ARC ARE
Insurance Regulation Liaison

Dear Mr. Plain:

DaVita appreciates the opportunity to provide comments to the Nevada Division of Insurance's (DOI) Issue Brief on Network Adequacy and Solicitation of Comments. The concerns expressed in this comment letter relate to the following section of the proposed issue brief: "narrow" networks.

Background

The DaVita patient population includes more than 163,000 patients who have been diagnosed with end-stage renal disease (ESRD), a group representing approximately one-third of all Americans receiving dialysis services. Spanning 44 States and the District of Columbia, the DaVita network includes more than 2,074 locations. DaVita's nationwide network is staffed by 46,000 teammates (employees). DaVita has the privilege of providing dialysis treatment for over 2,169 individuals with kidney failure throughout our twenty-five (25) centers across Nevada. Our comprehensive, in-center care team includes nephrologists, nephrology nurses, patient care technicians, pharmacists, clinical researchers, dieticians, social workers, and other highly-trained kidney care specialists.

ESRD, or kidney failure, is the last stage (stage five) of chronic kidney disease (CKD). This stage is reached when an individual's kidneys stop fully functioning and, therefore, cannot sustain life. When one's kidneys fail that individual requires either a transplant or regular dialysis treatment; traditional in-center dialysis is generally performed at least three times a week for about four hours each session.

It is for these reasons that DaVita, in its response to the federal Essential Health Benefits (EHB) Rule[1], suggested additional language in that rule to protect individuals with ESRD, particularly in light of certain statutory and regulatory prohibitions of benefit designs that result in discrimination against individuals with significant or high cost health care needs.[2] We note that in our review of EHB base-benchmark plans, dialysis is a covered service in *every* plan. We believe such uniform coverage is appropriate, although not surprising, given that dialysis is life-sustaining and truly an "essential" health benefit. As such, we believe the provision of inadequate dialysis coverage by a QHP due to an inadequate network would be inconsistent with EHB regulations and would put ESRD patients at risk. We believe that additional federal and state regulatory mechanisms are necessary in order to enforce existing network adequacy and anti-discrimination statutory requirements under the Affordable Care Act (ACA).

"Narrow" Networks

The DOI Issue Brief notes that a "narrow" network means "either a network of medical providers that offers a limited selection of physicians and facilities or one in which the geographic diversity of physicians and facilities is limited." The Issue Brief indicates that the DOI is struggling to balance the lower premiums inherent in such "narrow networks" with the legitimate concerns that such plans could disadvantage consumers. The DOI also notes the ACA requires qualified health plans to have networks adequate within a defined geographic service area and that this requirement is extended to all health plans in Nevada Revised Statute 687B.490.[3]

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[1] *77 FR 70644 (November 26, 2012)*

[2] *See, for example, 45 C.F.R. § 156.225*

[3] *See 45 C.F.R. § 156.225 which provides that QHP issuers must maintain "a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."*

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DaVita | HealthCare Partners

DOI's solicitation relates to the following issues:

- The appropriateness of narrow networks, generally; and
- The appropriateness of limiting narrow networks to ensure an appropriate amount of accessibility in the various defined geographic service areas.

We believe "narrow" networks are inappropriate for ESRD patients generally and that guaranteeing network adequacy is a particularly important issue for individuals with ESRD as an individual's life depends on their ability to access dialysis treatment a minimum of three times each week. Peer-reviewed studies have shown that longer travel time for ESRD patients is associated significantly with greater mortality risk and decreased quality-of-life.[4] Essentially, the longer the drive time to obtain a thrice-weekly dialysis treatment, the greater the chance of that individual missing a treatment, which could ultimately result in an unneeded trip to the emergency room. Regardless of their choice of health plan, ESRD patients should have access to care in a manner that does not negatively impact their health or their ability to stay employed, or increase the burden on their loved ones who often provide transportation to and from a treatment center. As a result, access to care in close proximity to their home or workplace is essential.

The appropriateness of limiting narrow networks to ensure an appropriate amount of accessibility in various defined geographic service areas begs the question of what is "appropriate". We understand the Division is not currently soliciting comments on specific standards to be used in determining adequacy of provider networks, such as physician count, travel time, or wait time. However, we do not know what other metrics would serve as reasonable metrics to determine "appropriateness" in the case of ESRD patients. Indeed, we note that the Center for Consumer Information and Insurance Oversight (CCIIO) recently issued a proposed 2015 Letter to Issuers on Federally-Facilitated Marketplace in which it specifically contemplates using information gathered through collected providers lists "to assist in its articulation of time and distance or other standards for FFM QHP networks that CCIIO intends to reflect in future rulemaking" and to "share its network adequacy findings with states."

Therefore, consistent with our previous comments to the Silver State Health Insurance Exchange (SSHIX) on this topic, continue to encourage the establishment of criteria to establish clear network adequacy criteria specific to ESRD and further defining "unreasonable delay" in terms of geographic distance or average drive time maximums. ***In metropolitan areas such as Reno and Las Vegas, we believe a requirement that ESRD patients drive more than 30 miles or endure more than a 30 minute drive from the patient's home should be considered "adequate." For ESRD patients living in more rural areas of Nevada, we urge the Nevada Division of Insurance to work with ESRD patients and dialysis providers to establish specific network adequacy requirements for the provision of care to ESRD patients.*** We believe these requirements will help to ensure ESRD patients have sufficient access to dialysis providers in Nevada.

We appreciate the opportunity to share DaVita's comments and recommendations with you. Please do not hesitate to contact me if you would like to discuss these recommendations in detail or have any questions.

Sincerely,

Jeremy Van Haselen
Vice President, State Government Affairs
DaVita HealthCare Partners
e-mail: jeremy.vanhaselen@davita.com

[4] *Moist, L. et al. (2008).* Travel Time to Dialysis as a Predictor of Health-Related Quality of Life, Adherence, and Mortality: The Dialysis Outcomes and Practice Patterns Study (DOPPS), *American Journal of Kidney Diseases, Vol. 51, No 4, pp. 641-650.*

TESTIMONY BY DWIGHT HANSEN, DIRECTOR OF FINANCIAL SERVICES
NEVADA HOSPITAL ASSOCIATION

BEFORE THE
NEVADA DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE

Public Workshop to Consider Proposed Regulations
LCB File No. R049-14 concerning Network Adequacy
July 1, 2014

Please accept the following testimony on behalf of the Nevada Hospital Association (NHA), which represents the acute care, psychiatric and rehabilitation hospitals in Nevada. NHA appreciates the opportunity to express our comments related to network adequacy and specifically to LCB File No.R049-14.

With the goal of ensuring the consumer is adequately protected and/or educated relative to health insurance products or health benefit plans they may purchase, NHA believes:

- The Division of Insurance should pursue development of a universal adequacy of network definition that takes into consideration the need for the insured or covered individual to have choice, proximity and timely access to health care services.

- This minimum standard definition should apply to all products governed by the Nevada Division of Insurance.

- All variations of health insurance products or health benefit plans that result in greater or fewer numbers of providers to be included in its contracted network will drive the premium and/or structure of the product or plan being sold.

- Those differences (such as PPO vs. HMO or all-inclusive vs. narrow networks) are business decisions for the payers and coverage options for those buying coverage.

However, any product or plan variations should at no time allow for a network that does not meet the MINIMUM STANDARD for network adequacy.

- Specific standards to determine adequacy of network should also include physician count, travel time and distance, wait time, and availability of in-network providers accepting new patients.

- The adequacy of network determination should include a biannual review/audit of the established network standards, a dispute resolution process for addressing complaints related to network standards, and an annual patient satisfaction survey that each product/plan will provide to their enrollees and is administered by a third party.

In order to protect those purchasing coverage, payers must provide adequate disclosure and education so that the member understands the financial implication of the product prior to purchase.

- The payer should be required to document (for each individual/family plan purchaser and subsequently to all enrollees in an employer plan prior to the effective date of the coverage) that they have disclosed both the details of the plan design as well as which providers/facilities are included in the network associated with the product being purchased.

- Comparable real-life examples showing the financial impact to the member related to use of in-network vs. out-of-network services should be provided, for both an emergent and non-emergent situation.

- While information disclosure is reasonable for elective, planned and/or non-emergent services, as Nevada lawmakers have already determined in current Nevada Revised

Statute (NRS 695G.170), the payer must protect the member/patient from significant financial risk when the patient seeks emergent care as a prudent person.

- The payer must either contract for those services with the potential providers of emergency services or, in the case where there is no contract, pay the bill less any in-network deductible and/or coinsurance for which the patient is responsible.

NHA also recommends that the Division establish limitations on network changes so that significant network reductions do not occur after the annual open enrollment period or during the plan year.

- When plans reduce their networks during or after the enrollee selection period, it causes great confusion for the enrollee and the provider.
- For those with chronic conditions, losing in-network providers can seriously impact their care plans and continuity of care. This can ultimately result in greater out-of-pocket expense at the point of service and can cause hardship for enrollees.

Additional considerations for rural communities:

- Consideration should be given to both physicians and midlevel providers (i.e., APNs, PAs, CRNAs, midwives, etc.) along with access to primary and specialty care either in person and/or via telemedicine visits when determining if specific network adequacy standards are met.

- In addition, as it relates to services provided by a hospital, sole community providers should be part of any network adequacy minimum standard.

- Adequate networks in rural areas will include referrals made based on established community patterns of care which will include referrals to intra- and inter-state providers and facilities.

- For services that are covered benefits, telemedicine must be included as an option as a vehicle to receive healthcare services if medically appropriate and the patient wants to receive the service using telemedicine technology.

- Given the significant distances between providers in rural Nevada, an adequate network should include air and ground transportation, as medically necessary, as a covered benefit.

We appreciate and support that the Division is attempting to define network adequacy and look forward to working with you in the future to refine not only the structure of network adequacy but also the development of the specific standards.

As related directly to LCB File No. R049-14, we have some specific comments as follows:

- Section 2, Subsection 2 – There needs to be a reference to ambulance and air ambulance which are very important in delivering adequate healthcare in rural areas.
- Section 3, Subsection 2 – The geographic region rather than by county should be used in the criteria. In addition, prior to the Commissioner issuing an annual list, there should be clarification as to whether the criteria used to establish the list was included in the public hearing/workshop process.
- Section 3, Subsection 3 – This standard has to be evaluated in correspondence with the requirements of Section 3, Subsection 2 so that ED services are available at any time "within the maximum travel distance or time."
- Section 8, Subsection 2b – What is the resolution process if the parties involved have different definitions of "reasonable terms and conditions"?

- Section 12 – The term "significant" should be defined for the purpose of determining whether "any significant change" has occurred within the network.
- Section 13 – Section 13 appears to contradict the objective of defining adequacy of network if a plan could be made "available to persons outside of the approved service area."
- Other comments:
    - The proposed regulation does not appear to address the education of the members as well as the financial impact of using non-network providers.
    - For other specific details, please refer to our comments previously submitted on February 28, 2014.

In closing, NHA appreciates the opportunity to participate in the important work of developing network adequacy standards. At this time, I would be happy to answer any questions.

July 1, 2014

Nevada Division of Insurance
1818 East College Parkway
Suite 103
Carson City, NV 89706

RE: LCB File No. R049-14

The Nevada State Medical Association (NSMA) submits these comments regarding the proposed regulation titled LCB File No. R049-14, relating to adequacy of network plans.

Page 2, Section 2, Paragraph 2, lists the 'categories of health care' which must be provided in a network. Although surgery is included on the list, anesthesiology and radiology are not. Similarly, pediatric dentistry is listed for inclusion but dentistry is not. Further, although treatment of 'mental health' and 'substance abuse' are listed, the medical specialty of psychiatry is not. Also absent and important is neurology. All of these specialties should be included in mandatory coverage.

Page 3, Section 3, Paragraph 2 states that the Commissioner will annually, by April 1, make available a list of the minimum number of providers and the maximum travel distance or time, by county, for each "category of health care necessary to serve members within network plans." The February 7, 2014 solicitation of comments from the Commissioner specifically directed that the Division "is not currently soliciting comments on specific standards to be used in determining adequacy of provider networks, such as physician count, travel time, or wait time." Will there be an opportunity for public input regarding the list prior to its release each April? Also, will the public be able to comment regarding how 'unreasonable travel' is defined as it relates to Section 3, Paragraph 1?

The NSMA strongly believes in the rights of patients to choose their healthcare providers and to have some autonomy over the manner in which such care is provided. Emerging technologies in telemedicine will continue to provide greater access for patients and a new avenue through which such care may be delivered; however, the NSMA would like to preserve the existing rights of patients who continue to choose delivery through a traditional, in-person visit with a

provider of healthcare. Accordingly, we have concerns about the ability of carriers to demonstrate network adequacy through telemedicine unless a carrier can show that similar services may not be obtained through reasonable means of traditional healthcare delivery within the geographic location of the patient. The Commissioner may also want to consider adding a provision which affirmatively establishes the right of a patient to have a covered service provided through an in-person visit with a provider of health care. Also relating to telemedicine, any provider who contracts with a carrier to provide treatment to a patient should be required to hold the pertinent Nevada license by the appropriate licensing Board. This would certainly not apply to cases where telemedicine is used purely as consultation and not as directing medical treatment.

Page 5, Section 8, states "If a carrier applies to the Commissioner for the issuance of a network plan that meets the requirements of sections 2 to 7, inclusive, of this regulation, the network plan is deemed to be adequate." Page 7, Section 11 further provides that each carrier's 'attestation' must be made on a form prescribed by the Commissioner. What type of documentation or proof of network adequacy will be required of a carrier in support of the attestation? Will there be a periodic audit by the Division of each carrier's application? Since the beginning of this year, when the Affordable Care Act became effective, narrow networks appear to be becoming the norm. As Nevada's insurance regulator, the Insurance Commissioner has a responsibility to proactively regulate network adequacy.

The NSMA continues to have concerns regarding the narrowing of provider panels by insurers as a cost reduction measure. Nevada presently has a severe shortage of both primary care physicians and specialists, which at times makes it difficult for patients to access appropriate care. Further arbitrary limitation by insurers will restrict access to care at a time when the implementation of the ACA will be ushering increased numbers of patients into the system. It is becoming too common an occurrence that physicians are turned away and forced 'out-of-network,' restricting patient choice to a small group of providers who ultimately are qualified to provide services but are not always able to handle the increased patient load. In combination with the changing insurance landscape, narrow provider panels may also disrupt the continuity of care and the physician-patient relationship, particularly for the those with chronic conditions or those in remote and frontier locations within Nevada.

Page 7, Section 11, Paragraphs 2 and 3 provide for carriers to notify the Commissioner within 30 days of any 'significant changes' to its network. How is a significant change defined? Specifically relating to preferred provider organizations (PPOs), over the last five years it is becoming increasingly frequent practice for a contracted discount agreed to by a physician(s) to be 'resold' by the contracted insurer to other 'downstream' PPOs and other entities. Physicians are expected to honor discounts for companies with whom they never personally contracted.

Further, physicians will also see an increased patient volume for which they may be not adequately prepared. Are these the types of significant changes which would require notice to the Division, and subsequently to providers? These changes are significant to physicians both from a workload and a financial perspective, and seem ripe for additional transparency.

Page 6, Section 10, addresses provider directory updates. Paragraph 1 requires carriers to update their provider directory at least every 30 days; however, Paragraph 2 stipulates that each update to a provider directory must be posted to the website of the carrier within 24 hours after the update is filed with the Division. From the patient's perspective, being able to access a provider directory is the only way to be certain that a provider is within their plan coverage. As a transparency issue, updating provider directories more frequently than every 30 days would increase patient opportunity to be treated by an in-network provider. Also, what provisions might be made for the elderly or the disabled who might not have ready access to the Internet? How might these groups access a current provider directory?

The NSMA believes the standards ultimately adopted by the Division of Insurance as they relate to network adequacy will play an important role in ensuring the provision of health care services within Nevada, and we appreciate the opportunity to participate in this process.

Sincerely,

Mitchell D. Forman, DO
President

Stacy M. Woodbury, MPA
Executive Director

cc: NSMA Council
NSMA Government Affairs Commission

July 9, 2014

Adam Plain
Nevada Division of Insurance
1818 E. College Parkway
Suite 103
Carson City, NV 89706

Dear Mr. Plain:

DaVita appreciates the opportunity to provide comments to the Nevada Division of Insurance's (DOI) proposed amendment to Chapter 687B of NAC, relating to network adequacy of health plan carriers.

Background

The DaVita patient population includes more than 145,000 patients who have been diagnosed with end-stage renal disease (ESRD), a group representing approximately one-third of all Americans receiving dialysis services. Spanning 44 States and the District of Columbia, the DaVita network includes more than 1,800 locations. DaVita's nationwide network is staffed by 35,000 teammates (employees). DaVita has the privilege of providing dialysis treatment for over 1,689 individuals with kidney failure throughout our nineteen (19) centers across Nevada. Our comprehensive, in-center care team includes nephrologists, nephrology nurses, patient care technicians, pharmacists, clinical researchers, dieticians, social workers, and other highly-trained kidney care specialists.

ESRD, or kidney failure, is the last stage (stage five) of chronic kidney disease (CKD). This stage is reached when an individual's kidneys stop fully functioning and, therefore, cannot sustain life. When one's kidneys fail that individual requires either a transplant or regular dialysis treatment; traditional in-center dialysis is generally performed at least three times a week for about four hours each session. Guaranteeing network adequacy is a particularly important issue for individuals with ESRD as an individual's life depends on their ability to access dialysis treatments. Peer-reviewed studies have shown that longer travel time for ESRD patients is associated significantly with greater mortality risk and decreased quality-of-life.[1]

Overview

[1] *Moist, L. et al. (2008).* Travel Time to Dialysis as a Predictor of Health-Related Quality of Life, Adherence, and Mortality: The Dialysis Outcomes and Practice Patterns Study (DOPPS)*, American Journal of Kidney Diseases, Vol. 51, No 4, pp. 641-650.*

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The proposed amendment lays out specific requirements for carriers applying to the Commissioner for the issuance of a network plan. Specifically, carriers must establish that the providers of health care with which the carrier has contracted provide services within the network plan without "unreasonable travel" for members of the plan. DaVita strongly supports this concept in general and the suggestions expressed in this comment letter relate to the following issues: (1) dialysis centers should be included on the list of categories of health care and (2) maximum travel distances should be established for dialysis centers.

Dialysis Centers Should Be Included on the List of "Categories" of Health Care

Section 2.2 and 2.3 of the amendment provide lists of the "specialties" and "categories," respectively, of health care necessary to members of a health carrier's network plan. While we note that "nephrology" is a listed specialty in Section 2.2(f), we also believe that such health care provided by a nephrologist may or may not include the provision of care at a dialysis center per se. As such, we believe that dialysis center health care may be more properly understood to be a "category" of care and should be listed in Section 2.3 of the amendment. Because dialysis services are life-sustaining services for ESRD patients, DaVita strongly urges Nevada to include dialysis centers as an explicit item on its list of "categories" of health care.

Maximum Travel Distances Should Be Established for Dialysis Centers

Section 3 of the amendment lays out a process for the adoption of lists of maximum travel distance for each category of health care. Section 5 also provides that "unreasonable travel" means a travel time or distance in excess of the standard promulgated by the Commissioner pursuant to Section 3. As noted above, DaVita believes "dialysis centers" should be listed as a category of health care and we believe that maximum travel distances should be established for patient access to such dialysis centers. Earlier this year, in response to Nevada's solicitation of comments to its Issue Brief on Network Adequacy, we supported (1) a maximum travel distance of 30 miles to dialysis centers for patients residing in a metropolitan area and (2) collaboration between the Nevada DOI and ESRD patients and dialysis providers in the establishment of network adequacy requirements in rural areas.

Subsequent to our February 2014 comment, the National Association of Insurance Commissioners (NAIC) solicited comments and edits to its own Network Adequacy Model Act (# 74). As part of the comment process, DaVita offered additional comments on maximum travel distance. Specifically, we supported edits to the Network Adequacy Model Act derived from maximum drive time requirements for dialysis centers in the Medicare Advantage program.[2] These Medicare Advantage requirements provide for the following maximum drive times for Nevada patients undergoing treatments at outpatient dialysis centers as follows: 10

[2] *These standards are contained in the CY 2015 Medicare Advantage Health Services Delivery Reference File for Outpatient Dialysis.*

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miles for large metropolitan areas, 30 miles for metropolitan areas, 50 miles for non-metropolitan areas, and 90 miles for counties with extreme access considerations.

Under the current draft amendment, we understand the Nevada Commissioner would make available for public comment a preliminary list of maximum travel distance for each category of health care and would then finalize the list for application to health plans issued or renewed on or after January 1 of the calendar year after the list is issued. DaVita would support the maximum drive times for dialysis centers as listed above and would intend to comment on the Commissioner's proposed list as appropriate.

We appreciate the opportunity to share DaVita's comments and recommendations with you. Please do not hesitate to contact me if you would like to discuss these recommendations in detail or have any questions.

Sincerely,

Jeremy Van Haselen
Vice President, State Government Affairs, DaVita Healthcare Partners Inc.
e-mail: jeremy.vanhaselen@davita.com

Air Methods®

DEFENDERS OF TOMORROW™

July 15, 2014

Mr. Adam Plain
Nevada Division of Insurance
1818 East College Parkway
Suite 103
Carson City, NV 89706

Re: LCB File R049-14

Dear Mr. Plain and to whom else it may concern

Air Methods (AMC), as the leading provider of air medical services in Nevada and around the world, transports over 100,000 patients each year across 48 states when requested by physician authorities or first responders. We appreciate an opportunity to provide comment on health care matters in Nevada and are committed to making our subject matter experts available to the state Nevada regarding emergency critical care transport as needed.

Upon our initial review, please consider our comments, as we ask that you continue to work with us to address our concerns and input:

- Section 2.3(a): Remove the "as appropriate" from the inclusion of air ambulance services in the categories of necessary health care. The provision should read: "Emergency medicine, including, without limitation, access to hospital emergency rooms, ground ambulance services and air ambulance services."
    - Reason: If air ambulance is going to be considered a necessary category to be included in beneficiaries' plans, that should be clear and the language "as appropriate" causes ambiguity on the issue.

- Section 3.1: Add the following italicized language to the end of the provision: "Except as otherwise permitted in section 8 of this regulation, the providers of health care used by the network plan to meet the requirements of this regulation must be located within the applicable geographic service area*, or otherwise be available to adequately serve the geographic area in the case of certain emergency services, such as ground and air ambulance services*."
    - Reason: Air ambulance providers, being mobile and high speed in nature, are able to get to the patient very quickly and don't need to be as geographically restricted as other stationary health care providers.

- Section 3.5: Correct typo "un" at beginning of sentence so that provision reads: "As used *in* this section…"
    - Reason: Typo.

- Section 4.2(a): Add the following italicized language to the beginning of the provision: "*Except for certain emergency services,* at least 30 percent of the available essential community providers in each geographic service area covered by the network plan…"
    - Reason: If the geographic region is defined too broadly, then it could be difficult for plans and providers to determine how many air ambulance providers service a certain geographic service area. For example, could an air ambulance provider at a significant distance away outside the state of Nevada be included as a provider to the geographic service area, thus making it uncertain how many providers the plans need to

include to meet the network thresholds.

- Section 5.3: Clarify the provision is limited to section 5, and thus revise to state: "Nothing in this section 5 prohibits…"
    - Reason: Clarify language to reflect what appears to be the intent.

- Section 12.5: With respect to the definition of a "significant change" in a network being a change that effects more than 10% of the members, how is that going to be measured?
    - Reason: Unclear how this will be measured.

AMC welcomes any questions or further discussion you may have, please contact our Government Relations Specialist Ruthie Hubka for prompt handling at (303) 792-7464 or ruthie.hubka@airmethods.com

Sincerely

Air Methods Government Relations

Jack Kim, Senior Associate General Counsel
UnitedHealthcare, Legal & Regulatory Affairs
NV019-0200 2724 N. Tenaya Way, Las Vegas, NV 89128
Tel (702) 240-8890 Fax (702) 242-1532

July 15, 2014

Scott Kipper
Commissioner of Insurance
Division of Insurance
State of Nevada
1818 E. College Pkwy, Suite 103
Carson City, Nevada 89706

RE: Proposed DOI network adequacy regulation LCB File No. R049-14

Dear Commissioner Kipper:

We have reviewed the July 15, 2014, proposed regulation on network adequacy regulation and believe that the proposed regulation as written will negatively impact the health insurance market by adding significant and unnecessary burdens on the health insurance industry and could result in no health insurance options for many Nevadans or result in significant premium increases to meet the requirements of this proposed regulation.

Specifically, it appears the DOI anticipates establishing a specific number of providers that have to be included in each network. We are concerned that carriers will not be able to meet these requirements because:

- There are not enough providers in many of these categories, including primary care and psychiatry and mental health; and
- There are very few providers in many parts of Nevada, including Clark and Washoe County.

Based on the proposed regulation, it appears that insurers may only be able to establish networks in parts of Clark and Washoe County and there will be few health insurance options in most of Nevada. We believe that this is not the intent of the proposed regulation, but will be the result of adopting this regulation without significant changes.

We have reviewed the proposed regulation and would suggest the following changes, which we believe will significantly improve the ability of carriers to meet the proposed regulation requirements, but even with these changes there could be significant challenges in complying with these regulations.

Section 2

- This section requires that carriers have an adequate number of providers in certain provider categories; however, this section does not address a network plan that includes out of network benefits that allow a member to receive medical care from any provider.
- We suggest that a network plan that contains out of network providers benefits as having met the network requirements.

Section 3

- This section requires that providers be located in the geographic service area that a network plan is sold. This requirement will likely result in carriers not offering products outside of Clark and Washoe County. The only option that will likely be available in most of Nevada will be an indemnity option where a member is responsible for a significant percentage of the cost of their health care.

- In rural Nevada, individuals often travel to Las Vegas, Reno or often Salt Lake City to receive medical care because of the lack of providers in rural Nevada. Section 3 would require a carrier to provide a network in many parts of Nevada where there are no providers. The DOI should consider allowing carriers to include providers outside of Nevada that are consistent with the normal pattern of care for the rural Nevada.
- If the DOI believes that a requirement that a provider be located in a geographic service area is necessary, we would suggest that the DOI review its service areas and create a service area for each County and also review whether Clark and Washoe County should have multiple service areas to account for the rural nature of parts of Clark and Washoe County.

Section 4 – Essential Community Provider

- This section appears to impose an exchange requirement on carriers not offering products on the exchange.
- We suggest that this section be removed or limited to plans on the exchange.

Section 5 – Non-credentialed providers at Indian Health Services Facility

- This section indicates that Indian Health Service Facilities and providers do not need to be credentialed by carriers.
- It appears that the DOI believes that many of these facilities and providers may not be licensed by a state licensing agency or they could not be credentialed by a carrier. Since it appears that a carrier would still be required to contract with many of these facilities, we suggest that additional language be included in this section that indicates a carrier is not liable for any injuries resulting from medical care provided at these facilities.

Section 6 – Primary Care Physicians (PCP)

- It appears that the DOI is requiring that a carrier require a PCP to establish on call protocols, provide those protocols to the carriers and then enforce those protocols.
- We would suggest that the DOI require all PCPs to establish these on call protocols and provide those protocols to the carriers. Unless a carrier can get this information form the PCP, the carrier may not be able to comply with this requirement.

Section 7 – Data Collection

- This section requires a carrier to establish a network provider data collection system. Does the DOI have a list/type of data that should be collected? If so, we suggest that carriers be given that list for review.
- We also suggest that providers be required to provide this data to carriers. Unless a carrier can get this information form the PCP, the carrier may not be able to comply with this requirement.

Section 7.5- Network plan submission

- This section requires that a carrier submit its network plan by April 1 of the calendar year preceeding the year that the plan will be available in the individual market and at least 60 days prior to the plan being available in the small group market.
- We would recommend that the DOI include an additional provision that a network plan will be deemed approved after 30 days. In order to meet many of the carrier's internal operational timelines and also to meet many of the state renewal requirements, a carrier needs the timely approval of these network plans.

Section 8 – Commissioner's review of a network plan

- It appears that as part of the Commissioner's review to determine if a network is adequate, the DOI will determine if the provider or facility is providing "clinically safe" medical care.
- This section raises the following questions:
    - Is the DOI determination of clinical safety in addition to the review and oversight completed by State/County Health Departments and/or medical licensing boards?
    - What metrics will the DOI use to determine whether medical facilities and/or physician's offices meet the clinical safety requirements?
    - Will the DOI report to the various licensing agencies when they have made a determination that a medical facility or a provider is not providing clinically safe medical care?

Section 9 – Monitoring networks

- This section requires a carrier to monitor both medical facilities and providers to determine that the ability of the medical facility and provider to provide medical care.
- We would suggest that the DOI establish guidelines that medical facilities and providers must meet to ensure that they have the capacity to provide medical care and/or require that these medical facilities and provider attest to each carrier that they are able to timely provide medical care.
- Unless a carrier can get the appropriate information from a medical facility and provider, the carrier may not be able to comply with this requirement.

Section 10 – Provider Directories

- We are opposed to the requirement that we include a list of providers joining and leaving a network. It appears that that DOI is requesting that we include a list of providers that are currently not contracted with a carrier but may be joining on our provider list. We believe that this requirement will only cause confusion because there are no guarantees that a provider will become part of a network until all the contracts/agreements are completed.
- Additionally, a provider will indicate that they are terminating a contract but then a new contract is entered into between the provider and carrier.
- We are supported of section 10.1 without the additional language and section 10.2 should be deleted.

Section 12 – Significant change to a network

- This section defines a significant change as a change in the network of 10%. Is the 10% calculated on a statewide, county or service area basis?

We may have additional comments after the regulation workshop and after any additional changes are proposed. Please feel free to contact me if there are any questions.

Sincerely,

Jack Kim

cc: Adam Plain

July 15, 2014

Nevada Division of Insurance
1818 East College Parkway, Suite 103
Carson City, NV 89706

RE: LCB File No. R049-14

The Nevada State Medical Association (NSMA) submits these comments regarding the proposed regulation titled LCB File No. R049-14, relating to adequacy of network plans. These comments address the drafted dated July 15, 2014.

On pages 1 and 2, the differentiation between specialties and categories of health care is a welcome addition to the regulation and clears up much of the confusion surrounding the previous listing. The Commissioner may still want to add the specialty of neurology in Paragraph 2 and the area of reconstructive plastic surgery in Paragraph 3(c).

Page 3, Section 3, Paragraph 2 now provides a 15-day period for public comment regarding the preliminary list of the minimum number of providers and the maximum travel distance or time, by county, for each specialty and category of health care necessary to serve members within network plans. We appreciate the Commissioner adding this period for public comment, and would suggest the addition of a public workshop during the comment period so that interested members of the public can interact with the Commissioner regarding their comments. We suggest that, in addition to minimum numbers of providers and their geographic distribution, access to care on a timely basis is also a measure of adequacy and would help avoid delays that may exacerbate medical conditions.

Page 5, Section 5, Paragraph 3 allows carriers to limit payments "to that amount payable if the health care service were obtained from a provider or facility that is part of the network plan." This language does not address two major challenges that have been discussed at length in the last several legislative sessions, namely:

1) A requirement for carriers to educate beneficiaries about the financial consequences of using out-of-network providers, specifically the requirement that beneficiaries will be subject to and responsible for balance billing. We suggest that such a requirement be added.

2) The need for a state agency to track and report annually the number of complaints and the resolution thereof regarding our-of-network balance billing; such a tracking system will allow the Commission to readily assess problem areas in both carrier and provider arenas so that policy decisions regarding balance billing may be considered based on actual data.

Section 8 of the regulation describes the network adequacy review and determination by the Commissioner when a network is not deemed to be adequate. Specifically Paragraph 2(e) allows the use of telemedicine or telehealth services to supplement or replace in-person care. We suggest revising this to read "The use of telemedicine or telehealth services to supplement in-person care. Telemedicine must only be used in place of in-person care where reasonable in-person care is not available in the geographic service area." Under this standard, a carrier would need to demonstrate reasonable in-person care was not available in the geographic service area prior to being able to completely substitute telemedicine or telehealth for in-person medical treatment. Also relating to telemedicine, any provider who contracts with a carrier to provide treatment to a patient should be required to hold an active Nevada license from the appropriate licensing Board.

Regarding Paragraph 2(b), what criteria will the Commission use to assess "the willingness of providers" to contract with a carrier "under reasonable terms and conditions"? Per Paragraph 5, for the purposes of this section 'reasonable' includes "the reimbursement rate requested by the provider or facility in relation to similarly situated providers or facilities in the same geographic area." How will the Commissioner monitor and assess 'requested' rates?

Paragraph 2(f) of Section 8 successfully incorporates the ability of a carrier to use providers outside of the plan's geographic service area but within the travel standards as a demonstration of adequacy. We applaud this language as it appears to allow carriers to use providers across state lines but near to our border communities to demonstrate adequacy, which will be a huge benefit to frontier and rural Nevadans. We do want to point out that page 8, Section 8, Paragraph 5 defines 'reasonable' as it relates to the use in Paragraph 2(b) on page 7 regarding contracting under 'reasonable terms and conditions.' This same definition of reasonable would apply to the revised Paragraph 2(e) proposed above. However, the term 'reasonable' is also used in Paragraph 2(f) in a different context, relating to 'reasonable travel standards.' In this second context, the definition of reasonable is not applicable and may cause confusion. The Commission should consider striking 'reasonable' from this paragraph, which actually tightens the language.

Page 8, Section 10, addresses provider directory updates. We appreciate the new language in Paragraph 2 which now requires carriers to update their provider directory within 24 hours of the effective date of any 'significant change' to its network; however, Paragraph 3 requires the provider directory and updates to be posted to the carrier's web site within 72 hours of making the update in accordance with the relevant NAIC system for doing so. These provisions seem to conflict. If carriers can update their directories within 24 hours of a significant change, are there technological or other barriers which prevent that directory from then being uploaded to the web site? Why must the consumer wait an additional two days prior to being able to access the revised provider directory?

The new definition of 'significant change' contained in Section 12, Paragraph 5 on pages 9 and 10 is a good start. Concerns remain regarding the language in Section 10, Paragraphs 1 and 2 on page 8. Having the provider directory updates clearly indicate the providers joining and leaving the network is important information for both consumers and providers to be able to access; however, the regulation continues to lack a requirement for patients or providers to be notified of these network changes. From the patient's perspective, without notification that the plan's providers have changed, a patient operating on outdated information may be treated by a provider or facility which is out of network and may incur substantial out of pocket costs. As a transparency issue, updating provider directories more frequently than every 30 days would increase patient opportunity to be treated by an in-network provider. Also, as we questioned in our last comments, what provisions might be made for the elderly or the disabled who might not have ready access to the Internet? How might these groups access a current provider directory?

Further, if 'significant changes' which affect capacity are made in a carrier's plan and require an immediate directory update, yet carriers are not required to give providers notice of such changes – how is a provider expected to learn of such a change? As defined, the term significant change seems to include rental networks, which is appreciated as rental networks are not adequately addressed in existing regulation. However, providers should not have to seek out major changes in the physician-carrier contract when such changes are made unilaterally and greatly impact a physician's ability to manage patient caseload. Carriers leasing or selling their network must be required to clearly and specifically notify physicians of significant changes in the contractual arrangement.

Of material discussion at the July 1, 2014 workshop was the length of time between the Commissioner's determination of network adequacy and the start of the plan year for which the determination applies, which based on the April 1 annual submission date for carriers would be 9 months in advance of the plan year. As the NSMA commented on July 1, there should be some sort of review process whereby a covered beneficiary may contact the

Insurance Commissioner with concerns about the network, whether it be the length of days it takes to see a provider or the absence of available providers. Upon receiving such an inquiry or complaint the Commissioner would review the network adequacy of that specific specialty or category of health care to ensure the network continued to be adequate and that no significant changes had occurred which might disrupt patient access to care. Adding a new section to this effect would greatly benefit the public interest.

The NSMA appreciates the due diligence of the Commissioner regarding this important policy decision and the transparency of the workshop process.

Sincerely,

Mitchell D. Forman, DO
President

Stacy M. Woodbury, MPA
Executive Director

Abdi Raissi, MD
President
Nevada Orthopaedic Society

AMERICAN ACADEMY OF OPHTHALMOLOGY
The Eye M.D. Association

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August 4, 2014

Mr. Adam Plain, CPCU AIE AFSB AIAF API ARC ARe
Insurance Regulation Liaison
Nevada Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, NV 89706

Dear Mr. Plain:

The American Academy of Ophthalmology, the world's largest association of eye physicians and surgeons (EyeM.D.s) with more than 18,000 members in the U.S., appreciates the opportunity to provide input on Nevada's proposed network adequacy regulations. The Academy applauds the Commissioner of Insurance's attempts to build suitable networks for Nevada's citizens but has concerns with the third draft of the proposed amendment (LCB File No. R049-14).

In the second draft of the proposed amendment dated July 15, 2014, ophthalmologists are listed as one of the specialties of health care necessary to serve members pursuant to subsection 1. However, in the third draft dated August 6, 2014, ophthalmologists have been deleted as a network requirement. This deletion poses a threat to Nevada citizens' access to all eye health care services including surgery. For this reason, the Academy requests that the Commissioner reinstate ophthalmology in the list of specialties necessary for network adequacy.

Ophthalmologists are medical and osteopathic doctors who provide comprehensive eye care, including medical, surgical, and optical care. Eye M.D.s are an essential part of the eye care team and are specially trained to provide the full spectrum of eye care, from prescribing glasses and contact lenses to complex and delicate eye surgery. Ophthalmologists treat a variety of diseases and conditions including diabetic retinopathy, glaucoma, cataracts, and macular degeneration to name just a few that may lead to blindness if left untreated. These treatments and surgeries are crucial in the efforts to provide adequate health care services to the citizens of Nevada. In fact, children's vision coverage is considered an Essential Health Benefit under the Affordable Care Act. There is no comprehensive health plan today that does not include

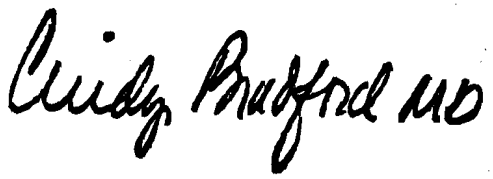
ophthalmologists in its network. Excluding these essential providers from the list of specialists necessary for network adequacy places the health and well-being of thousands of Nevadans at risk.

The Academy appreciates the opportunity to participate in this review of network adequacy and point out the important care that ophthalmologists provide to their patients. We urge you to reconsider the language present in the third draft of the proposed amendment to the proposed regulation of the Commissioner of Insurance and continue to consider ophthalmology as a specialty necessary for network adequacy.

Sincerely,

Gregory L. Skuta, MD
President

Daniel J. Briceland, MD
Secretary for State Affairs



Cindy Bradford, MD
Senior Secretary for Advocacy

Michael X. Repka, MD
Medical Director for Governmental Affairs

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

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August 5, 2014

Mr. Adam Plain
Insurance Regulation Liaison
Nevada Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, NV 89706

Re: AMA comments on LCB File No. R049-14

Dear Mr. Plain:

On behalf of the physician and medical student members of the American Medical Association (AMA), I write to state our support for efforts by the Nevada Department of Insurance to consider issues related to network adequacy. And we appreciate the continued opportunity to comment on proposed regulations addressing changes to your network adequacy requirements.

Despite our support for your efforts, we agree with the Nevada State Medical Association (NSMA) and many specialty societies, who are concerned that recent changes reflected in the August 12th draft of the proposed regulation (LCB File No. R049-14) are a step in the wrong direction and may negatively impact patient access to care.

For example, the August 12th draft includes seemingly arbitrary ratios of provider to covered lives for select specialties that do not take into account factors such as the ability of physicians to accept new patients, and other factors that may complicate access. We believe that strong network adequacy requirements are needed to ensure access to timely and convenient medical care, including all essential health benefits and emergency services. The current proposal would not accomplish this.

The AMA believes that the Department is in a unique position to work with the Nevada health care community, including the NSMA, to help ensure that patients have access to truly adequate provider networks. We urge you rescind the August 12th version of the regulation and return to the draft dated July 15, 2014 for continued dialogue with NSMA, medical specialty societies and other stakeholders.

If you have any questions or want more information, please contact Emily Carroll, JD, Senior Legislative Attorney, Advocacy Resource Center at emily.carroll@ama-assn.org or 312-464-4967 or Daniel Blaney-Koen, JD, Senior Legislative Attorney, Advocacy Resource Center at daniel.blaney-koen@ama-assn.org or 312-464-4954.

Thank you for your consideration.

Sincerely,

James L. Madara, MD

cc: Nevada State Medical Association

Anthem Blue Cross and Blue Shield
9133 W Russell Road
Las Vegas, Nevada 89148

Anthem

August 5, 2014

Mr. Adam Plain
Insurance Regulation Liaison
Nevada Division of Insurance
1818 East College Parkway
Carson City, NV 89706

RE: LCB File No. R049-14

Dear Mr. Plain:

We write today to comment on the latest draft of the above regulation concerning network adequacy. We understand the Division intends to finalize a regulation later this fall.

In general, we ask the Division to keep the proposed standards as close to existing state and federal standards as reasonably possible, with the understanding that certain ACA requirements related to network adequacy must be adopted. Market conditions are fluctuating greatly during the continued implementation of the ACA. To ensure carriers are able to continue to offer products to consumers at reasonable premium rates, we request the Division adopt standards that will not unduly burden consumers by increasing costs of compliance by the insurer which will be reflected in rates.

The progression of the drafts to date represents increasing specificity and more detailed compliance points for carriers. We encourage the Division to reconsider the focus of this effort. If the focus is on consumer satisfaction, then the standard can be much simpler. For example, the regulation might require that any network provider must maintain a log of consumer complaints about access to care. Over time, the Division could evaluate that carrier's system for validating and responding to the complaints. Alternatively or even additionally, there could be a requirement that consumers be annually surveyed for their satisfaction. Low complaints and satisfied consumers reflect adequate access to care which reflects an adequate "network".

Creating detailed mandates "presumes" the consumer will be satisfied if they are met. We suggest that evaluating whether the consumers are satisfied would be more relevant to the "efficacy" of the network. As is stated in the opening chapter of Title 57, "The purposes of this Code are to: …Insure that the State has an adequate and healthy insurance market characterized by competitive conditions and the exercise of initiative".

In the event that the Division chooses to pursue its current course, please see the following comments:

Page 2

Sec. 1.3 delete the word "county" after Carson City

Sec. 2 change the wording to read as follows:

"1. A carrier who applies to the Commissioner for the approval of a network plan must present a plan that has an adequate number and geographic diversity of providers for each geographic service area covered by the network plan to serve the healthcare needs of plan enrollees covered by the plan.

2. In addition to the general requirement to maintain an adequate network, an network carrier must maintain a network plan that meets the specific requirements relating to minimum number of providers or facilities and/or maximum travel distance or time for certain specialties or categories of health care."

Subsection 3 should be renumbered 4 and subsection 4 renumbered 5.

Sec. 3 "approval" should be substituted for "issuance"

Sec 3.5 "approval" should be substituted for "issuance"

Sec. 4 "approval" should be substituted for "issuance"

(a) Essential Community Provider -We recommend removing this requirement. It's already federally required.

Sec. 5 "approval" should be substituted for "issuance"

(4) Suggest adding language making clear carriers are not liable or responsible for credentialing Indian Health Services

Sec 6 "approval" should be substituted for "issuance"

(1) Suggest language added that makes it clear that there are comparable requirements on PPOs and HMOs.

Sec 7 "approval" should be substituted for "issuance"

Suggest language be added to reflect that "data" collection is no greater than that currently required under NAC 695C1255

Sec. 7.5 "approval" should be substituted for "issuance"

Sec. 8 Add language that makes it clear that a carrier submitting a plan for approval is deemed to be approved unless specifically disapproved. Due process rights to appeal such disapproval should be stated.

Sec. 10 Delete subsection 3 as redundant to the second sentence in subsection 1. Delete subsection 4(a) as redundant to the requirement to timely update the carrier's website subsection b will become subsection 4.

Sec. 12 should be renumbered 11

Sec. 13 should be renumbered 12

Sec. 14 should be renumbered 13.

Thank you for your consideration. Please let me know if you have any questions.

Tracey Woods

Senior Director, Government Relations
Anthem Blue Cross Blue Shield
Cc: Mike Murphy

Planned Parenthood®
Act. No matter what.

Nevada Advocates for Planned Parenthood Affiliates, Inc.

To: Scott Kipper, Commissioner of Insurance & Adam Plain, Insurance Regulation Liaison

From: Elisa Cafferata, President & CEO NAPPA

Re: Comments Regarding Network Adequacy Standards Regulations: **LCB File No. R049-14**

Date: August 5, 2014

We greatly appreciate the Division of Insurance's outreach to craft the Network Adequacy regulations. Thank you for the opportunity to offer written feedback regarding network adequacy standards for Nevada. We offer this feedback on behalf of our health center operations as well as on behalf of our clients.

Consider Adding Any Willing Provider to the Standard

CMS has recently provided additional guidance on the definition of "any willing provider" to clarify that insurance companies should contract with essential community providers who are willing to sign contracts that offer reasonable terms.

The essential community provider provision in the health care reform law is especially important for women. When health insurance coverage is expanded and made available to a larger number of Americans, women's health providers are often the first to be overwhelmed with the increased demand. For example, after Massachusetts implemented health care reform, there were tremendous shortages of primary care providers, but it was especially challenging for women's health care providers.[1]

Clarifying the Essential Community Provider Standard

Proposed Regulation

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections [2] ***1.3*** to [13] 14, inclusive, of this regulation….

Sec. 4. *1. A carrier who applies to the Commissioner for the issuance of a network plan 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 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:

[1] Merritt Hawkins & Associates, *2009 Survey of Physician Appointment Wait Times*, May 2009.

(a) ~~[at]~~ At least ~~[20]~~ 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 the federal Center for Consumer Information & Insurance Oversight.

Drafting note: The Division recognizes that CCIIO has a procedure in place for entities not appearing on the non-exhaustive list of essential community providers to be used to meet the ECP requirement.

We just want to clarify that Sec. 4, subsection 2 does not go beyond the safe harbor standard and allows insurance companies to contract with at least one essential community provider from each category established by federal law ***where available***. In Nevada, few of the rural counties will have a full set of essential community providers.

We also want to clarify that Sec. 4, subsection 3 would allow and encourage insurance companies to contract with essential community providers as listed in 42 U.S.C. as outlined, AND "look-alike" providers that are on the non-exhaustive list of essential community providers, AS WELL AS essential community providers the insurance carrier completes the write-in procedure for.

One of each ECP type per service area

There are five basic types of ECPs, and QHPs may contract with additional providers who serve similar underserved individuals. The categories of ECPs are listed below:

Major ECP Category	ECP Provider Type
Federally Qualified Health Center (FQHC)	FQHC **and FQHC "Look-Alike" Clinics**, Native Hawaiian Health Centers
Ryan White Provider	Ryan White HIV/AIDS Providers
Family Planning Provider	Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics
Indian Providers	Tribal and Urban Indian Organization Providers
Hospitals	DSH and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominately low-income, medically underserved individuals

Sensitive Services

In rural Nevada especially, but also in the urban areas, there can be a great deal of patient concern and sensitivity concerning certain health services, for example, STI testing and treatment. In 2013, California passed S.B. 138, SB-138, a law dealing with the confidentiality of a patient's health care information and it defined sensitive services as health care relating to mental health treatment, prevention / treatment of pregnancy, STD test / treatment, medical treatment for rape, treatment for sexual assault, alcohol or substance abuse counseling, and HIV test / treatment.

To meet the needs of Nevada enrollees, the state should cover sensitive services at "in-network" or "preferred provider" rates. NAPPA recommends that the DOI consider incorporating these concerns in the network adequacy standards by incorporating the following:

- To be a qualified health plan, a carrier must cover sensitive services offered by out-of-network / non-preferred providers at no additional cost (relative to in-network / preferred provider services). Each QHP will allow clients to go to the health care provider of their choice for sensitive services without prejudice and without requiring pre-authorization.

Nevada Advocates for Planned Parenthood Affiliates (NAPPA) is the independent, non-partisan, nonprofit education, legislative and political advocacy arm of Planned Parenthood's two affiliates (Mar Monte and the Rocky Mountains). Planned Parenthood's three Nevada health centers handle over 48,000 patient visits each year. We offer a sliding fee scale as many of our patients have nowhere else to go for basic health care. We are proud of our long record of quality care -- over 35 years in Nevada -- always affordable, confidential, culturally appropriate, and welcoming to our clients.

Elisa Cafferata
Nevada Advocates for Planned Parenthood Affiliates
550 W Plumb Lane, c/o UPS Mail #B-104, Reno, NV 89509
ecafferata@NevadaAdvocates.org
775-412-2087

August 5, 2014

Nevada Division of Insurance
ATTN: Adam Plain
1818 East College Parkway, Suite 103
Carson City, NV 89706

RE: LCB File No. R049-14

Dear Mr. Plain,

The Nevada State Medical Association (NSMA), Nevada Osteopathic Medical Association and our partner specialty medical societies submit these comments regarding the proposed regulation titled LCB File No. R049-14, relating to adequacy of network plans. Also attached is a letter supporting these comments from the American Medical Association. The comments herein address the drafted dated August 12, 2014.

The Affordable Care Act ("the Act") and its provisions require, among other things, that its implementation will serve the public interest. Each state through an appropriate regulatory body is charged with the responsibility to assure that the public's interest is protected as it implements the Act. The determination of an adequate network of physician and other health care delivery services in Nevada and whether that network, once defined, meets and protects the public interest is the challenge facing the Division of Insurance. The NSMA's Medical Specialties Council believes the current version of the regulation that attempts to define an adequate health care delivery network and establish other administrative constructs necessary for regulatory oversight fails in fully protecting the public interest.

As stated in the preamble to this regulation, the purpose of this regulation is to *"establish certain requirements relating to the adequacy of a network plan issued by a carrier."* (emphasis added) It is unclear how the adequacy of the large variety of medical services for patients will be ensured given the new approach taken in the August 12 version of the regulation.

For example, the change in direction from providing a list of required specialties and categories of health care to focusing on a specific and narrow group of categories and placing ratios within the regulation creates a rigid, inflexible structure which is not in the public interest. The previous version of the regulation created an annual process through which the Division would issue proposed travel distances, times and provider to patient capacity ratios and the public would have an opportunity to comment on these standards prior to their adoption and issuance to provider networks. That mechanism gave the Insurance Commissioner maximum flexibility to address the changing market and population dynamics. As the concept of network adequacy is in its infancy, it is both advisable and preferable to leave that flexibility in place – at least until a few years have passed and the insurance market has a chance to stabilize from the many new requirements under the Act. Moving forward with the ratios and distances as detailed in the August 12 version of the regulation would provide the Commissioner, at best, with only limited ability to address such issues and only every second year. Further, the change in nomenclature and segregation between 'urban,' 'rural' and 'frontier' counties appears unworkable because even within those categories, the counties which comprise the group have vastly different populations, population centers and geographic distributions of both patients and providers. These differences make lumping the counties within these new categories inappropriate.

We strongly encourage the Division to return to the version of the regulation dated July 15, 2014, which more appropriately addressed the breadth of services that are reflective of the practice of medicine and appropriate standards for patient care.

In order to fully protect the public interest, the users of insurance networks must have assurances about not just the types of providers included and their geographic proximity, but also the reasonable timeframe within which patients should be able to access a provider. We suggest again that the Division include a standard for a timeframe within which a patient must be assured they can be seen by a provider in the network.

In order to fully protect the public interest, the users of these networks must be fully apprised and educated as to how their problems and complaints about possibly inadequate networks will be addressed by the Division.

We therefore suggest again the Division consider including:

1) A requirement for carriers to educate beneficiaries about the financial consequences of using out-of-network providers, specifically related to the requirement that beneficiaries will be subject to and responsible for balance billing.

2) A requirement that DOI track and report annually the number of complaints and the resolution thereof regarding the adequacy of networks, including the challenge of balance billing. This tracking system will allow DOI to readily identify sand address problem areas in both the carrier and provider arenas.

3) A mechanism such as a review or complaint process whereby a covered beneficiary may contact the Insurance Commissioner with concerns about deficiencies within an approved network, whether it be the length of days it takes to see a provider or the absence of available providers, etc. Upon receiving such an inquiry or complaint the Commissioner would review the network adequacy of that specific specialty or category of health care to ensure the network continued to be adequate and that no significant changes had occurred which might disrupt patient access to care. Adding a new section to this effect would greatly benefit the public interest.

As the Division has acknowledged on the record that it lacks expertise in the areas of health care delivery and the practice of medicine, we have reached out to subject matter experts at the University of Nevada School of Medicine who are willing to assist the Division and provide valuable technical expertise to assist in the development of these regulations. John Packham is a technical expert on the Nevada health care provider workforce, including current and future projections on provider specialties and present distribution within the state. Gerald Ackerman is a technical expert on rural and frontier health care delivery systems. Input by both Mr. Packham and Mr. Ackerman would allow the Division to establish realistic provider to patient network ratios based on actual population and provider data.

These health policy experts may be reached at:

John Packham, PhD, Director of Health Policy Research
University of Nevada School of Medicine
Office: (775) 784-1235
Cell: 775- 232-3614
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Gerald Ackerman
Program Director, Nevada State Office of Rural health
University of Nevada School of Medicine
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In conclusion, we strongly encourage the Division to return to the version of the regulation dated July 15, 2014 and to continue the dialogue from previous workshops. The August 12 version of the regulation changes the course and tenor of the discussion so drastically as to make comments on individual provisions in the new regulation virtually impossible.

Thank you for considering these comments as you further refine this regulation.

Sincerely,

Mitchell D. Forman, DO
President
Nevada State Medical Association

Veronica Sutherland, DO
President
Nevada Osteopathic Medical Association

Abdi Raissi, MD
President
Nevada Orthopaedic Society

Adam J. Rovit, MD
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Nevada Academy of Ophthalmology

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Lesley Dickson, MD
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Ross H. Golding, MD
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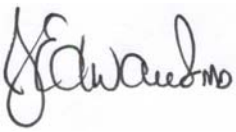
Nevada Psychiatric Association
American Psychiatric Association
Council on Advocacy & Government Relations



Michael Edwards, MD
President
American Society for Aesthetic Plastic Surgery

Bret W. Frey, MD
Board of Directors, Nevada Chapter
American College of Emergency Physicians

Attachment: Letter from James L. Madara, MD, Executive VP/CEO
American Medical Association

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

August 5, 2014

Mr. Adam Plain
Insurance Regulation Liaison
Nevada Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, NV 89706

Re: AMA comments on LCB File No. R049-14

Dear Mr. Plain:

On behalf of the physician and medical student members of the American Medical Association (AMA), I write to state our support for efforts by the Nevada Department of Insurance to consider issues related to network adequacy. And we appreciate the continued opportunity to comment on proposed regulations addressing changes to your network adequacy requirements.

Despite our support for your efforts, we agree with the Nevada State Medical Association (NSMA) and many specialty societies, who are concerned that recent changes reflected in the August 12th draft of the proposed regulation (LCB File No. R049-14) are a step in the wrong direction and may negatively impact patient access to care.

For example, the August 12th draft includes seemingly arbitrary ratios of provider to covered lives for select specialties that do not take into account factors such as the ability of physicians to accept new patients, and other factors that may complicate access. We believe that strong network adequacy requirements are needed to ensure access to timely and convenient medical care, including all essential health benefits and emergency services. The current proposal would not accomplish this.

The AMA believes that the Department is in a unique position to work with the Nevada health care community, including the NSMA, to help ensure that patients have access to truly adequate provider networks. We urge you rescind the August 12th version of the regulation and return to the draft dated July 15, 2014 for continued dialogue with NSMA, medical specialty societies and other stakeholders.

If you have any questions or want more information, please contact Emily Carroll, JD, Senior Legislative Attorney, Advocacy Resource Center at emily.carroll@ama-assn.org or 312-464-4967 or Daniel Blaney-Koen, JD, Senior Legislative Attorney, Advocacy Resource Center at daniel.blaney-koen@ama-assn.org or 312-464-4954.

Thank you for your consideration.

Sincerely,

James L. Madara, MD

cc: Nevada State Medical Association

Position Statement on Teledermatology

(Approved by the Board of Directors February 22, 2002
Amended by the Board of Directors May 22, 2004
Amended by the Board of Directors November 9, 2013
Amended by the Board of Directors August 9, 2014)

Telemedicine is an innovative, rapidly evolving method of care delivery. The Academy supports the appropriate use of telemedicine as a means of improving access to the expertise of Board certified dermatologists to provide high-quality, high-value care. Telemedicine can also serve to improve patient care coordination and communication between other specialties and dermatology.

The Academy strongly supports coverage and payment for telemedicine services provided by Board certified dermatologists when several important criteria are met (see details below in section III). These criteria are essential to ensure that dermatologic care provided by telemedicine is of high quality, contributes to care coordination (rather than fragmentation), meets state licensure and other legal requirements, maintains patient choice and transparency, and protects patient privacy.

While teledermatology is a viable option to deliver high-quality care to patients in some circumstances, the Academy supports the preservation of a patient's choice to have access to in-person dermatology services.

Teledermatology is the practice of medicine. Board certified dermatologists have extensive knowledge and expertise in cutaneous medicine, surgery, and pathology. Whether in-person or via teledermatology, the optimal delivery of dermatologic care involves board certified dermatologists.

Teledermatology providers choose between or combine two fundamentally different care delivery platforms (Store-and-Forward vs. Live Interactive), each of which has strengths and weaknesses.

I. LIVE INTERACTIVE TELEDERMATOLOGY

a. Definition
Live interactive teledermatology takes advantage of videoconferencing as its core technology. Participants are separated by distance, but interact in real time. By convention, the site where the patient is located is referred to as the originating site and the site where the consultant is located is referred to as the distant site.

b. Technology
A high resolution video camera is required at the originating site, and a monitor with resolution matched to the camera resolution is required at the distant site. Videoconferencing systems work optimally when a connection speed of >384 kbps is used. Slower connection speeds may necessitate that the individual presenting the patient perform either still image capture or freeze frame to render a quality image. For most diagnostic images, a minimum resolution of 800 x 600 pixels (480,000) is required, but higher resolution may increase diagnostic fidelity.

c. Credentialing and Privileging
The Joint Commission (TJC) has implemented standards for telemedicine. Under the TJC telemedicine standards, practitioners who render care using live interactive systems are subject to credentialing and privileging at the distant site when they are providing direct care to the patient. The originating site may use the credentialing and privileging information from the distant site if all the following requirements are met: (i) the distant site is TJC-accredited; (ii) the practitioner is privileged at the distant site for those services that are provided at the originating site; and (iii) the originating site has evidence of an internal review of the

practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance management.

d. Privacy and Confidentiality
Practitioners who practice telemedicine should ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, and it's implementing regulations. While video or store-and-forward transmissions over ISDN infrastructure are thought to be secure, IP transmissions should be encrypted when transmitted over the public internet to ensure security. IP encryption in other settings such as private or semi-private networks is also highly recommended. The handling of records, faxes, and communications is subject to the same HIPAA standards as apply in a standard office environment.

e. Licensing
Interactive telemedicine requires the equivalent of direct patient contact. In the U.S., teledermatology using interactive technologies is restricted to jurisdictions where the provider is permitted, by law, to practice. In other words, the provider using interactive technologies usually must be licensed to practice medicine in the jurisdiction where the patient is located.

f. Current Reimbursement
Medicare reimburses for live-interactive consultations, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system for patients located in non-metropolitan statistical areas (non-MSAs). This includes nearly all rural counties. A definition and listing of qualified areas is available via U.S. Census data at http://www.census.gov/population/metro. However, there is no limitation on the location of the health professional delivering the medical service. In some states, Medicaid reimburses for telemedicine services as well, but many have restrictions. Private insurers vary in their policies, but most will reimburse services provided to patients in rural areas. It is recommended that the provider write a letter of intent to the insurer informing them that the provider will be billing for telemedicine services. For the latest reimbursement information, see the American Telemedicine Association or CMS websites.

g. Responsibility / Liability
If a direct-patient-care-model (provider to patient) is used (no provider at the referring site), the consulting dermatologist bears full responsibility (and potential liability) for the patient's care. The diagnostic and therapeutic recommendations rendered are based solely on information provided by the patient. Therefore, any liability should be based on the information available at the time the consult was answered. In a consultative model (provide to provider), liability may be shared; however, the allocation of responsibilities will vary on a case-by case and state-by state basis. In either case, dermatologists should verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

II. STORE-AND-FORWARD TELEDERMATOLOGY

a. Definitions
Store-and-forward teledermatology refers to a method of providing asynchronous consultations to referring providers or patients. A dermatologic history and a set of images are collected at the point of care and transmitted for review by the dermatologist. In turn, the dermatologist provides a consultative report back to the referring provider or patient at the point of care.

Store-and-forward teledermatology is used in several settings:

1. Teletriage involves the review of patient cases transmitted by a referring provider to determine which patients need to be seen in-person by a dermatologist, which patients can be cared for by teleconsultation, and which patients may not need dermatologic referral.

2. Teleconsultation involves the review of patient cases transmitted by a referring provider and the provision of a consultative report back to the referring provider. Unless the patient's care is then transferred to the consulting dermatologist, the referring provider typically maintains responsibility for carrying out treatment recommendations.

3. Direct-to-patient telemedicine involves a patient originating his/her own consultation by transmitting a medical history and images to a dermatologist, who then receives some form of care from the dermatologist

b. Technology
A digital camera, whether integrated in a mobile handheld device or comprehensive telecommunications system or a stand-alone product, with a minimum of 800 x 600 pixel (480,000) resolution is required; however, higher resolutions may increase diagnostic fidelity. For systems that transmit over the Internet, a minimum 128-bit encryption and password-level authentication are recommended.

c. Credentialing and Privileging
Practitioners who render care using store-and-forward systems are viewed by TJC as "consultants" and may not be required to be credentialed at the originating site. However, standards can vary by state and organization.

d. Privacy and Confidentiality
In this case, HIPAA compliance is largely a matter of the originating site letting patients know that their information will be traveling by electronic means to another site for consultation. This should be noted in the consent form at the point of care, and the HIPAA notice of privacy practices. In addition, all electronic transmissions should be encrypted and reasonable care should be taken to authenticate those providers who have electronic access to the records.

e. Licensing
Most states require the physician to be licensed in the same state as where the patient resides, even when he or she acts only as a consultant. Providers who wish to provide store-and-forward consultations across state lines should limit such consultations to originating states in which they are permitted, by law, to provide care.

f. Current Reimbursement
As of 2014, CMS reimburses store-and-forward teledermatology only as a demonstration project in Hawaii and Alaska. However, several states are currently reimbursing store-and-forward teledermatology for Medicaid patients. There are also private insurers that are paying for store and forward modalities, including those that are part of a Medicare Advantage plan. Providers who wish to provide store-and-forward services should inquire with their payers regarding reimbursement.

g. Responsibility / Liability
In the teletriage and teleconsultation models (provider to provider), the referring provider ultimately manages the patient with the aid of the consultant's recommendations. The referring provider may accept the recommendations in part or whole or none at all, and the responsibility and potential liability in this scenario may be shared (between the referring provider and the consultant) based on the extent to which the recommendations were followed by the referring provider. If a direct-to-patient model (provider to patient) is used (no provider at the referring site), the responsibility and potential liability rests entirely on the teledermatologist. In this case, the teledermatologist would also be responsible to ensure proper follow up and to address any medication complications. Dermatologists should verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

III. CRITERIA for HIGH QUALITY TELEDERMATOLOGY

The Academy supports the use of telemedicine services provided by Board certified dermatologists, as well as coverage and payment for those services, when several important criteria are met:

a. Physicians delivering teledermatology services must be licensed in the state in which the patient receives services, and must abide by that state's licensure laws and medical practice laws and regulations. Emergency treatment and situations that arise when a dermatologist's existing patient is traveling to another state should be exceptions to this requirement, though existing laws and regulations may still apply. The Academy supports efforts by State Medical Boards to facilitate and lower burdens for physicians to obtain licenses in multiple states.

b. Patients or referring physicians seeking teledermatology services must have a choice of dermatologist, and must have access in advance to the licensure and board certification qualifications of the clinician providing care. The delivery of teledermatology services must be consistent with state scope of practice laws. The Academy strongly believes that any use of non-physician clinicians in the delivery of teledermatology should abide by the supervision requirements in the Academy's Position Statement on the Practice of Dermatology.

c. The patient's relevant medical history must be collected as part of the provision of teledermatology services. For teletriage and teleconsultation, appropriate medical records should be available to the consulting dermatologist prior to or at the time of the telemedicine encounter. Consulting dermatologists should have a good understanding of the culture, health care infrastructure, and patient resources available at the site from which consults are originating.

d. The provision of teledermatology services must be properly documented. These medical records should be available at the consultant site, and for teletriage and teleconsultation services, should also be available at the referral site.

e. The provision of teledermatology services should include care coordination with the patient's existing primary care physician or medical home, and existing dermatologist if one exists. This should include, at a minimum, identifying the patient's existing primary care physician and dermatologist in the teledermatology record, and providing a copy of the medical record to those existing members of the treatment team who do not have electronic access to it. This is especially important so that information about diagnoses, test results, and medication changes are available to the existing care team.

f. Organizations and clinicians participating in teledermatology should have an active training and quality assurance program for both the distant and receiving sites. In addition, those programs that are using teledermatology should have documentation of their training programs for any technician who is capturing clinical images and for any manager who is handling consults. Each organization should also maintain documentation on how the program protects patient privacy, promotes high quality clinical and image data, continuity of care, and care coordination for patients who may require subsequent in-person evaluations or procedures.

g. Organizations and clinicians participating in teledermatology must have protocols for local referrals (in the patient's geographic area) for urgent and emergency services.

h. The physician-patient relationship:

    a. For teletriage and teleconsultation services where a referring provider ultimately manages the patient (including the prescription of medications), the consulting dermatologist is **not** required to have a pre-existing, valid patient-physician relationship. It is optimal, however, if the patient has available access to in-person follow-up with a local, board-certified dermatologist if needed.

    b. For direct-to-patient teledermatology, the Academy believes that the consulting dermatologist must either:

        i. Have an existing physician-patient relationship (having previously seen the patient in-person), or

        ii. Create a physician-patient relationship through the use of a live-interactive face-to-face consultation before the use of store-and-forward technology, or

        iii. Be a part of an integrated health delivery system where the patient already receives care, in which the consulting dermatologist has access to the patient's existing medical record and can coordinate follow-up care.

i. The use of ***direct-to-patient teledermatology*** raises several additional issues (and all of the above criteria still apply):

    a. Providers must exercise caution regarding direct prescribing for patients via electronic communications. Most states have regulations that discourage or prohibit practitioners from prescribing for patients that they have not seen face to face. In many cases, the wording of these regulations is such that a live interactive teleconsultation would meet the requirements for a "face to face exam." The Federation of State Medical Boards established a National Clearinghouse on Internet Prescribing located at http://www.fsmb.org/ncip_overview.html. The Clearinghouse includes a state-by-state breakdown of jurisdiction, regulations, and actions related to the regulation of Internet prescribing.

    b. Dermatologists providing direct-to-patient teledermatology must make every effort to collect accurate, complete, and quality clinical information. When appropriate, the dermatologist may wish to contact the primary care providers or other specialists to obtain additional corroborating information.

c. Photographs obtained by patients, their family members, or their friends outside of a clinical setting may not be of adequate quality, or may not include the appropriate lesions or areas, to make an accurate diagnosis.

d. Mechanisms to facilitate continuity of care, follow-up care, and referrals for urgent and emergency services in the patient's geographic area must be in place. Any new medications prescribed or changes in existing medications must be communicated directly to the patient's existing care team (unless they have easy electronic access to the teledermatology record).

e. The Academy does not support direct-to-patient teledermatology services designed ***primarily*** for profit, or direct-to-patient teldermatology services designed ***primarily*** to provide prescriptions to patients via electronic means.

Air Methods®

DEFENDERS OF TOMORROW™

August 11, 2014

Mr. Adam Plain
Nevada Division of Insurance
1818 East College Parkway
Suite 103
Carson City, NV 89706

Re: LCB File R049-14, Draft Proposed Amendment August 6, 2014

Dear Mr. Plain and to whom else it may concern

Air Methods (AMC), as the leading provider of air medical services in Nevada and around the world, transports over 100,000 patients each year across 48 states when requested by physician authorities or first responders. We appreciate an opportunity to provide comment on health care matters in Nevada and are committed to making our subject matter experts available to the state Nevada regarding emergency critical care transport as needed.

Upon our initial review, please consider our comments, as we ask that you continue to work with us to address our concerns and input:

- Section 2.3(b): The provision should be amended with the italicized language to read: "Emergency medicine: *Including medically necessary emergency medical transport and*; 1 facility for every 30,000 covered lives;"
    - Reason: In the interest of not making the regulation too prescriptive, this addition will ensure that a necessary benefit is included in beneficiaries' plans. Emergency medicine without the coverage of emergency transport, when medically necessary, would be inadequate coverage. The Covered California exchange Standard Benefit Plan Designs adopted in March of 2013, delineated between emergency room care and emergency medical transportation under its "Need[s] Immediate Attention" emergent care category. Following this logic, the proposed revisions to Chapter 687B of NAC referring only to facilities for emergency medical treatment ignores a key component of emergent care, which will result in inadequate networks to serve beneficiaries.

- Section 3.1: Add the following italicized language to the end of the provision: "Except as otherwise permitted in section 8 of this regulation, the providers of health care used by the network plan to meet the requirements of this regulation must be located within the applicable geographic service area*, or otherwise be available to adequately serve the geographic area in the case of certain emergency services, such as ground and air ambulance services*."
    - Reason: Air ambulance providers, being mobile and high speed in nature, are able to get to the patient very quickly and don't need to be as geographically restricted as other stationary health care providers.

- Section 3.5: Correct typo "un" at beginning of sentence so that provision reads: "As used *in* this section…"
    - Reason: Typo.

- Section 4.2(a): Add the following italicized language to the beginning of the provision: "*Except for certain*

emergency services, at least 30 percent of the available essential community providers in each geographic service area covered by the network plan…"

- Reason: If the geographic region is defined too broadly, then it could be difficult for plans and providers to determine how many air ambulance providers service a certain geographic service area. For example, could an air ambulance provider at a significant distance away outside the state of Nevada be included as a provider to the geographic service area, thus making it uncertain how many providers the plans need to include to meet the network thresholds.

- Section 5.3: Revise with the addition of the italicized language to state: "Nothing in this section prohibits a health benefit plan from limiting coverage to those *Indian Health Service* 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 *Indian Health Service* health care service"
  - Reason: Clarify language to reflect what appears to be the intent, that the provision is limited to the subject area of Section 5.

- Section 12.5: With respect to the definition of a "significant change" in a network being a change that effects more than 10% of the members, how is that going to be measured?
  - Reason: Unclear how this will be measured.

AMC welcomes any questions or further discussion you may have, please contact our Government Relations Specialist Ruthie Hubka for prompt handling at (303) 792-7464 or ruthie.hubka@airmethods.com

Sincerely

Air Methods Government Relations

Dignity Health.
St. Rose Dominican

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August 11, 2014

Insurance Commissioner Scott Kipper
Nevada Division of Insurance
1818 E. College Pkwy., Suite 103
Carson City, NV 89706

Re: Network Adequacy Definition; LCB File No. R049-14

Dear Mr. Kipper:

On behalf of our three hospitals in Nevada, Dignity Health-St. Rose Dominican appreciates the opportunity to submit comments on the proposed network adequacy recommendations. As the nation's fifth-largest health system, Dignity Health is committed to our mission of providing compassionate, high-quality care to all and strongly supports a system of health care that includes choice, proximity and timely access to services. Dignity Health believes there should be a minimum standard for these provisions and that at no time should a health insurance plan be so narrow that it doesn't meet the minimum requirements.

Along with choice, proximity and timely access to health care services, Dignity Health-St. Rose Dominican believes the network adequacy definition should include these three principles:

1) Education of the Consumer – In order for consumer to properly purchase the best health insurance plan for their needs, payers need to provide sufficient information about the plan and the composition of the provider network in order for the consumer to make an educated choice. Health insurance companies should meet a minimum standard for documentation of details related to the plan so that consumers will know what exactly they're purchasing, which providers are in the network and examples of coverage when it comes to in-network and out-of-network coverage.

2) Protection of the Consumer in Emergent Situations – According to EMTALA, all hospitals are required to treat patients during an emergent crisis, whether their services are covered or not by a consumer's health plan. Both the Affordable Care Act (ACA) and state law require health plans to cover emergent care through stabilization, but many times the financial burden of the post-stabilization care is passed onto the consumer by the health insurance companies when attempts are made to transfer the patient to their covered provider and it doesn't happen. This continues to happen despite the fact that many patients don't have a choice in choosing a hospital in an emergent situation. Protecting the consumer from financial burden when seeking emergent care as

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St. Rose Dominican

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a prudent person should be covered under all health plans.

3) Limitations of Network Changes – The network adequacy definition should also forbid health insurance companies from making severe changes to networks after the open enrollment period has ended. Changes to networks, including the narrowing of networks, creates confusion for consumers, especially those with chronic conditions that rely on their health coverage more than the average consumer, along with higher out-of-pocket costs.

While Dignity Health-St. Rose Dominican fully supports the effort to create the network adequacy definition, we have specific concerns. There are two specific items we would like to add to this proposal:

1) Primary Care Focus – To develop effective partnerships between providers and health plans, comprehensive primary care networks must be in place in order to build alternative network models which promote quality and cost efficiencies. Requirements related to primary care, which includes internal medicine, general practice and family practice are mentioned in section 2.2.f, but access standards and capacity requirements should be developed to monitor plan compliance. Based on models elsewhere, including California, we are recommending a set of standards which address the following with the suggested metrics:

    a. One (1) primary care physician per 2000 commercial enrollees
    b. One (1) physician, including specialists, per 1200 enrollees
    c. One (1) full time physician extender (physicians assistants and nurse practitioners) per 1000 enrollees
    d. Radius for primary care physicians to member residence should be no further than 10 miles or 30 minutes
    e. Minimum number of physician panels that must be open to new patients.

2) Electronic Health Records – Section 6.2 addresses the maintenance of health records and Section 7 mentions patient data. We believe that any new regulation should encourage the development and implementation of the electronic health record (EHR). This focus supports the ACA and enables health plans and providers to fully coordinate a patient's care across the continuum.

Dignity Health.
St. Rose Dominican

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Dignity Health-St. Rose Dominican appreciates the opportunity to respond to the network adequacy recommendations and hopes our input is helpful as your office proceeds further. If you have any questions, please feel free to contact Katie Ryan, Director of Communications and Public Policy at (702) 616-4847 or at katie.ryan@dignityhealth.org.

Sincerely,

Lisa Farnan
Dignity Health, Nevada Market
Vice President, Managed Care

Katie Ryan
Dignity Health-St. Rose Dominican
Director, Communications and Public Policy

NHA
Nevada Hospital Association

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August 11, 2014

Adam Plain, CPCU AIE AFSB AIAF API ARC ARe
Insurance Regulation Liaison
Nevada Division of Insurance
1818 E. College Parkway, Ste. 103
Carson City, NV 89706

Nevada Hospital Association
Network Adequacy - Proposed Regulation: LCB File No. R049-14
August 12, 2014 Workshop

The Nevada Hospital Association (NHA) appreciates the leadership and effort of the Division of Insurance to ensure that Nevada's network adequacy regulations protect the consumers' access to high quality and affordable health care. NHA is dedicated to representing the interests of our member hospitals, including general acute care, long-term acute care, rehabilitation and psychiatric hospitals, located in both urban and rural settings all of whom furnish vital health care to Nevadans. With respect to the draft of the proposed regulation (LCB File No. R046-14) circulated on July 30th, 2014, we hope you will take into consideration the following comments.

Consumer Education:

Problem: Health care cost can be a major expense for most households, even for those who have coverage. Yet, **health insurance is one the only products that a consumer can purchase which does not come with an operating manual or directions for use**. One of the chief advantages to having health insurance is the discount received when the consumer uses an in-network provider. Many consumers are not knowledgeable about the financial impact of using an out-of-network provider and the Division could remedy this situation within the network adequacy regulations.

Solution: A simple-to-understand one-page description with examples of the financial impact on the consumer should be provided to the consumer when he/she is issued an insurance plan. Ideally, the Division would develop a template for consistency and simply require the insurer to provide it to the consumer with their plan specific details included. See attached- Section 13.5..

Emergent Healthcare:

Problem: The hospital has an obligation to provide life-saving services to patients when they face an emergency situation. The insurer also has the responsibility to protect the patient from financially crippling expense if they need to seek emergency care and the nearest facility is an out-of-network hospital. When seek medically necessary emergent care as defined in NRS 695G.170 subsection (3), the patient should not expect to have to pay any more than he would if he had sought that care at an in-network provider. The proposed regulation states that an adequate network is one with emergency care available within 40 miles or 40 minutes in an urban setting. Since proximity is often the key to good outcomes when a person needs medically necessary emergent care, this is the equivalent of not really having any network adequacy requirement for emergency medicine, since no reasonable person is going to (nor should be expected to) travel that far in a true emergency.

Solution: There are two ways to solve this in the interest of the patient:

1. The network adequacy regulation could state that the patient shall not experience any greater cost when he/she seeks care at an out-of-network provider for emergency care than he/she would had he/she obtained the care at an in-network provider (see attached – Section 2 subsection 3) , or,
2. The network adequacy regulation could state that the insurer is required to include in its network all emergency care providers for emergent care situations. This would not require all hospital care to be covered as in-network, just the emergency care until the patient could be transferred home or to an in-network provider.

Trauma Care:

Problem: This issue is very similar to emergent care. There is only one trauma care hospital in the North and three in the South, all offering different levels of trauma care. Similar to emergency care, the patient has no choice in the case of trauma care; he/she will receive care at the nearest and most appropriate trauma center for his/her injuries.

Solution: When the patient has no choice, the insurer needs to assure that the patient will not experience any financial penalty, and one of the solutions provided above needs to be part of the network adequacy regulation (see attached – Section 2 subsection.3).

Minimum Number of Providers per Covered Lives and Distance Requirements: In the most recent draft of the regulation, you have compressed the section on travel distances, and we believe this is an improvement on the previous versions. Since it is too cumbersome to try to identify every specialty, we would recommend that the Division identify those specialties for which specific number of providers per enrolled lives is appropriate (as you have done) and then create a requirement for "all other specialties". Otherwise, such specialties as endocrinology, pulmonary, anesthesia, gastroenterology etc. get excluded from the network adequacy requirement. See attached - Section 2 subsection 3 (k).

Other:

- **Neurosurgery**: At Section 2 subsection 3 (g), we do not believe that neurosurgery should be included with orthopedics. See attached - Section 2 subsection 3 (h).
- **Maximum vs. Unreasonable Travel**: In Section 2 subsection 3 (which should be 2. 4.) The Division identifies the maximum travel distances which are different from the travel distances shown as "unreasonable travel" in Section 3 subsection 3. There should only be one standard. See attached - Section 3 subsection 3.
- **Missing Healthcare Services**: How do the proposed regulations ensure there are adequate hospital beds in-network?
- **Provider Directories:** Section 10. NHA supports the provision in the regulation which requires the insurer to indicate which providers are not accepting new patients. This is essential for a consumer to make an educated decision regarding the purchase of a health plan and to be able to avoid financial problems when the patient is seeking care.
- **Multi-tier network tiers and reference pricing:** When health plans use reference pricing along with a tiered provider network, where enrollees pay different cost-sharing rates for each tier of providers, the lowest cost-sharing tier must include only those providers that accept the reference rate and the health plan should be required to meet network adequacy standards in the first tier alone.

We look forward to working with the Division and other stakeholders to assure that the adopted network adequacy rules are effective in providing the patient with timely access to care and protection against financial risk related healthcare decisions out of their control.

Sincerely,

Bill M. Welch
President & CEO

VERSION DISTRIBUTED JULY 30, 2014

PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R049-14

DRAFT PROPOSED AMENDMENT

August 12, 2014

EXPLANATION – Matter in (1) ***blue bold italics*** is new language in the original regulation, (2) ***green bold italic underlining*** is new language proposed in this amendment, (3) ~~red strikethrough~~ is deleted language in the original regulation, (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment, (5) orange double underlining is deleted language in the original regulation that is proposed to be retained in this amendment, and (6) **green bold underlining** is newly added transitory language.

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 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.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections ~~[2]~~ *1.3* to ~~[13]~~ 14, inclusive, of this regulation.

Sec. 1.3 *As used in this chapter, "urban county" means Carson City county, Clark county and Washoe county.*

Sec. 1.5 *As used in this chapter, "rural county" means Douglas county, Lyon county and Storey county.*

Sec. 1.8 *As used in this chapter, "frontier county" means Churchill county, Elko county, Esmeralda county, Eureka county, Humboldt county, Lander county, Lincoln county, Mineral county, Nye county, Pershing county and White Pine county.*

Sec. 2. *1. A carrier who applies to the Commissioner for the issuance of a network plan must establish that the network plan has an adequate number and geographic diversity of providers ~~[in each category of health care necessary to serve its members in]~~ , for each geographic service area covered by the network plan, in order to meet the anticipated health care needs of plan enrollees based upon the benefits offered under the plan.*

Drafting note: The Division intends this provision to apply to all benefits offered under a health benefit plan. While certain benefits may be called out for special scrutiny (below), networks must be able to prove adequacy for the entirety of the plan. The Division no longer intends to issue a comprehensive list of specialties and categories of care as such a list is administratively burdensome, the Division does not possess data sufficient to create such a list. The fact that a specialty or category of care is not called out for special scrutiny does not indicate that there is no adequacy requirement for said specialty or category.

2. In addition to the general requirement to maintain an adequate network contained in subsection 1, an applicable carrier must establish that the network plan meets specific requirements relating to minimum number of providers or facilities and/or maximum travel distance or time for certain specialties or categories of health care.

Drafting note: The Division has, on a preliminary basis, identified ten (10) specialties or categories of care as requiring additional scrutiny. The count of ten (10) specialties or categories is 250% higher than will be applied by CCIIO to exchanges in the federal marketplace.

3. The ~~[categories of health care necessary to serve members pursuant to subsection 1]~~ minimum number of providers or facilities for certain specialties or categories of health care for each geographic service area covered by the network plan are:

(a) Cardiology; 1 provider for every 7,500 covered lives;

(b) ~~[Dermatology;~~

~~(c) Emergency medicine;~~

~~(d) Gastroenterology;~~

~~(e) Hematology and oncology;~~

~~(f)~~ Emergency medicine: 1 facility for every 30,000 covered lives;

(c) General medical services, which may include ~~[Internal]~~ internal medicine, general practice and family practice as well as physician assistants and nurse practitioners: 1 provider for every 2,500 covered lives;

~~[(g)]~~ (d) Mental health: 1 facility for every 50,000 covered lives;

~~[(h) Nephrology;~~

~~(i)]~~ (e) Obstetrics and gynecology: 1 provider for every 2,500 covered female lives age 14 and older;

~~[(j) Ophthalmology;~~

~~(k)~~ (f) Oncology: 1 provider for every 17,500 covered lives;

(g) Orthopedics, ~~[including, without limitation,]~~ which may include general orthopedic surgery, and hand surgery ~~and neurosurgery~~: 1 provider for every 10,000 covered lives;

(h) Neurosurgery: 1 provider for every xx,xxx covered lives

~~[(l) Otolaryngology;~~

~~(m)~~ ~~(h) Pediatrics, not including pediatric dentistry~~ essential health benefits: 1 provider for ~~every 2,500 covered~~ lives age 17 and younger;

[(n) Except as otherwise provided in subsection 3 , pediatric dentistry;

(o) Pulmonology;

~~(p)~~ (i) Substance abuse: 1 facility for every 50,000 covered lives; and

~~[(q) Surgery, including, without limitation, general, cardiovascular, cardiothoracic, vascular and colorectal;~~

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~~(r)~~ (j) *Urgent care: 1 facility for every 10,000 lives.* ~~; and~~

~~(s) Urology.]~~

(k) All other specialties: 1 provider for every xx,xxx lives

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Drafting note: The provider and facility ratios presented are intended as a starting point for discussion of an appropriate standard. The Division recognizes that certain proposed metrics, such as "covered lives per facility" for mental health treatment, may need extensive revision.

3. The maximum travel distances or times for the specialties or categories of health care specified in subsection 2 with the exception of Emergency medicine for medically necessary emergency services as defined in NRS 695G.170 subsection (3) or Trauma Care , the patient can receive care at the nearest emergency room or Trauma Center and their share of cost should be no more than their in-network co-insurance and deductible, if applicable, are:

Comment [RH1]: As the key to receiving care in an emergent situation is proximity to the emergency services, a facility to covered lives ratio alone shouldn't describe the standard. To be consistent with state and federal law, the prudent person should be able to access emergency services when needed without incurring costs beyond the in-network co-insurance and deductibles. See NRS 695G.170.

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(a) For urban counties: 40 miles or 40 minutes;

(b) For rural counties: 60 miles or 60 minutes;

(c) For frontier counties: 75 miles or 75 minutes.

Drafting note: The proposed standards are intended to apply to the ten (10) specialties or categories of care ~~subject to special scrutiny~~.

4. [If a network plan does not offer pediatric dental coverage pursuant to 42 U.S.C. § 18022(b)(4)(F), the carrier is not required to establish that the network plan has an adequate number of providers of pediatric dentistry pursuant to paragraph (n) of subsection 2] The Commissioner shall review the requirements and categories in subsections 2 and 3 on an annual basis.

Sec. 3. *1. A carrier who applies to the Commissioner for the issuance of a network plan must establish that the providers of health care with whom the organization has contracted to provide services within the network plan are located so that the members of the network plan may obtain health care without unreasonable travel.*

Drafting note: The unreasonable travel standard is intended to apply to any benefit offered under a health benefit plan which is not subject to special scrutiny. The Division understands that circumstances may dictate that the unreasonable travel standard cannot be met, such a scenario is subject to the Commissioner's discretionary powers under section 8.

2. ~~*[On or before April 1 of each year, the Commissioner will make available a list of the minimum number of providers and maximum travel distance or time, by county, for each*~~

~~*category of health care necessary to serve members within network plans. The 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.]*~~ *A carrier shall ensure that nonemergency services are available and accessible during normal business hours and that emergency services are available at any time.*

3. As used in this section, "unreasonable travel" means a travel time or distance in excess Of those distances outlined in Section 2 subsection 3;

~~*(a) For urban counties, 60 miles or 60 minutes;*~~

~~*(b) For rural counties, 90 miles or 90 minutes; and*~~

~~*(c) For frontier counties, 180 miles or 180 minutes.*~~

Sec. 3.5. *A carrier applying for the issuance of a network plan shall submit sufficient data to the Commissioner to establish that the proposed network plan has the capacity to adequately serve the anticipated number of enrollees in the network plan.*

Sec. 4. *1. A carrier who applies to the Commissioner for the issuance of a network plan 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 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]*~~ *At least* ~~*[20]*~~ *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 the federal Center for Consumer Information & Insurance Oversight.

Drafting note: The Division recognizes that CCIIO has a procedure in place for entities not appearing on the non-exhaustive list of essential community providers to be used to meet the ECP requirement.

4. As used in this section, "essential community provider" has the meaning ascribed to it in 45 C.F.R. § 156.235(c).

Sec. 5. *1. A carrier who applies to the Commissioner for the issuance of a network plan 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.*

2. A member described in subsection 1 must be able to obtain covered services from the Indian Health Service at no greater cost to the member than if the service were obtained from a provider or facility that is part of the network plan.

3. 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 service were obtained from a provider or facility that is part of the network plan.

4. Carriers are not responsible for credentialing providers and facilities 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. 6. *A carrier ~~[which is a health maintenance organization who]~~ issued a certificate of authority pursuant to chapter 695C of NRS that applies to the Commissioner for the issuance of a network plan must ensure that:*

1. Each member of the network plan has access to his or her primary care physician through on-call procedures after normal business hours;

2. Each provider of health care with whom the ~~[health maintenance organization]~~ carrier has contracted to provide services maintains health care records for the members of the network plan which are accessible, only as required for the diagnosis and treatment of the member, to other professionals within the ~~[health maintenance organization]~~ n etw ork pl an 's contracted network. Nothing in this section shall be construed to impinge upon a provider of health care's responsibility to maintain health care records consistent with all applicable state and federal laws;

3. The ~~[health maintenance organization]~~ carrier provides a health care professional who is primarily responsible for coordinating the overall health care services offered to members of its network plan; and

4. The ~~[health maintenance organization]~~ carrier has established a quality assurance program required pursuant to NAC 695C.400.

Sec. 7. *A carrier who applies to the Commissioner for the issuance of a network plan must establish a system to collect data related to the health care services provided to members of the network plan.*

Sec. 7.5. *A carrier applying for the issuance of a network plan shall submit all required data, in a form to be determined by the Commissioner, in conjunction with the applicable rate and form filing.*

Sec. 8. *1. ~~If a carrier applies to the Commissioner for the issuance of a network plan that meets the requirements of sections 2 to 7, inclusive, of this regulation, the network plan is deemed to be adequate.~~*

Drafting note: It is not appropriate to have a deemer clause upon the proposed removal of the comprehensive list of specialties and categories of care. Without a safe harbor standard a network cannot be deemed adequate.

~~2. If a network plan is not deemed to be adequate pursuant to subsection 1, a carrier may request that the Commissioner determine whether the network plan is adequate. To determine~~ In determining whether a network plan is adequate, the Commissioner may consider, but is not limited to considering:

(a) The relative availability of health care providers or facilities in the geographic service area covered by the network plan, including, without limitation, the operating hours of available health care providers or facilities;

(b) The ~~[willingness]~~ refusal of providers or facilities ~~[in the geographic area covered by the network plan]~~ within the time or distance standards outlined in section 2 of this regulation to contract with the carrier ~~[under reasonable terms and conditions]~~;

Drafting note: It no longer appears viable to enforce a reasonableness standard.

(c) The system for the delivery of care to be furnished by the providers or facilities ~~[in the geographic area covered]~~ contracted by the network plan; ~~[and]~~

(d) ~~[The clinical safety of the providers or facilities in the geographic area covered by the network plan.]~~ The use of telemedicine or telehealth services to supplement or provide an alternative to in-person care; and

(e) The availability of health care providers or facilities located outside of the network plan's geographic service area but within the reasonable travel standards promulgated by the Commissioner pursuant to section 3 of this regulation.

3. The Commissioner will not determine that a network plan is adequate pursuant to subsection 2 if the network plan fails to meet the requirements of section ~~[4 or]~~ 5 of this regulation.

4. The Commissioner may determine that a network plan which fails to meet the requirements of section 2 ~~[or 3]~~ to 4, inclusive, of this regulation is adequate pursuant to subsection 2. If such a network plan is determined to be inadequate, the Commissioner will notify the carrier of the requirements of sections 2 ~~[and 3]~~ to 4, inclusive, of this regulation which the network plan:

(a) Satisfies; and

(b) Does not satisfy.

5. ~~[For each requirement of sections 2 and 3 of this regulation which a carrier has been notified by the Commissioner pursuant to subsection 4 that its network plan does not satisfy, the carrier shall:~~

~~*(a) Ensure, through referral by the primary care provider or otherwise, that each covered person may obtain covered services 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 or facilities; or*~~

~~*(b) Make other arrangements acceptable to the Commissioner.]*~~

Sec. 9. *A carrier whose network plan is ~~[deemed or]~~ determined to be adequate pursuant to section 8 of this regulation 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.*

Sec. 10. *1. A carrier whose network plan is ~~[deemed or]~~ determined to be adequate pursuant to section 8 of this regulation shall update its provider directory no less frequently than every 30 days. Any updates to a provider directory shall clearly indicate those providers which have joined network since the directory was last updated and those providers that are not accepting new patients.*

2. A carrier with a significant change to its network pursuant to section 12 of this regulation shall update its provider directory within 72 hours of the effective date of the significant change in network.

3. Any updates to a provider directory shall clearly indicate:

(a) Those providers that have joined network since the directory was last updated;

(b) Those providers that have left the network since the directory was last updated; and

(c) Those providers that are not accepting new patients.

Drafting note: This should standardize provisions relating to provider directories. It is noted that the requirement to indicate providers not accepting new patients is a federal exchange standard that appears appropriate to apply market-wide.

4. The provider directory and each update thereto must:

(a) ~~[be]~~ Be posted to the Internet website maintained by the carrier and filed with the Division within ~~[24]~~ 72 hours after the update is made in accordance with the System for Electronic Rate and Form Filing developed and implemented by the National Association of Insurance Commissioners; and

(b) Be made available in hard copy upon request.

Sec. 11. ~~*1. Each carrier whose network plan is deemed or determined to be adequate pursuant to section 8 of this regulation shall attest that its network or networks meet the requirements of sections 2 to 13, inclusive, of this regulation:*~~

~~*(a) For a health benefit plan for individuals available for sale during the open enrollment period described in NRS 686B.080, by January 1 of the calendar year in which the coverage is to be effective.*~~

~~*(b) For a health benefit plan for individuals not available for sale during the open enrollment period described in NRS 686B.080, at least 30 days before the health benefit plan is made available for purchase by any individual.*~~

~~*(c) For a health benefit plan for small employers, at least 30 days before the health benefit plan is made available for purchase by any small employer.*~~

~~*2. Each carrier shall renew its attestation on or before January 1 of each subsequent calendar year.*~~

~~*3. The attestation must be made on a form prescribed by the Commissioner and signed by an officer of the carrier issuing the health benefit plan.*~~

~~*4. Each attestation must be accompanied by an Access Plan Cover Sheet Template specified by the Centers for Medicare and Medicaid Services and filed in accordance with the*~~

~~*System for Electronic Rate and Form Filing developed and implemented by the National Association of Insurance Commissioners.*~~

Sec. 12. *1. A carrier whose network plan is* ~~*[deemed or]*~~ *determined to be adequate pursuant to section 8 of this regulation shall notify the Commissioner within* ~~*[30 days]*~~ *72 hours after the effective date of any significant change to its network.*

2. If a significant change in a carrier's network results in a deficiency in the network, the notification must include a corrective action plan to resolve the deficiency within 60 days of the effective date of the significant change to the network.

3. If a significant change in a carrier's network results in a deficiency in the network with respect to any category of provider or facility, the carrier shall, during the period the corrective action plan is being implemented and with respect to that category of provider or facility:

(a) Ensure through referral by the primary care provider or otherwise that each covered person may obtain the covered service for which there is a deficiency from a provider or facility within reasonable proximity of the covered person at no greater cost share to the covered person than if the service were obtained from network providers or facilities; or

(b) Make other arrangements acceptable to the Commissioner.

4. If the network is still deficient at the end of the time period for the corrective action plan~~*:*~~

~~*(a) For a health benefit plan made available for purchase through the Silver State Health Insurance Exchange, the health benefit plan will be declared deficient pursuant to 42 U.S.C. § 18031(c)(1) and decertified pursuant to 45 C.F.R. § 156.290.*~~

~~*(b) For any other health benefit plan,*~~ *the health benefit plan shall submit a statement of network capacity to the Commissioner pursuant to 42 U.S.C. § 300gg-1(c).*

5. As used in this section, "significant change" in a network is any change or combination of changes taking effect within 30 days of each other that:

(a) Affects network capacity in any single specialty or category of health care for which a benefit is offered under the plan by more than 10 percent; or

(b) Causes the travel time or distance associated with the benefit to exceed the standards under section 2 of this regulation.

Sec. 13. *1. A carrier whose network plan is* ~~*[deemed or]*~~ *determined to be adequate pursuant to section 8 of this regulation may, upon the approval of the Commissioner, make health benefit plans using that network plan available to persons outside of the approved geographic service area.*

2. A health benefit plan made available outside of the approved geographic service area pursuant to subsection 1:

(a) Must include a disclaimer, the content and placement of which must be approved by the Commissioner, notifying potential enrollees located outside of the approved geographic service area that the network plan may not provide contracted physicians or facilities within the enrollee's approved geographic service area; and

(b) Is subject to all relevant state and federal laws regarding guaranteed availability of coverage.

Sec. 13.5 *1. A carrier whose network plan is* ~~*[deemed or]*~~ *determined to be adequate pursuant to section 8 of this regulation must, upon the approval of the Commissioner, provide each member, annually, using a Division of Insurance approved template, a summary that demonstrates the financial impact of utilizing in-network versus out-of-network providers incorporating the specific plan design of each member with the purpose of providing education. The examples provided should include both an emergent and elective*

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services.

Sec. 14. *1. The provisions of sections 2 through 13, inclusive, of this regulation do not apply to a network plan issued by an insurer that:*

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

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

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

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

3. A network plan exempt pursuant to subsection 2 that exceeds 1,250 covered lives in any calendar year to which the exemption applies shall submit a statement of network capacity to the Commissioner pursuant to 42 U.S.C. § 300gg-1(c).

America's Health Insurance Plans

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September 4, 2014

Mr. Adam Plain,
Insurance Regulation Liaison
Nevada Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, NV 89706

Re: Network Adequacy Proposed Rules

Dear Mr. Plain,

I write today on behalf of America's Health Insurance Plans (AHIP) to provide comments in response to the proposed regulations issued by the Nevada Division of Insurance (Division) on network adequacy.

AHIP is the national trade association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs. Health plans have been committed to providing consumers with affordable products that offer robust networks of quality, cost-efficient providers. We continue to have concerns, some of which we previously raised in our May 12 comment letter (see attached), and respectfully stress the following points:

Applying the network adequacy standards in the Affordable Care Act for Exchange plans more broadly to all network plans at this time of change and uncertainty in the Nevada marketplace creates unnecessary challenge and confusion.

The Affordable Care Act (ACA) Exchange Rule *(45 C.F.R. § 156.230(a)(2))* established network adequacy requirements for qualified health plans (QHPs) and the Nevada health benefit exchange (Exchange) board approved network adequacy standards for QHPs that meet the federal ACA requirements.[1] Stakeholders, including AHIP and members, were heavily involved in the development of the Nevada Exchange standards for QHPs and were assured that pending network adequacy rules developed by the Division would be similar to the Exchange network adequacy requirements. We understand the need for updated standards for Exchange QHPs and ECPs related to those plans for the Division to maintain state oversight authority. However the

[1] Network Adequacy Standards Approved by the Silver State Health Insurance Exchange Board. Available at: http://exchange.nv.gov/uploadedFiles/exchangenvgov/Content/Resources/Final_Exchange_Network_Adequacy_Standards.pdf

Division's proposed rules would apply those QHP ECP standards to all network plans, many of which are not QHPs. This will create unnecessary challenges for health plans and confusion for consumers. The proposed rules to update requirements for Exchange plans are overly aggressive if applied to all other network plans, and we encourage the Insurance Commissioner to apply the standards in Section 4 paragraph 2 to Exchange QHPs only, which will allow those standards to comply with the current federal guidance for ECPs in QHPs. This can be done by inserting the "QHP" before the phrase "network plan" in paragraph 2.

We also urge that, where possible, applying similar standards both inside and outside the Exchange will provide a common understanding for providers, health plans, and patient advocates of what standards apply. We also note that specific network adequacy standards are required in order to meet National Committee for Quality Assurance (NCQA) and URAC accreditation for health plans both inside and outside of exchanges. With these existing structures in place, we urge the Division to utilize the amended state approach for QHPs that is already providing sufficient network adequacy protections for consumers rather than creating unnecessary new or potentially conflicting requirements.

The timing of the requirement to utilize the Division's list of minimum number of providers and maximum travel time or distance by county/specialty/category, which would be published no later than January 30 of each year, is unclear.

Health plans require adequate time to respond to any changes in standards regarding network adequacy, especially if it involves additional provider contracting activity. Thus the language in Section 3 paragraph 3 should clearly specify that the final list of those standards will be applicable to health benefit plans issued or renewed on or after January 1 of the following calendar year after the list is issued. To make it retroactive, as the current language seems to suggest, is both unreasonable and unfair.

The time and distance standards in the proposed rules are not realistic for health plans to monitor, and create an unreasonable administrative burden.

Nevada faces a number of challenges related to the rural environment in large portions of the state, which is reflected in the CMS designation of ten of Nevada's 17 counties as "counties with extreme access considerations." Compounded by the severe shortage of providers in many areas of the state, it is imperative that the state find new network access solutions without returning to outdated methods of measuring by distance, travel times, wait times, and number of providers per person. These old approaches do not provide high quality, high value care for consumers and will not resolve the access issues in Nevada. We urge use of more streamlined state standards where 1) plans develop networks that include the required providers, 2) plans review their networks to assure adequate number of providers to assure covered members have access to covered services, 3) plans provide their list of providers by county to the Division, and 4) plans

continuously monitor any complaints or concerns about access from covered members and address them.

Health plans have taken, and continue to take, a leadership role in addressing gaps in provider networks and also gaps in quality of care. We appreciate that the Division included recognition of telemedicine and telehealth in considering network standards, and urge recognition of other steps undertaken by health plans regarding delivery system reforms and new alternative provider payment models including patient centered medical homes, accountable care organizations (ACOs), "Centers of Excellence", and single case reimbursement of providers to help fill gaps in coverage. These innovative alternatives can be applied to various plan structures and various consumer needs, whether urban or rural, and can be more cost effective than requiring plans to contract with every provider in an area – some of whom may not meet the plan's credentialing or quality standards.

The provider directory requirements are cumbersome and difficult for health plans to administer.

We request that the proposed rule language be amended to allow carriers 45 days to update their provider directory. This will help ensure that updates are as accurate and as timely as they can be, thus providing the most value to enrollees. Alternately, we propose that a SERFF filing only be required if there is a significant change to the provider network. Further, we request these rules allow health insurers to post what information they may get from providers, with the full acknowledgement that some information may be missing if the provider does not report that information to the health plan.

AHIP will continue to work to promote and provide a transparent, value-based health care system. Collaboration with the Division, health care providers, and other stakeholders is critical to the overall goal of achieving an affordable and broad choice of health care options to Nevadans. We appreciate the opportunity to provide comments and look forward to continued discussions with you on this important issue. If you have any questions, please do not hesitate to contact me at gcampbell@ahip.org or 971-599-5379.

Sincerely,

Grace Campbell

Grace Campbell
Regional Director

American Cancer Society Cancer Action Network
691 Sierra Rose Drive | Suite A | Reno, NV 89511
www.acscan.org

September 4, 2014

The Honorable Scott Kipper, Commissioner
Nevada Division of Insurance
Office of the Commissioner
1818 E. College Parkway
Carson City, NV 89706

Comments sent by email to: aplain@doi.nv.gov

Re: American Cancer Society Cancer Action Network comments on Network Adequacy Proposed Rule LCB File No. R049-14, Draft Proposed Amendment 8/12/14

Dear Commissioner Kipper:

The American Cancer Society Cancer Action Network (ACSCAN) thanks you for the opportunity to comment on the current draft of the proposed rule on network access standards in the state of Nevada. ACS CAN, the nonprofit, nonpartisan, advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

Overall we are pleased with the current direction of the proposed rule, which attempts to ensure that health insurance plans in Nevada provide an adequate plan network in order to meet the needs of its enrollees. Access to specialty care is vitally important to cancer patients – including the 14,450 Nevadans who are estimated to develop cancer in 2014.[1]

As the Office of the Commissioner continues its work to finalize the proposed rule on network access standards, we welcome the opportunity to work with you and the Division to further refine the proposed rule. We offer the following specific comments and requests for further clarification on the draft rule.

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1 American Cancer Society, Cancer Facts and Figures 2014, available at http://www.cancer.org/acs/groups/content/@research/documents/webcontent/acspc-042151.pdf

Sec. 2. 3 Minimum number of providers for certain specialists or categories of health care

The current draft rule imposes a minimum requirement for oncology to be one provider for every 17,500 covered lives. We thank you for recognizing the importance of providing oncology services as a covered benefit. We also appreciate the emphasis on availability within geographic service areas. As your office works to finalize the proposed rule we ask for clarification on the following:

Minimum number of providers: We are concerned the current number of oncology providers may be insufficient to guarantee enrollees with adequate access to oncology services. We urge the Division to ensure that individuals with cancer – including individuals who are newly diagnoses, those in active treatment as well as survivors – have access to oncology services. Further, individuals with cancer often need a second opinion regarding their treatment options. Therefore, we urge the Division to ensure that, at a minimum, individuals have access to at least two oncologists who are trained to provide care and treatment for the individual's unique needs. In addition, it would be helpful if the Division could provide additional information regarding their methodology in deciding to make the required ratio of oncology providers to enrollees 1:17,500 – particularly as it compares to the required ratios for other providers.

Definition of "oncology": We note the proposed rule fails to define the term "oncology provider." Given the complex layers of specialty care that exist within the "oncology" space, we have some concern about the term "oncology" being too general and leaving open the possibility of networks having, for example, one medical oncologist but not a surgical oncologist or a radiation oncologist. We urge the Division to ensure that individuals have access to a wide variety of oncology services.

We appreciate the drafting note on page 2 which states in part: "the fact that a specialty or category area of care is not called out for special scrutiny does not indicate that there is not an adequacy requirement for said specialty or category." One interpretation of the note suggests these unstated requirements by the Division would include an analysis of specialty providers within the oncology space. We urge the Division to further elaboration to provide greater clarity regarding how the Division will ensure that patients have access to specialty care.

Hematology and oncology: We note the previous draft of the rule listed "hematology and oncology" as a category of health care necessary to serve members. However, in the current draft, the Division appears to have deleted "hematology and oncology" and replaced it with "oncology." It is not clear what necessitated the change and it would be helpful if the Division – as part of the workshop and hearing process – could provide further elaboration.

Appeals: Finally, we suggest that the Division include a requirement that health plans have a process to allow enrollees to request in-network coverage of an out-of-network provider when no in-network provider is qualified to treat their condition and available within a reasonable geographic distance and timeframe. Any denial of such an appeal should be considered an adverse benefit determination and subject to external appeals requirements.

Sec. 2 –Travel time and distance requirements

The current draft mandates specific maximum and distance requirements: 40 miles or minutes for urban counties; 60 miles or minutes for rural counties; and 75 miles or minutes for frontier counties. The length of time is takes for someone to travel to their provider can often be much different when measured by miles as opposed to minutes. We urge the Division to consider adding language to require that the provider be the lesser of x miles or x minutes to ensure that a patient won't, for example, face a three hour drive to a provider that is 75 miles away.

We note that Section 3 of the current draft requires that enrollees be able to obtain necessary services without "unreasonable travel" which is defined as 60 miles/minutes for urban counties; 90 miles/minutes for rural counties; and 180 miles/minutes for frontier counties. We suggest the Division consider consolidating the maximum time and distance requirements and unreasonable travel requirements so that plans must meet the maximum time and distance requirements for all benefits (e.g., 40 miles or minutes for urban counties; 60 miles or minutes for rural counties; and 75 miles or minutes for frontier counties).

Section 10 –Provider Directory

The current draft requires that plans update provider directories no less frequently than every 30 days and update any "significant changes" within 72 hours of the change. This section also requires that disclosures be made in these updates for any providers who have joined, left, or stopped taking new patients since the last update. ACS CAN applauds the Division for including a requirement that enrollees are provided in accurate provider directory. Such information will help enrollees in choosing a provider to meet their needs. We note the current draft language does not contain a requirement that such provider directory be available to individuals who are not yet members of the plan. Individuals who are choosing health care coverage need access to a plan's provider directory to determine whether a given plan could be the right choice to meet their specific needs. We urge the Division to ensure that provider directories are publicly available and do not limit to enrollees of a specific plan.

Thank you for your time and consideration of our comments. We look forward to working with you and the Division staff to ensure cancer patients have access to the providers and facilities that will best help them fight their disease. If you have any additional questions regarding these comments, please do not hesitate to contact me at: 775-828-2206 or tom.mccoy@cancer.org.

Sincerely,

Tom McCoy
Nevada Government Relations Director
American Cancer Society Cancer Action Network

Biotechnology Industry Organization

September 4, 2014

Scott J. Kipper
Commissioner, Division of Insurance
Department of Business and Industry
1818 E. College Parkway Suite 103
Carson City, NV 89706

RE: Proposed Regulation on Network Adequacy [LCB File No. R049-14]

Dear Commissioner Kipper:

The Biotechnology Industry Organization (BIO) appreciates this opportunity to submit the following comments on the Proposed Regulation on Network Adequacy (the "Proposed Regulation") issued by the Division of Insurance ("Division") on April 21, 2014.[1] BIO represents more than 1,000 biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and in more than 30 other nations. BIO members include manufacturers and developers of vaccines, therapeutics, and diagnostics, and we have worked closely with stakeholders across the spectrum, including the public health and advocacy communities, to support policies that help expand access to preventive, wellness, and therapeutic services for all individuals.

BIO believes that patient access to the most appropriate healthcare providers is crucial to be able to translate insurance coverage to real healthcare access. Patients must be able to access providers with the expertise to provide highly-specialized care if needed, who are located in sufficient proximity to them, and who can provide essential care in a timely manner in settings where they may already seek care. BIO applauds the Division for addressing this important issue of network adequacy through the Proposed Regulation.

BIO reviewed the August 12, 2014 amendment to the Proposed Regulation (the "Amendment"),[2] and it is based on this Amendment that we have addressed the following comments. We believe this Amendment makes important strides in ensuring that insured patients in the state are able to obtain timely access to the most appropriate providers for their healthcare needs. Nonetheless, in the subsequent sections of this letter, we propose several recommendations to strengthen the Proposed Regulation as amended. Our comments are organized by subject, but generally follow the order in which these issues were addressed in the Amendment.

I. The Division Should Clarify its Process for Revising and Finalizing the Proposed Regulation, Including Opportunities for Stakeholder Input.

In the following sections of this comment letter, BIO describes several concerns around, and recommendations to address specific issues within, particular provisions of the Proposed Regulation. However, in general, we ask the Division for more clarity regarding the process being pursued for drafting this regulation, and the potential opportunities for public

[1] Nevada Division of Insurance. 2014 (April 21). Proposed Regulation of the Commissioner of Insurance LCB File No. R049-14.
[2] Nevada Division of Insurance. 2014 (August 12). Amendment to the Proposed Regulation of the Commissioner of Insurance LCB File No. R049-14. Hereafter "the amendment".

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comment at each stage in the drafting and consideration process. This is of particular interest since the comment deadline is September 4, but it is unclear whether further amendments to the Proposed Regulation will be available for comment prior to or after that date. Nevertheless, we appreciate the Division's engagement with stakeholders thus far, including through the upcoming workshop on the proposed regulation—to be held in Carson City on September 11—and believe continued engagement is important to better inform the Proposed Regulation.

II. The Division Should Provide Formal Definitions of Key Terms Used in the Proposed Regulation to Provide a Clear Foundation for Assessing the Potential Impact of the Proposed Changes.

To be able to provide this meaningful feedback, BIO requests that future iterations of the Proposed Regulation include comprehensive definitions for the terms used so that stakeholders can better articulate the potential impact of specific proposals. For example, definitions are needed for the terms "geographic service area" and healthcare "facility." How these terms are defined will influence the ability of the final provisions to ensure patient access to needed care, and thus, are of great interest to all stakeholders.

III. BIO Applauds the Inclusion of Minimum Geographic Proximity Standards and Urges the Division to Clarify their Applicability to "In-Network" Providers.

BIO believes that the Amendment makes progress in more specifically defining the parameters a plan must meet in order to have an adequate provider network. In particular, BIO supports the Amendment's inclusion of a requirement for an adequate number "and geographic diversity" of providers "in order to meet the anticipated health care needs of plan enrollees based upon the benefits offered under the plan."[3] This is important to ensure that patients have timely access to the most appropriate provider for their healthcare needs without having to travel unreasonable distances, which for some of the sickest, most vulnerable patients, is not feasible. Additionally, BIO applauds the inclusion of general standards for maximum travel distances or times, as well as specific standards for specialty categories of particular scrutiny.[4]

However, to provide even further clarity, BIO recommends that Section 2 of the Amendment further specify that the requirements of the Proposed Regulation apply to a plan's in-network inclusion of providers. This is a crucial aspect of the requirement that will help to ensure that patients have meaningful access to providers without being subject to prohibitive cost-sharing, which may only give the impression of access without the reality of achieving it for some patients.

IV. The Division Should Outline its Methodology for Setting Standards for the Inclusion of Specialty Providers.

Section 2 of the Amendment includes drafting notes that identify a need for additional scrutiny of plans' inclusion of certain provider specialties, presumably those responsible for treating some of the most complex and/or life-threatening conditions. In addition, while the Amendment scaled back the number of provider specialties included in the Proposed Regulation's original list, it added requirements for the number of providers per number of

[3] The Amendment at Section 2, p. 2.
[4] Id. at Section 2, subsection 1, p. 2.

covered lives that must be met for each identified specialty in order for a plan to be deemed in compliance with the network adequacy standards.

BIO requests that the Division clarify what criteria were used to compile the current list of provider specialties. We believe that enumerating the specific criteria used to for this purpose will be helpful to allow stakeholders to provide meaningful feedback on the criteria themselves and how they are applied. BIO also urges the Division to comprehensively assess currently excluded provider specialties—such as hematologists, rheumatologists, neurologists, and pain specialists—using these specific criteria prior to finalizing the Proposed Regulation and to establish a mechanism to update this list at appropriate intervals if and when the regulation is finalized. In this review, the Division should also consider the potential to include provider subspecialties on the "list for particular scrutiny." For example, while we agree that plans' inclusion of oncologists should be specifically assessed—given the importance of timely and convenient access to this type of specialist for those with cancer—not all cancers are the same, and access to subspecialists, where they are available in a given geographic area, can be crucial to ensuring patients obtain expert and individualized care. Thus, we ask the Division to consider including the subspecialties of the five most prevalent cancers by incidence—breast, prostate, lung, colorectal, and melanoma—in the list of specialties requiring specific scrutiny.[5]

In terms of providing specific provider-per-population requirements for the enumerated specialties, BIO recommends that the Division articulate the methodology for how it arrived at these requirements, perhaps as an addendum to the Proposed Regulation itself. We further ask that the methodology be made available for stakeholder comment, as it will form the basis for patient access to these important providers. For example, BIO was surprised by and concerned that the Proposed Regulation requires that a plan include a minimum of 1 oncologist per 17,500 covered lives. While this minimum standard may be appropriate for plans that exclusively cover the state's frontier counties, we believe it may be inadequate to ensure access to this crucial specialty provider for patients in the state's urban, and potentially rural, counties. Instead, BIO recommends that the Division include a separate minimum inclusion standard more appropriate for the urban density of specialty providers—based on city- or county-level data, as available—to which plans that offer coverage in such counties are subject.

V. The Division Should Articulate Requirements for the Inclusion of Providers Not Identified by Specialty in the Final Regulation.

BIO appreciates that the first drafting note in Section 2 of the Amendment specifically states that "the fact that a specialty or category of care is not called out for specialty scrutiny [in subsection 3] does not indicate that there is no adequacy requirement for said specialty or category."[6] We applaud this recognition and encourage the Division to include this language in any final regulation. Additionally, we recommend that the final regulation require plans to meet a general benchmark for the in-network inclusion of primary care providers as well as those specialty care providers not enumerated in subsection 3. Establishing this minimum standard of provider inclusion will better ensure that patients will be able to access all benefits offered under a plan without delay.

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[5] National Cancer Institute, National Institutes of Health. 2014. Common Cancer Types. Available at: http://www.cancer.gov/cancertopics/types/commoncancers (last viewed 9/4/2014).
[6] Id. at Section 2, subsection 1, p. 2.

We also appreciate the Amendment's assertion that any specialty-specific requirements should be considered the minimum standard, and ask that this assertion be extended to the general benchmark for the in-network inclusion of primary care and specialty providers suggested in the prior paragraph. BIO also recommends that the Proposed Regulation explicitly state that meeting these minimum inclusion standards does not exempt plans from review by the state Insurance Commissioner. Moreover, in assessing whether a plan has met the minimum inclusion standards pursuant to such reviews, we strongly urge the Division to consider not just the types of specialty providers that are included in-network, but also whether the services offered by these providers enable beneficiaries to obtain in-network access to all of the plan's covered benefits. We also urge the Division to assess whether the plan provides access to the highest quality providers in a given service area (e.g., integrated cancer centers within the number of oncologists) in making a determination that the plan has met the network adequacy standards.

Finally, subsection 4 of section 2 of the Amendment includes a requirement that "the Commissioner shall review the requirements and categories in subsections 2 and 3 on an annual basis." BIO requests that, if the Proposed Regulation continues to include a numerical provider-per-population requirement (whether general or specialty-specific), subsection 4 be expanded to include more specific process elements—such as changes in population demographics, disease incidence, and an account of patient satisfaction/complaints—to guide the Division's review and regular update of these requirements. A formal requirement to solicit and incorporate public comment into the review process should also be included in this subsection.

VI. The Division Should Establish Standards for the Inclusion of Complementary Immunization Providers.

BIO requests that the Division consider adding language to Section 2 of the Amendment requiring plans to include all types of complementary immunizers in their provider networks as a means to ensure broad access to this critical preventive service. One of the most important provisions of the Affordable Care Act was the establishment of the "immunization coverage standard," which requires plans to cover immunizations recommended by the Centers for Disease Control and Prevention's (CDC's) Advisory Committee on Immunization Practices (ACIP) without cost-sharing when administered by an in-network provider.[7] Ensuring that health plans include immunization providers in their networks has been identified as a critical issue by a diverse group of stakeholders who have worked together through the National Adult and Influenza Immunization Summit (NAIIS) to advance the goals of expanding access to immunizations for the entire population and achieving the *Healthy People 2020* goals for immunization.[8]

Immunization services have a unique set of providers. In addition to traditional immunizers, such as pediatricians and other primary care providers, complementary immunizers—pharmacists, public health department clinicians, school-based clinicians, and other community providers operating within their state scope of practice laws—provide many vaccines.

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[7] See ACA § 1001 (codified as Public Health Service Act § 2713(a)(2)).

[8] NAIIS is a public-private partnership compromised of more than 140 organizational stakeholders, including vaccine manufacturers, professional medical societies, public health organizations, federal agencies, pharmacists, health insurers, and hospitals, among others. NAIIS has identified the issue of network adequacy for immunization providers as critical to vaccine access

Complementary immunizers are particularly important for the hard-to-reach adolescent and adult populations. Indeed, adults have demonstrated a preference to be vaccinated outside of their medical home, where and when it is convenient for them, and the system has evolved to support that access. For instance, more than 230,000 pharmacists have been trained to administer vaccines in the United States,[9] and nearly all Americans (94 percent) live within five miles of a community pharmacy.[10] During the 2011-2012 influenza season, nearly 20 percent of adult influenza vaccines were administered in retail pharmacies.[11] All 50 states allow pharmacists to administer pneumococcal and zoster vaccines, and many adults seek these vaccines in the pharmacy setting.[12]

Complementary immunizers also serve low-income, medically underserved populations, mitigating the barriers these vulnerable patients have long faced with respect to access to care. For instance, community pharmacies provide patient access to important immunizations against vaccine-preventable diseases, including for individuals residing in medically underserved areas (MUAs). One nationwide community pharmacy corporation, Walgreens, indicated that over one-third of their influenza vaccines administered last year were in pharmacies located in MUAs; in states with the largest MUAs, they provided up to 77.1 percent of their influenza vaccines in these areas. Moreover, of all influenza vaccinations Walgreens delivered last flu season, 31 percent were during off-peak times (59 percent on weekends and 31 percent in the evenings), and approximately 31 percent of patients during off-peak times were age 65 or older, and 36 percent had underlying medical conditions. Notably, efforts to provide immunizations other than influenza were complicated by lack of insurance coverage or recognition of community pharmacies as in-network providers.

Many public health stakeholders have supported efforts underway at the CDC to include additional complementary immunization sites, such as public health and school-based clinics, in provider networks. The most significant such CDC initiative, known as the "Third Party Billing Project," works with state health departments, public health clinics, and health insurers to include public health clinics in provider networks.[13] Thirty-five states and large cities are currently planning or implementing the Billing Project, which will allow them to bill insurers for immunization services provided to insured persons of all ages. Data from the Billing Project underscore the sheer volume of immunizations furnished by these complementary immunizers: in 2010, local health units billed private insurance for $1,964,267 in immunization-related costs in North Dakota alone.[14] Other states such as Arizona, California, Arkansas, Georgia, and Montana experienced success with the Billing Project.[15]

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[9] Rothholz M. Opportunities for Collaboration to Advance Progress towards "The Immunization Neighborhood:" Recognition and Compensation of Pharmacists. Presentation. American Pharmacists Association. August 30, 2012.
[10] NCPDP Pharmacy File, ArcGIS Census Tract File, National Association of Chain Drug Stores Economics Department.
[11] CDC, March Flu Vaccination Coverage United States, 2011-12 Influenza Season (March 2012), available at: http://www.cdc.gov/flu/pdf/fluvaxview/national-flu-survey-mar2012.pdf.
[12] See American Pharmacists Association, Pharmacist Authority to Immunize, available at: http://www.pharmacist.com/sites/default/files/PharmacistIZAuthority.pdf.
[13] CDC, Billing Project Success Stories, http://www.cdc.gov/vaccines/programs/billables-project/success-stories.html (last accessed Feb. 6, 2014).
[14] Sander M. Lessons Learned: Billing Insurance at Local Health Units in North Dakota (PowerPoint). March 30, 2011. North Dakota Department of Health. Available at: https://cdc.confex.com/cdc/nic2011/webprogram/Paper25418.html.
[15] Kilgus D. Billing Program Final Plans. February 2012. CDC. Available at: http://www.cdc.gov/vaccines/programs/billables-project/downloads/billing-final-plans-from-stkhldr-mtg-slides.pdf.

In spite of these efforts, when a health insurance plan does not include complementary immunization sites in its provider network, the ACA's intent of expanding access to immunizations is compromised. For instance, a plan enrollee who seeks to be immunized at a public health clinic or pharmacy that has been excluded from a plan's provider network would be denied first dollar coverage (or coverage at all) for that service. In turn, the patient may decide not to receive the vaccine due to cost and an immunization opportunity would be lost. Alternatively, a more affluent patient could elect to pay the bill, but none of these costs would count toward the patient's deductible, and the patient would understandably be upset and confused as to why they did not receive the benefits they were promised.[16]

In our experience, complementary immunizers are currently being excluded from provider networks across the country. In Nevada, school-based clinics in Carson City have been excluded from the network of a major health insurer. As acknowledged by the National Vaccine Advisory Committee (NVAC) in the updated Standards for Adult Immunization Practice, "there is an increased recognition of community vaccinators and pharmacists as integral to achieving higher adult vaccination rates."[17] BIO urges the Division to consider requiring plans to include all types of complementary immunizers in their provider networks, as expanded access to immunization services will improve vaccination rates and thereby reduce morbidity, mortality, and overall medical care costs for enrollees.

VII. BIO Applauds the Division for Aligning Standards for the Inclusion of Essential Community Providers with Federal Requirements.

BIO appreciates that the Amendment to the original Proposed Regulation updates the requirements for plans' inclusion of essential community providers to reflect updated federal requirements for plans subject to the Affordable Care Act.[18] We strongly support aligning the definition in the Proposed Regulation with current federal regulations. The final regulation should retain this minimum standard, together with an appropriate reference to the applicable federal requirements.

VIII. The Division Should Consider Certain, Additional Criteria In Determining Whether Network Adequacy Standards Have Been Met.

In Section 8, the Amendment proposes to include specific criteria that the Division can consider when reviewing a plan for network adequacy, including:

1. The relative availability of healthcare providers or facilities in the geographic service area covered by the plan;
2. The refusal of providers or facilities within the time or distance standards established by this regulation to contract with the plan;
3. The system for the delivery of care to be furnished by the providers or facilities contracted by the plan;
4. The use of telemedicine or telehealth services to supplement or provide an alternative to in-person care; and

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[16] Andrews M. Consumers Expecting Free "Preventive Care" Sometimes Surprised by Charges (Jan. 21, 2014), available at: http://www.kaiserhealthnews.org/Stories/2014/January/21/Michelle-Andrews-Consumers-Expecting-Free-Preventive-Care.aspx.

[17] National Vaccine Advisory Committee. Standards for Adult Immunization Practice. Available at: http://www.hhs.gov/nvpo/nvac/meetings/pastmeetings/2013/adult_immunization_update-sept2013.pdf.

[18] The Amendment at Section 4, subsections 1-4, pp. 5-6.

5. The availability of healthcare providers or facilities located outside of the plan's geographic service area but within the reasonable travel standards established by the regulation.

With respect to this fourth consideration, while BIO realizes the burgeoning potential of telemedicine and telehealth services to provide care in rural and frontier counties and agrees that the availability of these services should be considered in the review of a plan's network for purposes of determining adequacy, we caution the Division that, in some cases, allowing telemedicine or telehealth services to "provide an alternative to in-person care" may create delays or other barriers to accessing care. Also, we are concerned that these providers may not be able to deliver the same breadth of diagnostic and treatment services as in-person providers. Thus, to balance the utility of leveraging these services with the need to contextualize their limitations, BIO urges the Division to further amend this consideration to read (underlined text proposed for addition): "the use of telemedicine or telehealth services to supplement <u>in-person care or provide interim care in the event that the equivalent in-person provider is not available within a reasonable geographic proximity to the location where the patient requires care</u>."

BIO also recommends that the final regulation include several other considerations that the Division can take into account when determining whether a plan's network is adequate, including:

1. The location of the participating providers and facilities;
2. The location of employers or enrollees in the health plan;
3. The range of services offered by providers and facilities for the health plan (as discussed previously in Section IV of these comments);
4. Health plan provisions that recognize and provide for extraordinary medical needs of enrollees that cannot be adequately treated by the network's participating providers and facilities;
5. The number of enrollees within each service area living in certain types of institutions or who have chronic, severe, or disabling medical conditions, as determined by the population the plan is covering and the benefits provided; and
6. Accreditation as to network access by a national accreditation organization including, but not limited to, the National Committee for Quality Assurance (NCQA), the Joint Commission, Accreditation Association of Ambulatory Health Care (AAAHC), or URAC.[19]

IX. BIO Supports the Requirement that Plans Monitor Continued Network Adequacy.

BIO agrees with the text included in Section 9 of the Amendment that requires that plans continue to monitor, on an ongoing basis, "the ability and clinical capacity of its network providers and facilities to furnish health care services to covered persons." We also appreciate the requirements set forth in Section 12 of the Amendment, requiring plans to notify the Division if changes are implemented that "affect network capacity in any single specialty or category of health care for which a benefit is offered under the plan by more than 10 percent" or "cause the travel time or distance associated with the benefit to exceed the standards [established by the regulation]." We believe these two requirements together

[19] For an example of how these criteria were included in a network adequacy regulation adopted in Washington state, *See* Washington State, Office of the Insurance Commissioner. 2014. WSR 14-10-017, Section 284-43-230. available at: http://apps.leg.wa.gov/documents/laws/wsr/2014/10/14-10-017.htm.

are critically important to ensure that patient care is not interrupted and that patients are able to access care whenever it is needed.

To further strengthen these provisions, BIO requests that the Division clarify that "by more than 10 percent," Section 12 of the Amendment intends to indicate a change that impacts the number of a plan's in-network providers in any primary or specialty category. Additionally, we recommend that the final regulation include a requirement that plans establish a process for receiving and adjudicating beneficiary appeals for access to out-of-network providers, applying no more than in-network cost-sharing requirements, if such a process does not already exist. We also recommend the inclusion of a provision in the final regulation that encourages plans to provide aggregate information around the number and types of appeals requests received annually at the request of the Division. This information can be utilized to inform the Division's annual review of inclusion requirements, as provided for in subsection 4 of Section 2 of the Amendment.

X. BIO Supports Proposed Provisions Ensuring Clarity Regarding Provider In-Network Inclusion.

BIO strongly supports the requirements in Section 10 of the Amendment that specify the information that a plan's provider directory must include—namely, any providers that have joined or left the network and those that have stopped accepting new patients since the last update—as well as how that directory should be updated—no less frequently than every 30 days—and how it should be made available—on the Internet and in hard copy, as requested. BIO recommends that the final regulation state that this clarity should be available to all interested individuals and not just those who are already beneficiaries of a plan. This requirement is important so that patients are able to determine which providers are in-network in a given plan at the time they are making enrollment decisions, as well as once they are enrolled in a plan.

XI. The Division Should Establish Processes and Timelines for Submitting and Reviewing Network Adequacy Information.

The Amendment proposes to omit the original Section 11, which set deadlines by which plans must attest to the adequacy of their networks. BIO is unsure why this section was proposed for deletion, but urges the inclusion of provisions for the timely supply of information from plans to the state for the purposes of reviewing whether a plan has met network adequacy requirements. Additionally, we encourage the inclusion of a provision for the timely and diligent review of this information by the Division to prevent plans with inadequate networks from being offered in the marketplace. BIO also encourages the Division to develop and implement internal processes and timelines for review of the initial information submitted regarding plan networks, for adjudication between the Division and plans where a plan's network is found to be out of compliance with the final regulation, and to enable the Division to assess the sufficiency of the final regulations in promoting and protecting network adequacy over time.

XII. Conclusion

BIO is pleased to be able to comment on the Amendment to the Proposed Regulation and looks forward to additional opportunities to provide feedback on the evolution of these provisions. We encourage the Division to continue to inclusively engage stakeholders in the development and implementation of the provisions, and appreciate your attention to this important issue. Please do not hesitate to contact me with any questions or if I can provide any further information.

Sincerely,

/s/

Erin Estey Hertzog, J.D., M.P.H.
Director
Reimbursement & Health Policy

ASDSA
American Society for Dermatologic Surgery ASSOCIATION

September 8, 2014

Nevada Division of Insurance
ATTN: Mr. Adam Plain
1818 East College Parkway, Suite 103
Carson City, NV 89706

RE: LCB File No. R049-14

Dear Governor Brown:

On behalf of the American Society for Dermatologic Surgery Association (ASDSA), a surgical specialty organization representing over 5,800 physician members, I am to writing to you in reference to the August 12, 2014 draft of LCB File No. R049-14, relating to adequacy of network plans.

First, I want to thank you for your work in addressing the issue of network adequacy. The ASDSA is very concerned about the impact of patient access to care associated with the narrowing of provider networks and subsequent dropping of dermatologists. Our dermatologic surgeons often treat some of the sickest and most complicated cases related to skin cancer and the subsequent removal of tissue in complicated Mohs surgery procedures. .

However, I echo the concerns already voiced by the Nevada State Medical Association, the American Medical Association, and other physician organizations in relation to the most recent approach of proposing a rigid number of specialists per “covered lives,” or providing a maximum patient drive time in number of minutes and miles. This approach may look sensible on its face, but not every specialist provides every type of procedure. For example, there are some specialized skin cancer procedures, such as Mohs surgery, which are not performed by every dermatologist, and thus having a set number of dermatologists in a given geographic area does not necessarily ensure access to this life-saving procedure. ASDSA believes the previous approach, proposed in July, which addresses the width and breadth of services needed would be preferable to that proposed in the August draft. Fundamentally, there are several components that we believe should be a part of a network adequacy bill. They are described in the paragraphs below.

Patients deserve to have accurate, up-to-date information so that they can make informed decisions about where to receive their healthcare. Physicians should be able to know why they have been dropped from a network so that they can determine how best to proceed in the future. Without these protections, patients will experience the loss of their established doctor-patient relationships, longer wait times and further distances to see a dermatologist

Additionally, we believe that any decision to drop providers should not be based on cost alone. While some physicians may be incurring higher reimbursement than others, there may be good reason for these differences. Some relate to the socioeconomic make-up of their patient populations. Seniors and other at-risk populations may be more costly to treat. Dropping physicians that treat these populations from networks can seriously threaten patient access to care.

Finally, any decision with regard to physician evaluation or network inclusion should take into account comparative effectiveness of treatment. While some treatments or procedures may be more costly in the short term, their high cure rates save healthcare system costs in the long run. For example, a Mohs surgeon will stand out as being more expensive per patient encounter than a general dermatologist seeing patients for psoriasis and eczema. This is due to a different mix of patients and not to being a costly provider. The cost data is usually not risk-adjusted, so that the providers taking care of the oldest and sickest patients get penalized as being "high cost".

Thank you for your consideration. We look forward to working with you as you continue to draft regulation on this important issue. Should you have any questions or need further information, please feel free to contact Director of State and Grassroots Advocacy Lisle Thielbar at (847) 956-9126 or *lthielbar@asds.net*.

Sincerely,

George J. Hruza, MD, President-Elect
American Society for Dermatologic Surgery Association

cc: Mitchel P. Goldman, President
Timothy C. Flynn, MD, Immediate Past President
Naomi Lawrence, MD, Vice President
Abel Torres, MD, Treasurer
Murad Alam, MD, Secretary
Katherine J. Duerdoth, CAE, Executive Director
Lisle Thielbar, Director of State and Grassroots Advocacy
H.L. Greenberg, MD, ASDSA Nevada State Advocacy Network for Dermatologic Surgery Representative

Planned Parenthood®
Act. No matter what.

Nevada Advocates for Planned Parenthood Affiliates, Inc.

September 21. 2014

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

RE: Comments Regarding Proposed Regulation LCB File No. R049-14 (Network Adequacy)

Dear Commissioner Kipper:

Nevada Advocates for Planned Parenthood Affiliates (NAPPA) greatly appreciates the opportunity to submit comments regarding the Nevada Division of Insurance's ("Division") proposed regulation R049-14 to be heard September 25, 2014.

NAPPA is the independent, non-partisan, nonprofit education, legislative and political advocacy arm for the three Nevada health centers operated by Planned Parenthood Mar Monte and Planned Parenthood of the Rocky Mountains. We offer this feedback on behalf of our health center operations as well as on behalf of our clients.

NAPPA supports the following changes:

Several of the updates to the proposed regulation help to clarify provisions or strengthen access to care. We support the following proposals:

- Section 1.5: The definition of "geographic services area"
- Section 2: The requirement for an adequate number and geographic distribution of providers
- Section 2: The removal of the list of health care categories and specialties
- Section 4: The inclusion of a write-in procedure for additional essential community providers
- Section 10: The requirements for maintaining accurate provider directories

NAPPA has concerns about the following provision:

Our concern is that the following provisions undermine critical consumer protections:

- Section 8, subsection 1 b:
    - This provision originally evaluated the "willingness of providers or facilities ….to contract with the carrier under reasonable terms and conditions." We do not have concerns with the changes to the geographic standard.

- We are concerned that this section now evaluates the "refusal of providers or facilities … to contract with the carrier."

Specifically, this new standard would allow an insurance company to offer a contract with very low or unacceptable terms and then use "provider refusal to contract" as a rationale for severely limited networks. The responsibility for bargaining in good faith no longer applies evenly to both sides.

We understand the challenge of defining "reasonable terms and conditions." Typically, this has been defined as a reimbursement rate requested by the provider or facility in relation to similarly situated providers or facilities within the same geographic service area. The responsibility for good faith businesses practices and standards must apply equally to both parties.

We would urge you to consider restoring the balance in this section:

> ***(b) The willingness or refusal of providers or facilities within the maximum average travel distance or time promulgated pursuant to section 3 of this regulation to contract with the carrier under reasonable terms and conditions;***

This standard is needed to protect consumer access to care.

Thank you for the opportunity to offer written feedback regarding the state's network adequacy standards. Please let me know if I can provide additional information.

Thank you!

Elisa Cafferata
Nevada Advocates for Planned Parenthood Affiliates
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Issue Brief

High-Value Provider Networks

America's Health
Insurance Plans

Issue Brief

Introduction

Evidence over the last decade indicates that by nearly every measure, the United States spends more money on health care than any other nation in the developed world. Economists estimate that national health care spending will grow at an average annual rate of 5.8 percent over the next decade—a full percentage point faster than overall economic growth.[1] And, as our health care spending grows, it crowds out other investment and spending in areas such as deficit reduction, infrastructure, education, and other priorities. Moreover, despite the trillions of dollars we invest in health care each year, we are missing opportunities to improve the value of that investment and continue to waste limited resources at the expense of improved health outcomes.

Health plans and employers have explored and implemented a range of strategies designed to improve efficiency, clinical effectiveness, and value—and have a meaningful impact on bending the current, unsustainable health care cost curve. One such strategy involves the use of high-value provider networks. Over the past several years, health plans and employers have begun to redesign benefits to encourage the utilization of higher-value providers. Relying on data relative to provider performance, health plans and employers can identify providers with a demonstrated ability to deliver quality, efficient health care and offer consumers incentives, such as reduced cost-sharing, to obtain care from those high-value providers.

Health plans' use of high-value networks is also an important way that plans can preserve benefits and keep premiums affordable as changes in the health reform law are implemented. This is particularly the case for the Medicare Advantage (MA) program—which faces major funding challenges as a result of more than $200 billion in payment cuts, the phase-out of the quality bonus demonstration program and related program financing challenges.

Background Information on Provider Networks

Provider networks have been a mainstay of private health insurance coverage for the past 25 years—providing consumers with access to a broad range of high-

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quality hospitals, physicians and other health care providers along with financial incentives for members to obtain care within the plan's provider network. Virtually all private health insurance coverage—including benefits administered by private plans in public programs such as Medicare and Medicaid/CHIP—utilizes provider networks to deliver health care benefits and services. It is estimated that 90% of all hospital and physicians participate in health plan networks.[2]

The most prevalent option for individuals and families covered under employer-sponsored coverage are preferred provider organization (PPO) plans—covering 57% of covered workers and dependents.[3] PPOs provide subscribers with access to both in-network and out-of-network care—with lower cost-sharing requirements and out-of-pocket costs when using care delivered by in-network, preferred providers. Other network-based plans—including Health Maintenance Organizations (HMOs), Exclusive Provider Organizations (EPOs), and Point of Service (POS) plans—cover the remainder of individuals.[4] Today, less than 1% of employees and families are covered under traditional indemnity products which do not use provider networks.

Provider networks are part of a broad array of tools and strategies used by health plans—including financial incentives for consumers, disease and care management for individuals with chronic conditions, prevention and wellness, and collaborating with providers on payment and delivery reforms—to deliver high-quality and cost-effective care to patients and consumers. By contracting with hospitals and physicians that have met standards set by established accrediting organizations, health plans work to ensure that patients have access to high-quality and effective care. These industry-wide standards, established by independent accrediting organizations such as The Joint Commission (on Accreditation of Healthcare Organizations), are used to evaluate health care organizations such as hospitals, home health, rehabilitation and other facilities to ensure that these facilities meet state-of-the-art standards including patient safety goals and credentialing standards for practitioners to ensure high quality care for patients.[5] Consumers benefit when receiving care in-network—because they have peace of mind that the provider meets such standards for the quality of care they deliver—and lower cost-sharing and out-of-pocket costs. Moreover, using network providers protects patients and consumers from excessive costs due to "balanced billing." That is, consumers benefit from health plans' negotiated payment rates to contracted providers (when satisfying deductible or co-insurance amounts) and, likewise, participating providers are barred from charging any additional costs to subscribers.

2014 Federal Marketplace Plans

Data from the states where the federal government is operating the Exchange (Federally-Facilitated Marketplace, or FFM) show that consumers will have a large number of health plans to select from when making coverage choices for 2014. On average, individuals shopping in the FFM will be able to choose from 53 qualified health plans.[6] Consumers in many states will also have the option to choose among different plan designs—PPO, HMO, EPO, or POS—selecting the one that best fits their needs. The vast majority of states will offer at least two different plan design types, with half of these states (17) offering three or four plan design choices (Appendix 1). Across all FFMs, the PPO is the most prevalent plan design (40.6% of all plans), followed by HMO (39.8%), EPO (13%) and POS (6.6%).

Although these plans may differ in the way they structure their network of providers, all health plans must meet robust standards for network adequacy and access to care. Professional accrediting organizations—such as the National Committee for Quality Assurance (NCQA) and

URAC—require plans to meet standards for access and availability of services and measure themselves against these standards annually—including standards for the number and geographic distribution of providers. Plans are evaluated on how they meet network adequacy and access to care benchmarks—such as the ability of members to get regular appointments, urgent care appointments, after hours care, and member services by phone.[7] NCQA and other organizations are also seeking to improve measures for evaluating plans on their networks and access to care—including focusing on quality of care and related delivery system innovations.

The Emergence of High-Value Networks

The use of high-value provider networks is one component of a larger effort to redesign benefits by creating financial incentives to encourage the utilization of higher-value treatments and services, such as evidence-based preventive care, and lower utilization of unnecessary treatments and services.

Value-based provider networks are currently being designed in two ways:

(1) The use of tiers of health care providers and facilities based on specified performance metrics, including cost efficiency and measures of quality. Copayments are then reduced for consumers who seek care from those providers and facilities that fall into a higher-performing tier and are increased for those providers and facilities that fall into a lower performing tier.

(2) The creation of smaller provider networks comprised of selected, high-value providers who have a track record of providing high-quality, cost-efficient care to patients. Some health plans and employers have introduced products featuring these smaller networks of providers who have demonstrated their performance on quality and cost criteria.

State and federal network adequacy laws ensure that consumers have access to a sufficient number and type of physicians and hospitals in health plans' provider networks. These network designs have become part of a larger effort on the part of health plans and employers to help preserve benefits, mitigate the impact of rising costs, and promote quality care, while still providing access to a range of health care professionals and facilities.

A 2011 Mercer survey of employers found that 14 percent of large employers were using small networks of high performers. A 2011 Kaiser/HRET survey of employers similarly found that approximately 20 percent of all firms nationally offer a tiered or high-value network option.

Moreover, a recent study of small employers and their perspectives on health insurance coverage found that small employers were interested in health plans with smaller provider networks if they resulted in lower costs. Specifically, a majority of small employer respondents (57 percent) indicated that they would choose a smaller provider network if it resulted in 5 percent lower premiums and an even greater percentage (82 percent) would choose a smaller network if it resulted in 20 percent lower premiums.[8]

A poll of consumers showed a similar preference, with a majority of respondents (58 percent) preferring "less expensive plans with a limited network of doctors and hospitals" to "more expensive plans with a broader network of doctors and hospitals."[9]

Strong Quality Criteria

While the use of tiered or smaller networks have raised questions of similarities to the 1990s managed care products, the science of quality measurement has improved significantly since the 1990s and there is now a heavy emphasis on quality as well as efficiency in selecting providers for high-value networks.

Using widely recognized, evidence-based measures of provider performance, such as those endorsed by the National Quality Forum (NQF), health plans and employers can create tiered, or smaller, networks of providers comprised of clinicians and facilities that score well on measures of efficiency and quality. A recent survey of health plans examined performance measures used by private payers and found that the performance measures used in high-value network and tiering programs most often focus on cardiovascular conditions, diabetes, preventive services, and patient safety. Not surprisingly, these areas of focus were consistent across other payment and delivery reform strategies as well, including accountable care organizations, patient-centered medical homes, and pay-for-performance.[10]

Evidence Showing the Benefits of High-Value Provider Networks

A growing body of data indicates that high-value networks can help drive consumers to better-performing providers and facilities while helping to reduce spending. For example:

- One plan's program assesses providers across 21 specialties based on quality of care and cost efficiency, with the best value providers receiving "Premium Two-Star" designation. The program yields an estimated average savings of 14 percent, with savings ranging from 7 to 19 percent depending on physician specialty.[11]
- Another plan's tiered provider network uses clinical performance and cost efficiency criteria to assess providers in 12 specialties and enables employers to set the level of incentives to drive employee behavior. The plan reports that its high-value providers are 1 to 8 percent more cost efficient relative to other providers within the network.[12]
- Recognizing in-network hospitals and selected specialties (general surgery, ob-gyn, cardiology, orthopedics, and gastroenterology) on quality, cost efficiency, and accessibility performance generated savings for one plan of up to 10 percent.[13]
- A study of a high-value network in California found that use of provider tiers resulted in 20 percent lower health care costs and 20 percent higher quality.[14]
- In California, some of the largest employers—including the state employee program (CALPERS)—have offered a high-value plans option with premium savings of up to 25% over traditional broader network plans.[15]
- Health plans are also incorporating high-value and tiered networks as part of new innovations in care delivery and payment—including adoption of patient-centered medical homes and value-based insurance design. By combining multiple payment and benefit design strategies, these innovations are assuring greater value and efficiency in care delivery while promoting affordable coverage.[16]

Additional Advantages of High-Value Networks

Many of the new payment and delivery reform models rely on close collaborations between employers, health plans and provider groups to achieve better health outcomes, such as through accountable care organizations. Selective and/or smaller provider networks can make these

collaborations easier to implement and affect positive change in the patient population.

Additionally, while it may be too early to see quantitative evidence, some have suggested that the increased use of tiered or narrow networks based on performance metrics could have an effect among providers more broadly, motivating providers outside of these networks to improve their performance so that they may be included in such networks in the future.[17]

High-value networks can also be an effective way at addressing high provider prices that—according to health policy experts—lie at the heart of the health spending problem in the U.S.[18] By providing financial incentives for consumers to select high-quality and cost-efficient providers, high-value networks and related initiatives can help constrain provider prices through market forces while rewarding efficiency and value.

The Role of High-Value Provider Networks in Preserving Benefits and Affordable Coverage Amidst Sweeping Changes to the Health Insurance Marketplace and Health Care System

The Affordable Care Act (ACA) includes a broad array of insurance market reforms, such as guaranteed issue, community rating, and prohibiting pre-existing condition exclusions. These reforms are intended to work in tandem with the new insurance marketplaces, subsidies, and the individual coverage requirement to expand health insurance coverage. By expanding access to care and broadening coverage, the law adds new benefits and new costs to the health care system.

- The reform law expands access to insurance and broadens insurance benefits. Anyone can sign up, including those with pre-existing conditions. These new benefits bring new costs.
- New rules strictly limiting how much premiums can differ among people in the same community will increase premiums for younger and healthier individuals.
- A new sales tax on health insurance that begins in 2014 will result in higher costs for working families, small businesses, and seniors.

High-value networks are an important tool for health plans in assuring that premiums are affordable while preserving access to comprehensive and important benefits. As a result of the high-value networks that health plans have implemented, premiums in the new marketplaces are lower than they would be without these network changes. According to the U.S. Department of Health and Human Services (HHS), individuals purchasing coverage in the new exchanges will have "significant choice and lower than expected premiums."[19]

The health reform law also includes funding reductions to Medicare Advantage (MA)—the part of Medicare though which private plans provide comprehensive medical coverage to seniors and other Medicare beneficiaries. Over 14 million Americans, or roughly 28 percent of all Medicare beneficiaries, have chosen to enroll in a Medicare Advantage plan because of the better services, higher-quality care and additional benefits these plans provide. Analysis of federal data also shows that Medicare Advantage is an important option for low-income and minority Medicare beneficiaries. Beneficiaries who chose to enroll in Medicare Advantage express high satisfaction with their coverage and benefits.

The ACA imposes $200 billion in funding cuts on the Medicare Advantage program over a ten-year period. To date, only 10 percent of the cuts originally estimated by the Congressional Budget Office have gone into effect. In addition, not taken fully into account at the time of ACA passage was the impact of the health insurance tax that begins in January. Over the next two years, that tax alone will mean a reduction of

approximately $500 - $1,000 per beneficiary per year on top of the Medicare Advantage cuts made in the legislation. Finally, further destabilizing this program is the impact of sequestration cuts and the threat that such cuts will continue into the future. Due to the cumulative impact of these cuts, overall Medicare Advantage funding is failing to keep pace with the growth in health care costs.

These cuts are a direct threat to the choices and benefits of Medicare Advantage enrollees. While many beneficiaries are already seeing fewer choices and higher premiums as a result of these cuts, the impact is likely to be greatly exacerbated as even larger cuts are phased in over the next few years and the Quality Bonus Demonstration Project comes to an end. Establishing high-value provider networks is one way health plans can help preserve benefits and mitigate the cost impact on beneficiaries as these changes take effect.

Further Opportunities for High-Value Provider Networks

Currently, Medicare Advantage plans are not permitted to vary copayments within their provider networks, making them unable to differentiate higher-value providers from lower-value providers. Yet, efforts are underway to use provider performance data to calculate hospital and physician payment modifiers within the traditional Medicare fee-for-service program. Similar provider performance data could be used to promote value-based choices by beneficiaries in Medicare Advantage plans if such plans were allowed to tier providers based on value and offer beneficiaries cost-sharing incentives to act on this information.

As the use of high-value networks continues to grow in the private sector, similar strategies to promote value should be explored for use within public programs so that consumers enrolled in all types of health insurance products have the information necessary and opportunity to make decisions based on value.

FFM Health Plan Options – By State[20]				
Alaska	PPO			
	30			
Alabama	PPO			
	13			
Arkansas	PPO	POS		
	29	24		
Arizona	PPO	HMO		
	101	71		
Delaware	PPO	HMO	EPO	
	4	5	12	
Florida	PPO	HMO	EPO	POS
	27	125	53	36
Georgia	PPO	HMO	POS	
	1	57	5	
Iowa	PPO	HMO	EPO	POS
	28	10	8	42
Illinois	PPO	HMO	POS	
	69	12	6	
Indiana	HMO	POS		
	53	1		
Kansas	PPO	POS		
	53	12		
Louisiana	PPO	HMO	POS	
	26	10	26	
Maine	PPO	HMO	POS	
	7	12	12	
Michigan	PPO	HMO		
	25	44		
Missouri	PPO			
	48			
Mississippi	PPO	HMO		
	11	18		
Montana	PPO	POS		
	25	4		
North Carolina	PPO	HMO	POS	
	26	8	22	
North Dakota	PPO	HMO		
	29	4		
Nebraska	PPO	HMO	POS	
	26	15	16	
New Hampshire	HMO			
	11			
New Jersey	HMO	EPO	POS	
	2	31	3	
Ohio	PPO	HMO		
	89	55		
Oklahoma	PPO	HMO	POS	
	36	21	3	
Pennsylvania	PPO	HMO	POS	
	70	49	16	
South Carolina	HMO	EPO	POS	
	8	27	17	
South Dakota	PPO	HMO		
	12	23		
Tennessee	PPO	EPO		
	66	8		
Texas	PPO	HMO	EPO	
	30	65	6	
Utah	PPO	HMO	POS	
	4	87	5	

FFM Health Plan Options – By State[20]				
Virginia	PPO	HMO	POS	
	28	52	26	
Wisconsin	PPO	HMO	EPO	POS
	29	112	12	32
West Virginia	PPO			
	13			
Wyoming	PPO	HMO		
	5	13		
TOTAL FFM	PPO	HMO	EPO	POS
	960	942	157	308

1 "National Health Expenditure Projections, 2012-22: Slow Growth Until Coverage Expands and Economy Improves," *Health Affairs*. September 2013, available online at http://content.healthaffairs.org/content/early/2013/09/13/hlthaff.2013.0721.full.pdf+html.

2 The Value of Provider Networks and the Role of Out-of-Network Charges in Rising Health Care Costs—A Survey of Charges Billed by Out-of-Network Physicians. America's Health Insurance Plans; August 2009.

3 Employer Health Benefits 2013 Annual Survey. Kaiser Family Foundation. http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf.

4 HHS offers the following description of different plan types (available at: https://www.healthcare.gov/what-are-the-different-types-of-health-insurance/):

"Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs): HMOs and EPOs may limit coverage to providers inside their networks. A network is a list of doctors, hospitals, and other health care providers that provide medical care to members of a specific health plan. If you use a doctor or facility that isn't in the HMO's network, you may have to pay the full cost of the services provided. HMO members usually have a primary care doctor and must get referrals to see specialists. This is generally not true for EPOs."

"Preferred Provider Organizations (PPOs) and Point-of-Service plans (POS): These insurance plans give you a choice of getting care within or outside of a provider network. With PPO or POS plans, you may use out-of-network providers and facilities, but you'll have to pay more than if you use in-network ones. If you have a PPO plan, you can visit any doctor without a referral. If you have a POS plan, you can visit any in-network provider without a referral, but you'll need one to visit a provider out-of-network."

5 http://www.jointcommission.org/assets/1/18/Physicians_and_The_Joint_Commission.pdf

6 "Health Insurance Marketplace Premiums for 2014." Department of Health and Human Services (HHS), Assistant Secretary for Planning and Evaluation (ASPE) Issue Brief. September 2013. Available at: http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_marketplace_premiums.cfm

7 NCQA—Network Adequacy and Exchanges White Paper. 2013.

8 J. Gabel, "Small Employer Perspectives on the Affordable Care Act's Premiums, SHOP Exchanges, and Self-Insurance," *Health Affairs* 32, no. 11 (2013): 2032-2039, available online at http://content.healthaffairs.org/content/32/11/2032.full.html.

9 The Morning Consult, National Healthcare Tracking Poll: August 2013, available online at http://themorningconsult.com/tracking-poll-topline-results-august-2013.

10 A. Higgins, "Provider Performance Measures in Private and Public Programs: Achieving Meaningful Alignment with Flexibility to Innovate," *Health Affairs* 32, no. 8 (2013): 1453-1461, available online at http://content.healthaffairs.org/content/32/8/1453.full.html.

11 UnitedHealthcare Insurance Company, UnitedHealth Premium Designation Program: FAQ for Employers (2011), available online at http://broker.uhc.com/assets/100-7939%20Premium%20Employer%20FAZ%20Singles.pdf.

12 Institute of Medicine, *U.S. Roundtable on Evidence-Based Medicine* (Washington: National Academies Press, 2010).

13 BlueCross BlueShield of North Carolina, *New BCBSNC Products Offer Cost Savings for Individuals and Employers* (Chapel Hill, NC: BlueCross BlueShield of North Carolina, December 12, 2012.

14 R. Steinbrook, "The Cost of Admission – Tiered Copayments for Hospital Use," *New England Journal of Medicine* 350, no.25 (2004): 2,539-2,542, available online at http://www.ncbi.nlm.nih.gov/pubmed/15201407.

15 Duke Helfand. "A shift toward smaller health networks." *Los Angeles Times*; April 3, 2011.

16 Joseph Burns. "Narrow Networks Found to Yield Substantial Savings." *Managed Care*; February 2012.

17 H. Meyer, "Return of the Narrow Network," *Managed Healthcare Executive*, July 1, 2012, available online at http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/return-narrow-network.

18 Chapin White et al. "High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power." *Center for Studying Health System Change*; September 2013.

19 ASPE Issue Brief. Health Insurance Marketplace Premiums for 2014. September 25, 2013. http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_premiumslandscape.pdf.

20 Counts are based on the number of unique "Plan Marketing Name" entries, by state and product type, on HHS's QHP Individual Medical Landscape File. Available at: https://data.healthcare.gov/dataset/QHP-Individual-Medical-Landscape/ba45-xusy. While these numbers represent the total number of plan offerings in a state, they may not represent the actual number of plans available to a specific individual since not all plans are offered in all geographic rating areas within a state. Similarly, catastrophic plans are included in these totals, although enrollment in these plans is restricted to those under 30 or those who meet certain income requirements.

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For additional information or questions about this Issue Brief, contact our Federal Affairs Department at 202.778.3200.

ASDSA
American Society for Dermatologic Surgery ASSOCIATION

September 23, 2014

Nevada Division of Insurance
ATTN: Mr. Adam Plain
1818 East College Parkway, Suite 103
Carson City, NV 89706

RE: LCB File No. R049-14 v4

Dear Mr. Plain:

On behalf of the American Society for Dermatologic Surgery Association (ASDSA), a surgical specialty organization representing over 5,800 physician members, I am to writing to you in reference to the version 4 of LCB File No. R049-14, relating to adequacy of network plans.

I appreciate that the approach of proposing a rigid number of specialists per "covered lives," or providing a maximum patient drive time in number of minutes and miles has been removed from this version of the proposed regulation. The most recent version of the proposed regulation, version 4, states that "a carrier who applies to the Commissioner for the issuance of a network plan must establish that the providers of certain specialties and categories of health care with whom the organization has contracted to provide services within the network plan are located so that the members of the network plan may obtain health care without unreasonable travel." ASDSA strongly recommends that "dermatologists" and "skin cancer surgery" be considered among the "certain specialties and categories of health care." Our dermatologic surgeons often treat some of the sickest and most complicated cases related to skin cancer and the subsequent removal of tissue in complicated Mohs surgery procedures.

Thank you for including the provision in section 10 requiring that carriers update their provider directories no less frequently than once every thirty days. Patients deserve to have accurate, up-to-date information so that they can make informed decisions about where to receive their healthcare.

ASDSA respectfully requests that the Nevada Division of Insurance consider adding language to the next draft of this regulation to ensure transparency for physicians with regard to physician evaluation and network inclusion, and provisions which would make it clear that network inclusion decisions be based on comparative effectiveness rather than cost alone.

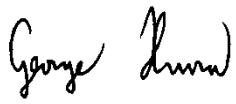
Physicians should be able to know why they have been dropped from a network so that they can determine how best to proceed in the future. Additionally, we believe that any decision to drop providers should not be based on cost alone. While some physicians may be incurring higher reimbursement than others, there may be good reason for these differences. Some relate to the socioeconomic make-up of their patient populations. Seniors and other at-risk populations may be more costly to treat. Dropping physicians that treat these populations from networks can seriously threaten patient access to care.

Finally, any decision with regard to physician evaluation or network inclusion should take into account comparative effectiveness of treatment. While some treatments or procedures may be more costly in the short term, their high cure rates save healthcare system costs in the long run.

For example, a Mohs surgeon will stand out as being more expensive per patient encounter than a general dermatologist seeing patients for psoriasis and eczema. This is due to a different mix of patients and not to being a costly provider. The cost data is usually not risk-adjusted, so that the providers taking care of the oldest and sickest patients get penalized as being “high cost”.

Thank you for your consideration. We look forward to working with you as you continue to draft regulation on this important issue. Should you have any questions or need further information, please feel free to contact Director of State and Grassroots Advocacy Lisle Thielbar at (847) 956-9126 or *lthielbar@asds.net*.

Sincerely,



George J. Hruza, MD, President-Elect
American Society for Dermatologic Surgery Association

cc: Mitchel P. Goldman, President
Timothy C. Flynn, MD, Immediate Past President
Naomi Lawrence, MD, Vice President
Abel Torres, MD, Treasurer
Murad Alam, MD, Secretary
Katherine J. Duerdoth, CAE, Executive Director
Lisle Thielbar, Director of State and Grassroots Advocacy
H.L. Greenberg, MD, ASDSA Nevada State Advocacy Network for Dermatologic Surgery Representative

September 24, 2014

Nevada Division of Insurance
ATTN: Adam Plain
1818 East College Parkway, Suite 103
Carson City, NV 89706

Re**:** LCB File No. R049-14, Network Adequacy

Dear Mr. Plain:

On behalf of the more than 13,000 U.S. members of the American Academy of Dermatology Association ("Academy"), I appreciate the opportunity to comment on proposed draft regulations that would establish network adequacy requirements. We support the Nevada Division of Insurance's ("Division") decision to amend the August draft proposal of Regulation R049-14, which would have excluded dermatologists, among other specialties, from the network adequacy standards; however, we continue to have concerns with several sections of the proposal. As such, the Academy requests the following amendments:

Recommendation # 1: Section 2 of the proposed regulation details specific requirements for carriers to establish network adequacy. In addition to the number and geographic distribution of providers, the Academy urges the Commissioner to consider patient wait-time. The Academy believes provider networks exist to serve patient needs, specifically by ensuring that patients have adequate and timely access to providers with appropriate training and specialty or subspecialty expertise. To this end, we recommend beneficiaries have an appointment with a specialist within at least 30 days, including weekends, for non-urgent care, which is consistent with the Department of Veterans Affairs' wait-time goal.

Skin cancer is the most commonly diagnosed cancer in the United States; however, with adequate access to dermatologic care most cases are manageable. Further, according to the recent Surgeon General's Call to Action to Prevent Skin Cancer:

> "Each year in the United States, nearly 5 million people are treated for all skin cancers combined, with an annual cost estimated at $8.1 billion.[1] Melanoma is responsible for the most deaths of all skin cancers, with nearly 9,000 people dying from it each year.[2] It is also one of the most

[1] Medical Expenditure Panel Survey. Rockville, MD: Agency for Healthcare Research and Quality. http://meps.ahrq.gov/mepsweb/data_stats/ download_data_files.jsp. Accessed January 2014

[2] U.S. Cancer Statistics Working Group. United States Cancer Statistics: 1999–2010 Incidence and Mortality Web-based report. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services and National Cancer Institute, National Institutes of Health; 2013. http://www.cdc.gov/uscs. Accessed January 20, 2014.

American Academy of Dermatology Association
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common types of cancer among U.S. adolescents and young adults.[3] Annually, about $3.3 billion of skin cancer treatment costs are attributable to melanoma.[2]"

Thus, requiring carriers to provide for a maximum 30-day wait-time, including weekends, for non-urgent care would save lives and reduce health care costs.

Recommendation #2: Subsection 4 of Section 2 would limit the physicians who must be included in the network plan to:

1) those specialties and subspecialties for which the American Board of Medical Specialties offers certification; *and*

2) those specialties that appear as options on the Network Adequacy Template issued by the Center for Consumer Information and Insurance Oversight.

While dermatopathology and pediatric dermatology are subspecialties recognized by the American Board Dermatology, these subspecialties, along with most other subspecialties, would be left out due to their failure to be included by the Centers for Medicare and Medicaid Services (CMS) in the Network Adequacy Template specialties. We recommend substituting "and" with "or" in order to include a larger category of specialties and subspecialties.

Recommendation # 3: According to Section 3.5, a carrier would submit "sufficient data", as determined by the Commissioner, to establish that the network plan adequately serves the anticipated number of enrollees in the network plan. This language lacks any guidance in determining what is "sufficient data"; therefore, we ask the Division to clarify the documentation required to prove network sufficiency.

Recommendation # 4: Section 8 sets forth standards to determine network adequacy. Among the criteria the Commissioner could consider are:

a) the "operating hours of available health provider or facilities";
b) refusal of certain providers to contract; and
c) and use of telemedicine.

In assessing the operating hours of health providers and facilities, it is essential that the carriers assess the hours the physician is available and seeing patients. It is common for physicians, particularly in rural regions, to practice part-time in multiple facilities to increase patient convenience. The Academy believes the proposed criteria would not accurately reflect network adequacy and we urge the Division to recommend considering the availability of full-time physicians rather than the facility's operating hours. Physicians working part-time could skew the accuracy of physician availability.

Additionally, Section 8, as amended, would ignore whether a carrier negotiates in good faith with a provider. It is recommended that the Division develop criteria carriers must submit to the Commissioner to validate good faith efforts were made while negotiating contracts with providers. The Academy believes that without specific requirements, carriers could potentially

[3] Weir HK, Marrett LD, Cokkinides V, et al. Melanoma in adolescents and young adults (ages 15-39 years): United States, 1999-2006. J Am AcadDermatol. 2011;65(5 suppl 1):S38-S49.

circumvent the adequacy requirements by failing to make good faith efforts to include physicians in its network.

Lastly, while teledermatology is a viable option to deliver high-quality care to patients in some circumstances, the Academy supports the preservation of a patient's choice to have access to in-person dermatology services (see attached Position Statement on Teledermatology).

Recommendation #5: The Academy supports providing patients with timely access to accurate provider directories as outlined in Section 10. Health care insurers should be required to maintain up-to-date directories listing their individual current providers by specialty, subspecialty, and practice focus. The lists should be easily accessible by telephone and Internet. The Academy supports the directories being updated every 30 days, which would include the notice of physicians who are not accepting new patients and those who have left the network.

Recommendation # 6: Lastly, the Academy requests that the Division include language that would provide physicians with a meaningful appeal whenever a physician is terminated from a network, regardless of how the plan characterizes the termination. The appeal review should consider whether the removal of the physician from the network would result in network inadequacy, and this should be a basis for reinstatement. Additionally, beneficiaries should always be provided reasonable and adequate notice of physician termination, and should be allowed to stay with a physician until the next open enrollment period if the provider is eliminated from a network mid-year.

I commend the Nevada Division of Insurance for its effort to ensure the citizens of Nevada have access to needed health care services in a timely fashion and urge the Division to include the proposed amendments described above. Should you have any questions, please contact David Brewster, Assistant Director for Practice Advocacy at 202-842-3555 or dbrewster@aad.org.

Sincerely,

Brett Coldiron, MD, FAAD
President
American Academy of Dermatology Association

Enclosure

cc: Stacy Woodbury, Executive Director, Nevada State Medical Association

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

ama-assn.org
t (312) 464-5000

September 25, 2014

Mr. Adam Plain
Insurance Regulation Liaison
Nevada Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, NV 89706

Re: AMA comments on LCB File No. R049-14

Dear Mr. Plain:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I write to state our support for efforts by the Nevada Division of Insurance (Division) to revise its network adequacy regulation. We very much appreciate the continued opportunity to comment on the proposed regulations.

First and foremost, we support many of the recent changes made to the August 12th draft rule that appear in the September 25th version. We see the most recent draft regulation as a step in the right direction. In particular, a movement away from the specific ratios and provider lists included in the last drafts is a marked improvement. Other important revisions include greater emphasis on quantitative standards for measuring adequacy, an increase in the required percentage of contracted essential community providers from 20 percent to 30 percent, and improvements to the provider directory requirements.

At the same time, we also see additional areas where the regulation can further the Division's intent to provide clarity, transparency, and meaningful access to care for Nevada's patients.

Quantitative measures

We strongly support the inclusion of quantitative, objective standards for measuring network adequacy. While we support the Division's movement toward quantitative measurement in Section 3, we recommend a stronger commitment in the regulations to the incorporation of multiple quantitative and objective measures when determining network adequacy. Such standards could include:

- Maximum travel time and distance standards to access a full time equivalent primary care physician, specialty physician, and other health care provider.
- Maximum allowable wait times for a primary care physician, specialty physician, and other health care provider.
- Minimum number of full-time equivalent physicians and other healthcare clinicians needed in a network to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, and with physical and mental disabilities.

- Maximum time and distance standards to access full time equivalent technological and ancillary services, including imaging and laboratory services.
- Maximum time and distance standards to access general hospital services with emergency care.

We also suggest that the Division consider other factors that contribute to patient access to quality care such as:

- Assessment of provider capacity, including the availability of providers to accept new patients;
- The variation in hours of operation for network providers;
- The quality measures used to evaluate providers for network inclusion; and
- The ability of physicians to admit patients to in-network hospitals.

Contract negotiations

Under Section 8.2(b), we are concerned that as amended, the draft regulation establishes unenforceable standards, and does not consider whether insurers are entering into fair contract negotiations with physicians. We urge the Division to consider developing specific criteria as to how it would measure or evaluate "good faith" negotiations between physicians and insurers.

Insurer attestation and network plan

Under Section 2.2, the proposed regulation states that "each year a carrier shall submit, in conjunction with the rate and form filing, a declaration that the network plan meets the requirements of subsection 1 of this section." Later in Section 3.5, the proposed regulation specifies that carriers must submit "sufficient data" to the Commissioner to "establish that the proposed network plan has the capacity to adequately serve the anticipated number of enrollees in the network plan." We recommend that further revisions identify more objective criteria to be submitted to the Division for these purposes, and that such information and data will be made available to the public.

Consumer protections against an inadequate network

The AMA supports strong consumer protections for patients who cannot access needed care from in-network providers, i.e. when a network is inadequate. Under Section 12.5, we encourage the Division to move forward with such strong protections and establish a fair and quick process by which consumers can access needed care.

The AMA advocates that all networks should meet or exceed Nevada's network adequacy requirements and provide patients access to needed care. However, when a patient cannot find needed care with an in-network provider, the patient should be held harmless for all additional costs associated with accessing out-of-network care. To be clear, insurers should not be able to pay non-contracted providers discounted, in-network rates to remedy inadequate networks. Such an allowance will not protect consumers, is contrary to fair contracting principles, and will have the unintended consequence of incenting insurers to develop inadequate networks. Instead, insurers should be held accountable for an inadequate network and cover the costs of out-of-network care, leaving patients with only the cost-sharing responsibilities that would have applied if the network was adequate.

Provider appeals

Given the environmental shift toward very narrow or tiered networks, the AMA hears from physicians who have been removed from (or denied entrance into) networks and are unable to continue seeing patients with whom they have long-standing relationships. Often these network terminations or denials come with little available recourse for physicians or their patients. These network disruptions impact patient-physician relationships essential to patient care.

Therefore, we strongly urge the Division to adopt language that provides physicians with a fair and timely process to appeal network decisions. We also recommend public disclosure of all provider selections standards.

Next steps

The AMA believes that the Department is in a unique position to work with the Nevada health care community, including the Nevada State Medical Association (NSMA), to help ensure that patients have access to truly adequate provider networks. The AMA supports the comments of the NSMA and others. We very much appreciate the opportunity to participate in this process.

If you have any questions or want more information, please contact Emily Carroll, JD, Senior Legislative Attorney, Advocacy Resource Center, at emily.carroll@ama-assn.org or 312-464-4967. Thank you for your consideration.

Sincerely,

James L. Madara, MD

cc: Nevada State Medical Association

American Psychiatric Association

1000 Wilson Boulevard
Suite 1825
Arlington, VA 22209
Telephone 703.907.7300
Fax 703.907.1085
E-mail apa@psych.org
Internet: www.psychiatry.org

September 25, 2014

Nevada Division of Insurance
Adam Plain, Insurance Regulation Liaison
1818 East College Parkway, Suite 103
Carson City, NV 89706

Re: LCB File No. R049-14

Dear Mr. Plain,

The American Psychiatric Association (APA) appreciates the opportunity to comment on the proposed regulations of September 25, 2014 issued by the Nevada Division of Insurance and cited above.

The APA is the medical specialty association representing over 35,000 psychiatric physicians nationwide and through the Nevada Psychiatric Association, approximately 140 psychiatrists in the State.

The APA applauds the efforts by the Division of Insurance and its Commissioner to listen to all interested and concerned parties regarding the establishment of the Network Adequacy requirements under the Patient Protection and Affordable Care Act (ACA). This new provision in the ACA is important for all of us to assure that the mental health is available to Nevada's citizens and we ask that the Commissioner continue to move forward.

The APA was encouraged by this most recent revision that included a broader inclusion of medical specialty providers and the elimination of specifically defined urban, rural and frontier geographic service areas. However, we do have some concerns with the revisions, which include:

1. **Section 3.5 and Section 8(1):** Network adequacy is subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA). We want to ensure that network adequacy receives appropriate input from the public and other professionals with expertise and is not left solely up to the Commissioner. We commend your office for the openness of public comments we have seen in your division and encourage you to continue this.

2. **Under section 8(1)(a),** there is a concern that the operating hours of a facility are not a sufficient indicator as the provider may not be present in the facility; a solution of requiring the posting the FTEs of the medical provider for each facility would help resolve this concern. Also at Section 8(1)(b), there is concern that carriers may not negotiate in good faith with providers or facilities in order to narrow/limit the network and/or may contractually offer rates to the providers that are insufficient to cover practice expenses than required thereby creating a misleading perception that providers are refusing to participate. We suggest revising the language to include a request that carriers must document the reasons for providers declining to participate. We bring to your attention that the MHPAEA law (45 CFR Parts 146-147) does include requirements and tests around provider networks, non-comparable terms for participation in the networks as compared to medical-surgical, including reimbursement rates that must be comparable as well.

3. **Complaint Processes:** We urge you to put in place a complaint process to allow feedback from health plan participants and providers. We are ready to assist you with language that would ensure the integrity of the complaint process.

4. **Under 45 CFR 156.230** network adequacy standards require that all services including mental health and substance abuse will be accessible without unreasonable delay. We are concerned about how network adequacy is going to be defined beyond just the listing of a provider, such as a psychiatrist, being available in a geographic area. Thus, the question becomes, how are settings or levels of care going to be defined and accounted for? This area, too, must be carefully considered and addressed if access to the actual scope of the services required by the essential health benefits are to be assured. We are ready to assist you with how this be might defined to ensure that patients have access to the best quality care.

The APA encourages the Commissioner to continue to hold workshops and to work closely with the Nevada Psychiatric Association to refined and define these areas of concern.

Thank you for the opportunity to comment on the proposed regulations. If you have any questions or concerns regarding these comments, please do not hesitate to contact Janice Brannon, Deputy Director, State Affairs at jbrannon@psych.org or by phone at 703-907-8588.

Sincerely,

Saul Levin, MD, MPA

Saul Levin, M.D., MPA
CEO & Medical Director

cc. Dr. Dickson

America's Health Insurance Plans

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Washington, DC 20004

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September 26, 2014

Mr. Adam Plain,
Insurance Regulation Liaison
Nevada Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, NV 89706

Re: Network Adequacy Proposed Rules

Dear Mr. Plain,

I write today on behalf of America's Health Insurance Plans (AHIP) to provide comments in response to the proposed regulations issued by the Nevada Division of Insurance (Division) on network adequacy.

AHIP is the national trade association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs. Health plans have been committed to providing consumers with affordable products that offer robust networks of quality, cost-efficient providers. We appreciate the changes that the Division has made to the proposed regulations and want to express our appreciation for taking into consideration the comments that have been made thus far by carriers and AHIP. While we agree with a majority of the Division's proposal, we continue to have these remaining concerns:

The timing of the requirement to utilize the Division's list of minimum number of providers and maximum travel time or distance by county/specialty/category is unnecessary and impractical.

The proposed timing scheme by which the Division puts out the number and time/distance standards by January 1 with a 15 day comment period and then publishes the final number and time/distance standards by January 20 is unnecessary. The qualified health plan standards adopted in May 2013 already outline the time/distance standards and have proven workable for plans and the Exchange. These standards should be the starting point for these proposed regulations and, should the Division wish to change them, a discussion should be held regarding the need for such deviation from proven standards in order to collaborate on the best way to solve whatever issue the current standard may be causing.

Health plans require adequate time to respond to any changes in standards regarding network adequacy, especially if it involves additional provider contracting activity. Health plans cannot be left waiting each January for the Division's proposed standards.

The proposed requirements for updating a plan's provider directory are burdensome and unworkable.

Section 10 continues to include provider directory requirements that will significantly impact the administration of health plans. We would prefer the provider directory updates be maintained on the plans' websites and the Division link to those websites. Further, we request these rules allow health insurers to post what information they may get from providers, with the full acknowledgement that some information may be missing if the provider does not report that information to the health plan.

The standards for a change in network to be classified as a "significant change" are too low.

Section 12 defines a "significant change" to a network as one which affects network capacity by more than ten percent or causes the average travel time or distance associated with a benefit to exceed the reasonable standards. This ten percent threshold is set too low to be deemed significant; we recommend that 20% would be a more appropriate standard of significant change.

AHIP will continue to work with the Division to develop these regulations and promote and provide a transparent, value-based health care system. We appreciate the opportunity to provide comments and look forward to continued discussions with you on this important issue. If you have any questions, please do not hesitate to contact me at gcampbell@ahip.org or 971-599-5379.

Sincerely,

Grace Campbell
Regional Director

October 6, 2014

Nevada Division of Insurance
ATTN: Adam Plain
1818 East College Parkway, Suite 103
Carson City, NV 89706

RE: LCB File No. R049-14

Dear Mr. Plain,

The Nevada State Medical Association (NSMA), the Nevada Osteopathic Medical Association and our partner specialty medical societies submit these comments regarding the proposed regulation titled LCB File No. R049-14, relating to adequacy of network plans. The comments herein address the drafted dated September 25, 2014, and include additional comments based on testimony and discussion during the September 25, 2014 public workshop.

As our testimony at the September 25 public workshop indicated, we have concerns about broad and undefined policy decisions placed on the Insurance Commissioner. The proposed regulation confers on the Commissioner full discretion to make all final determinations, without limitation, on matters dealing with network health service delivery adequacy, to include geographic availability of service providers, without any foundational metrics supporting such determinations relating to populations being served, among other determinations. The regulation must clearly set forth the deliberative process the office of the Commissioner must follow when ascertaining facts and developing findings to support any network adequacy initial determinations or subsequent changes to network adequacy resulting from changes related carrier plans and health care facilities and services. As presently drafted, the process which the Commissioner will use to make these critical decisions is not readily apparent, neither is there a requirement the Commission disclose the rationale or basis for his determinations. With the magnitude of impact these decisions will have on carriers, plan members, facilities and providers, a transparent and uniform decision-making process is both necessary and vital. This is especially vital to ensure continuity in the application of the regulation, as the person who is the Insurance Commissioner changes and decision making process must be consistent and fair.

Section 3, Subsection 2, at its maximum allowable time of January 1 to January 20, only provides 19 calendar days for interested parties to submit comments concerning the annual preliminary list the Commissioner will issue setting forth the minimum number of providers and the reasonable maximum average travel distance or time by county. This provides a very limited time for the public and affected health care providers and facilities to review the preliminary list and make appropriate, informed comments. This process could be pushed back into December to allow more time for public input.

Section 3, Subsection 4 clarifies that the specialties and categories of health care to which Section 3 applies are those that appear on the list of specialties and subspecialties for which the American Board of Medical Specialties offer certification *AND* the list of specialties and categories of health care that appear as options on the Network Adequacy Template issued by the federal Center for Consumer Information and Insurance Oversight. The *AND* (emphasis added) implies that a specialty, subspecialty or category of health care MUST appear on both lists in order for Subsections 2 and 3 to apply. Testimony indicated that yes, a category must appear on both lists, and that yes, the Network Adequacy Template is not easy to access. Can the Division provide a copy of the Network Adequacy Template for review? At this time we are still uncertain as to whether we have accessed the appropriate list.

Section 8, Subsection 1(b) addresses network deficiencies. The burden of contracting with a sufficient number of providers and facilities within its geographic service area lies with the insurance carrier. The present language does not require carriers to negotiate in good faith with providers, which could lead to the practice of offering unreasonably low reimbursements to providers so that they may be excluded from the network plan. We suggest the language be changed to appropriately reflect the burden:

> *"The refusal of carriers to negotiate in good faith, under reasonable terms and conditions, with providers and facilities within the maximum average travel distance or time…"*

Section 8, Subsection 1(d) addresses telemedicine. Plan members should have the choice as to whether to utilize telemedicine services in lieu of traditional in-person care. We suggest adding additional language, so that the provision reads:

> *"The use of telemedicine or telehealth services to supplement or provide an alternative to in-person care, when the plan member consents to receive services by telemedicine or telehealth services."*

Section 12.5 establishes important consumer protections when a network becomes deficient. Patients are allowed to obtain covered services from out-of-network providers or facilities when a carrier's plan is deficient and during implementation of a corrective action plan. Patient responsibility for out-of-network payments is capped at a "cost share not to exceed the cost share had the benefit been provided by a participating provider or facility." We applaud this important consumer protection. However, we have concerns at the position in which this places providers and facilities. Balance billing has been, and will continue to be, of major concern. The provisions of Section 12.5, while protecting consumers, appears to provide insurance carriers with very little, if no, liability for a deficient network while placing full liability on providers and facilities who cover treatments and procedures for patients who have no in-network choice through no fault of their own. If patients are protected from out-of-network charges and insurers are held harmless, then providers and facilities will be left to foot the remaining cost when the insurer failed to provide an adequate network. This is simply unacceptable. We suggest replacing Section 12.5, Subsection 2(b) with the following language:

> *"(b) Ensure that a covered person affected by the deficiency may obtain the service from a provider or facility not within the network. The carrier shall apply the covered person's deductible, copayment, coinsurance and out of pocket maximum, as applicable, as if these services were received from a network provider. The carrier shall take appropriate measure to ensure that the covered person's total cost share does not exceed the cost share applied had the benefit been provided by a participating provider or facility. The carrier must reimburse the out-of-network provider or facility at the rate of usual and customary charges."*

Still absent from the regulation is the establishment of a process that allows plan members to file a simple complaint with Commissioner about potentially inadequate networks and, further, a description of how such issues will be documented, resolved and reported by the Division. Such a process will allow the Commissioner to track and document carriers' possible use of "skinny" networks that impede access to timely care. We suggest adding a new Section to the regulation as follows:

> *"Section X. The Commissioner shall accept complaints regarding the adequacy of a network plan only from members of the network plan. Upon receiving such a complaint the Commissioner must examine that specific area of a network plan to determine whether the network is adequate or whether significant changes have occurred which may disrupt patient access to care or indicate a deficient network."*

Still noticeably absent from the regulation, we continue to suggest the Division consider including:

1) A requirement for carriers to educate beneficiaries about the financial consequences of using out-of-network providers, specifically related to the requirement that beneficiaries will be subject to and responsible for balance billing.

2) A requirement that the Division track and report annually the number of complaints and the resolution thereof regarding the adequacy of networks, including the challenge of balance billing. This tracking system will allow the Division to readily identify and address problem areas in both the carrier and provider arenas.

Of significant discussion at previous hearings was the question of where providers are located within Nevada. Attached is a table of information obtained on September 30 from the Board of Medical Examiners which breaks out allopathic physicians by specialty and county. Such information can easily be obtained for other providers or facilities from the appropriate licensing board or entity. This information also provides an illuminating snapshot regarding the true shortage of physician specialists within Nevada.

Although you indicated at the September 25 public workshop that the next step will likely be a public hearing in the November timeframe, we would like to request at least one additional public workshop for the purpose of reviewing and potentially codifying that process as well as being able to hear, discuss, and understand any changes to the proposed regulation subsequent to the September 25 workshop.

Thank you for considering these additional comments and considering their inclusion in these important and historic regulations.

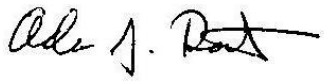
Sincerely,

Mitchell D. Forman, DO
President
Nevada State Medical Association

Veronica Sutherland, D.O.

Veronica Sutherland, DO
President
Nevada Osteopathic Medical Association

Abdi Raissi, MD
President
Nevada Orthopaedic Society



Adam J. Rovit, MD
President
Nevada Academy of Ophthalmology

Bret W. Frey, MD
Board of Directors, Nevada Chapter
American College of Emergency Physicians

Lesley Dickson, MD
Executive Director/State Legislative Representative
Nevada Psychiatric Association

Dean Polce, DO
President
Nevada State Society of Anesthesiologists

Charles S. Price, MD
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Nevada Psychiatric Association
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Council on Advocacy & Government Relations

Ross H. Golding, MD
Medical Director
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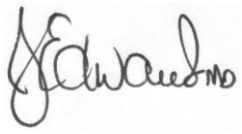
Keith Brill, MD, FACOG, FACS
Chair, Nevada Section
American Congress of Obstetricians
& Gynecologists



Michael Edwards, MD
President, Clark County Medical Society
President
American Society for Aesthetic Plastic Surgery

Attachment: Licensed Nevada Physicians in Nevada by Selected Specialty (Revised)

ASDSA
American Society for Dermatologic Surgery ASSOCIATION

October 30, 2014

Nevada Division of Insurance
ATTN: Mr. Adam Plain
1818 East College Parkway, Suite 103
Carson City, NV 89706

RE: LCB File No. R049-14 v5

Dear Mr. Plain:

As President-Elect of the American Society for Dermatologic Surgery Association (ASDSA), a surgical specialty organization representing nearly 6,000 physician members, I appreciate the opportunity to provide input on version 5 of LCB File No. R049-14, relating to adequacy of network plans.

As the largest dermatologic surgery association in the country, the ASDSA is very concerned about the impact on patient access to care associated with the narrowing of provider networks, particularly as it relates to skin cancer surgery. Our dermatologic surgeons often treat some of the sickest and most complex cases related to skin cancer and the subsequent removal of tissue in complicated Mohs surgery procedures.

Patient access to comprehensive, timely specialty and subspecialty care (Section 3)
Section 3, 4(a) refers to "The list of specialties and subspecialties for which the American Board of Medical Specialties Member Boards offer certification..." We respectfully request that this language be broadened to also include the list of specialties and subspecialties for which the American Osteopathic Association offers certification. Access to subspecialists should be included throughout the proposed rule. Not every specialist provides every type of procedure. For example, there are some specialized skin cancer procedures, such as Mohs surgery, which are not performed by every dermatologist.

Insurers have a responsibility to patients to provide comprehensive and timely access to primary, specialty and subspecialty care. Provider networks that do not have an adequate number of contracted physicians and other health care providers in each specialty, subspecialty and geographic region deprive patients' access to contractually entitled benefits. Of particular concern to ASDSA is access to dermatologists qualified and willing to perform skin cancer surgery.

Accurate, up-to-date provider directories (Section 10)
Thank you for including the provisions ensuring that provider directories are kept up-to-date so that patients have the most timely, accurate information possible to make informed decisions about where to receive their medical care in Section J. Patients continue to need access to an

up-to-date provider directory to enable them to determine which physicians, other health care professionals, and health facilities remain in the network as their medical needs change.

Appeals process, continuity of care

Currently there is no language included in the proposed rule with regard to an appeals process for physicians that have been excluded from networks. For physicians who have been excluded from participation in a provider network, there should be an explicit, fixed, and reasonable timeline for the appeals process.

Likewise, there is no provision for mid-term terminations. Too often, physicians are being terminated from networks in the middle of a plan year, making it very difficult for patients to keep their doctors as they would be subject to often very high out of network out of pocket costs that most cannot afford and they are not able to change plans in the middle of the plan year to one that has their doctors in it. Provider terminations should be carried out with an effective date that occurs during the plan open enrollment period. This way, patients will have the option of changing their doctor to one within the network or to switch their plan to one that has their current doctors within it. Enough notice should be given by the insurance plan to patients before provider terminations are final to allow the patient to make decisions about the best way to proceed to get their continuing health care.

Comparative effectiveness, patient population considerations in network inclusion decision-making

Currently, there is no language in the proposed rule to ensure that network inclusion decisions are not based on cost alone. Patients who live in high-risk areas or who require treatments that are costly on a short-term basis should not be penalized with reduced access to care resulting in network inclusion decisions made on the basis of cost alone. While some physicians may be incurring higher total reimbursement than others, there may be good reason for these differences. Some relate to the socioeconomic or ethnic make-up of their patient populations. Seniors and other at-risk populations may be more costly to treat. The cost data is usually not risk-adjusted, so that the providers taking care of the oldest and sickest patients get penalized as being "high cost." Dropping physicians that treat these populations from networks can seriously threaten patient access to care.

Any decision with regard to physician evaluation or network inclusion should take into account comparative effectiveness of treatment. While some treatments or procedures may be more costly in the short term, their high cure rates save healthcare system costs in the long run. For example, a Mohs surgeon may stand out as being more expensive per patient encounter. Mohs surgery is indicated for certain types of recurrent or aggressive cancers or cancers that are located in areas where there is a high risk of subsequent cancer recurrence and where it is important to preserve healthy tissue for functional reasons. While Mohs surgery can be more expensive than some other types of skin cancer treatments, clinical studies conducted at various national and international medical institutions - including the Mayo Clinic, the University of Miami School of Medicine and the Royal Perth Hospital in Australia - demonstrate

ASDSA
American Society for Dermatologic Surgery ASSOCIATION

that with a cure rate of 99 percent for basal cell carcinoma and 95 percent for squamous cell carcinoma, Mohs surgery has the highest cure rate in comparison to other skin cancer removal procedures that may result in recurrence and additional procedures.

The data insurance companies rely on is primarily based on claims. Such data, by its nature, is not granular enough to pick up different practice patterns and patient mix of various subspecialties of dermatology. For example, a dermatologist limiting their practice to treating patients with difficult skin cancers with Mohs surgery, will stand out as being "high cost" when compared with a dermatologist taking care of patients with psoriasis and eczema. His cost per patient encounter will stand out as being higher than the average. He is not high cost; he is just taking care of sicker patients that require a more intensive treatment to take care of their skin cancer.

Without the protections outlined above, patients will experience the loss of their established doctor-patient relationships, longer wait times and further distances to see a dermatologist at a time when skin cancer has reached epidemic status.

Thank you for your consideration. Should you have any questions or need further information, please feel free to contact Director of State and Grassroots Advocacy Lisle Thielbar at (847) 956-9126 or *lthielbar@asds.net*.

Sincerely,

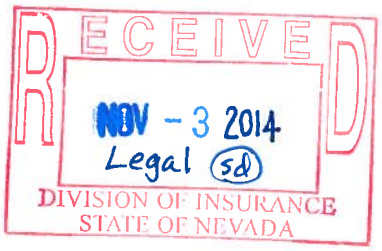
George J. Hruza, MD, President-Elect
American Society for Dermatologic Surgery Association

cc: Mitchel P. Goldman, President
Timothy C. Flynn, MD, Immediate Past President
Naomi Lawrence, MD, Vice President
Abel Torres, MD, Treasurer
Murad Alam, MD, Secretary
Katherine J. Duerdoth, CAE, Executive Director
Lisle Thielbar, Director of State and Grassroots Advocacy
H.L. Greenberg, MD, Nevada State Advocacy Network for Dermatologic Surgery Representative

Immune Deficiency Foundation

The National Patient Organization Dedicated to Advocacy, Education and Research for Primary Immunodeficiency Diseases

October 31, 2014



The Honorable Scott Kipper
Commissioner of Insurance
Division of Insurance
1818 East College Pkwy, Suite 103
Carson City, NV 89706

c/o: Adam Plain
Insurance Regulation Liaison

RE: Support for Proposed Regulations R074-14 and R049-14

Dear Commissioner Kipper:

The Immune Deficiency Foundation (IDF) is the national patient organization dedicated to improving the diagnosis and quality of life of individuals with primary immunodeficiency diseases (PI) through advocacy, education and research. We write today in support of proposed regulations R074-14 and R049-14, which provide additional consumer protections for individuals purchasing health insurance.

R074-14 clarifies that prescription drug formularies cannot be changed more frequently than annually, except in cases where the United States Food and Drug Administration has issued guidance on the safety of a particular prescription drug or rescinded approval of a drug. Federal law and guidance limit consumers' ability to change health insurance plans outside of the open enrollment except in limited circumstances so that consumers are effectively "locked in" to their selection for a calendar year. At the same time, regulations allow health insurers to remove prescription drugs from a formulary, or move prescription drugs among different cost-sharing tiers, while still maintaining compliance. The Division of Insurance has correctly identified this as a loophole wherein consumers needing certain specific prescription drugs may purchase a health Insurance plan with a favorable formulary design only to have the prescription drug moved or removed during the plan year.

For patients with PI, this poses a serious threat to patient safety. Primary immunodeficiency diseases occur in persons born with an immune system that is either absent or hampered in its ability to function. Many patients with PI rely on the complex biologic treatment immunoglobulin (Ig) therapy to replace the antibodies their bodies do not naturally produce. With lifelong immunoglobulin therapy, patients with PI are able to live normal, healthy and productive lives. In recent years there has been a steady increase in the use of coinsurance cost-sharing with patients who need expensive specialty drugs such as Ig therapy. A coinsurance requirement of 20, 30 or 40% on this lifesaving medication can easily cost a family thousands of dollars per month. Without this regulation, patients with PI could easily purchase a health plan thinking that their Ig therapy is covered with a flat copayment and then find it has been changed mid-year to a specialty tier with coinsurance cost sharing. The proposed regulation would protect our vulnerable patients from this scenario.

R049-14 outlines a procedure for a carrier wishing to apply for a network plan to have the application deemed adequate. We appreciate the attempt to mitigate some of the issues consumers, providers, facilities and insurers may experience in ensuring adequate access to medical care. It is an important quality of this regulation that it applies to the adequacy of all network plans in Nevada without regard to their status as a QHP.

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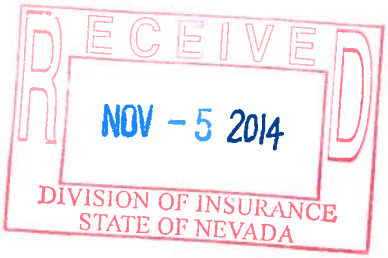
We support the creation of regulation that requires health plans to have an adequate number of providers to serve members in each geographic service, but because of the diversity of clinical manifestations, patients with PI may be cared for by immunologists, allergists, rheumatologists, otolaryngologists, pulmonologists, gastroenterologists, infectious disease specialists and hematology-oncologists. While we recognize that it would be nearly impossible to specifically outline every medical specialty as a necessary category of health care in the regulation, it is unclear how patients with PI who rely on expert treatment by a variety of specialists would be protected by the categories outlined in the regulation. The categories outlined are not all-inclusive and patients with rare diseases may need access to specialists not included. There should be a mechanism for patients, especially those who have rare and chronic conditions requiring the expertise of specialists to manage, to have access to their needed specialists whether in-network or out of network without incurring large out-of-pocket expenses.

Thank you for the opportunity to comment on these proposed regulations. Should you have any questions please contact Emily Hovermale at 443-632-2544 or at ehovermale@primaryimmune.org.

Sincerely,

Lawrence A. LaMotte
Vice President, Public Policy



November 5, 2014

Mr. Scott Kipper
Commissioner, Nevada Division of Insurance
1818 E. College Pkwy., Suite 103
Carson City, NV 89706

Re: Regulation R049-14, Network Adequacy

Dear Commissioner Kipper:

On behalf of the more than 13,000 U.S. members of the American Academy of Dermatology Association ("Academy"), I appreciate the opportunity to comment on proposed draft regulations that would establish network adequacy requirements. We support the Nevada Division of Insurance's ("Division") decision to amend the August draft proposal of Regulation R049-14, which would have excluded dermatologists, among other specialties, from the network adequacy standards; however, we continue to have concerns with several sections of the proposal. As such, the Academy requests the following amendments:

Recommendation #1: Subsection 4 would limit the physicians who must be included in the network plan to:

> 4. The specialties and categories of health care referenced in subsections 2 and 3 of this section shall be those specialties and categories of health care that appear on:
>
> (a) The list of specialties and subspecialties for which the American Board of Medical Specialties offers certification; *and*
>
> (b) The list of specialties and that appear as options on the Network Adequacy Template issued by the Center for Consumer Information and Insurance Oversight

The Academy is concerned that the proposed language would limit the Division's evaluation of provider access primarily to the general specialty for most specialties; however, adequate access to subspecialties should also be ensured where deemed appropriate.

While some dermatologic subspecialties, like dermatopathology and pediatric dermatology, are recognized by the American Board Dermatology, these subspecialties, along with most other subspecialties, would be left out under the proposed language due to their failure to be included by the Centers for Medicare and Medicaid Services (CMS) in the Network Adequacy Template specialties. Additionally, limiting access to Mohs Micrographic Surgery, a subspecialty of dermatology that exclusively treats skin cancer, could result in higher costs to the health care system if such treatment is delayed.

American Academy of Dermatology Association
Excellence in Dermatology™

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Failure to recognize widely-utilized subspecialties when determining network adequacy would hinder a patient's access to essential care in a timely manner; therefore, the Academy recommends substituting "and" with "or" in Section 4:

4. The specialties and categories of health care referenced in subsections 2 and 3 of this section shall be those specialties and categories of health care that appear on:
   (a) The list of specialties and subspecialties for which the American Board of Medical Specialties offers certification; or
   (b) The list of specialties and that appear as options on the Network Adequacy Template issued by the Center for Consumer Information and Insurance Oversight; or
   (c) Any additional specialty or subspecialty deemed appropriate by the commissioner

Recommendation #2: Section 8.1.a details the criteria the Commissioner would evaluate when determining the availability of providers within the network. The Academy recognizes the modification per our request, but we recommend the following language in order to clarify the intent is to determine the full-time equivalent (FTE) of providers within the network:

(a) The relative availability of health care providers or facilities in the geographic service area covered by the network plan, including, the available hours of the health care provider or facilities.

Recommendation #3: Section 8.1.b appears to put the burden to justify network inclusion or exclusion on the provider, whereas frequently the determination for inclusion or exclusion from network is made by the carrier. Additionally, the Academy is concerned that as currently worded the Division creates a "race to the bottom" in which a provider can accept below market rates which become the terms and conditions all other providers must accept or be considered not negotiating in "good-faith".

The Academy requests the division amend the language of Section 8.1.b to read:

(b) The refusal of the carrier to contract with providers or facilities within the maximum average travel distance or time promulgated pursuant to section 3 of this regulation in good faith. For the purposes of this regulation a contract offered by the carrier with terms and conditions that two-thirds (67%) of willing, similarly-situated providers would accept or have accepted is considered a contract offered in good faith.

Further, the Academy seeks clarification on how the Division will define "similarly-situated" providers. As you are aware, each providers practice is unique in that they vary in size and may contain specific sub-specialties which serve a distinctly different patient mix with a higher risk of complication and as a result, higher costs. The Academy is concerned too narrow of a definition will leave practices with a high-risk patient population at a disadvantage when negotiating their contracts.

Recommendation #4: Finally, the Academy requests that the Division include language that would provide physicians with a meaningful appeal whenever a physician is terminated from a network, regardless of how the plan characterizes the

termination. The appeal review should consider whether the removal of the physician from the network would result in network inadequacy, and this should be a basis for reinstatement. Additionally, beneficiaries should always be provided reasonable and adequate notice of physician termination, and should be allowed to stay with a physician until the next open enrollment period if the provider is eliminated "without cause" from a network mid-year.

Conclusion

I commend the Nevada Division of Insurance for its effort to ensure the citizens of Nevada have access to needed health care services in a timely fashion and urge the Division to include the proposed amendments described above. Should you have any questions, please contact David W. Brewster, Assistant Director for Practice Advocacy at 202-842-3555 or dbrewster@aad.org.

Sincerely,

Brett Coldiron MD

Brett Coldiron, MD, FAAD
President
American Academy of Dermatology Association

November 9, 2014

Nevada Division of Insurance
ATTN: Adam Plain
1818 East College Parkway, Suite 103
Carson City, NV 89706

RE: LCB File No. R049-14

Dear Mr. Plain,

The Nevada State Medical Association (NSMA), the Nevada Osteopathic Medical Association and our partner specialty medical societies submit these comments regarding the proposed regulation titled LCB File No. R049-14, relating to adequacy of network plans. The comments herein address the drafted dated November 12, 2014.

Section 3, Subsection 4 clarifies that the specialties and categories of health care to which Section 3 applies are those that appear on the list of specialties and subspecialties for which the American Board of Medical Specialties offer certification *AND* the list of specialties and categories of health care that appear as options on the Network Adequacy Template issued by the federal Center for Consumer Information and Insurance Oversight (emphasis added). In order to be consistent with medical licensing statutes, Section 3, Subsection 4 should also reference specialties and subspecialties certified through the American Osteopathic Association. At present osteopathic physicians go through a different specialty certification than allopathic physicians, thus the language in the current draft does not recognize osteopathic specialties.

Further, the *AND* discussed in the previous paragraph implies that a specialty, subspecialty or category of health care MUST appear on both lists in order for Subsections 2 and 3 to apply. Testimony at one workshop indicated that yes, a category must appear on both lists, and confirmed that yes, the Network Adequacy Template is not easy to access. Though it might require a bit more work on behalf of the Division vis-à-vis development of an additional reporting template, we believe that replacing the "*and*" with an "*or*."

Though the latest version of the draft does address good faith, the language still focuses on the refusal of providers or facilities to contract with a carrier in good faith. We again request that the language appropriately reflect the carrier's burden by changing the first line to read *"The refusal of carriers to contract with providers in good faith...."*

Section 8, Subsection 1(b) addresses network deficiencies. The burden of contracting with a sufficient number of providers and facilities within its geographic service area lies with the insurance carrier, as does the responsibility of maintaining a sufficient network. This Subsection appears to put the burden to justify network inclusion or exclusion on the provider, whereas most often the determination for inclusion or exclusion from network is made by the carrier. Additionally, as currently worded the Division may be creating a "race to the bottom," where one provider may accept below market rates which then become the terms and conditions all other providers must accept or be considered not negotiating in "good-faith." This situation could be remedied by amending the language of Subsection 1(b) to read:

> *"The refusal of the carrier to contract with providers or facilities within the maximum average travel distance or time promulgated pursuant to section 3 of this regulation in good faith. For the purposes of this regulation a contract offered by the carrier with terms and conditions that two-thirds (67%) of willing, similarly-situated providers would accept or have accepted is considered a contract offered in good faith."*

Further, we ask for clarification on how the Division will define "*similarly-situated*" providers. Each provider has their own, unique practice that varies in size and severity of population, and some contain specific sub-specialties which serve a distinctly different patient mix with a higher risk of complication and as a result, higher costs. If the definition of "similarly situated" is too narrow, practices with a high-risk patient population will be at a disadvantage when negotiating their contracts.

In addition, we believe that the concept of "quality" is a critical factor in the determination of network adequacy. Unfortunately, quality often takes a backseat to cost. We endorse and suggest the inclusion of model concepts proposed by the American Medical Association that include:

- All physician profiling programs used to develop networks must incorporate quality measures and must provide physicians the opportunity to review and appeal their profiles. Physicians should have full opportunity to challenge termination or denial of participation in a health insurance product or panel.

- The insurer must publicly provide the criteria and methodology used to evaluate a physician for network inclusion.
- The Division should require and review insurers' provider surveys to help determine network capacity and the accessibility of health care services, as well as to analyze providers' perspectives and concerns.

Section 8, Subsection 1(d) addresses telemedicine. Plan members should have the choice as to whether to utilize telemedicine services in lieu of traditional in-person care. We again suggest adding additional language, so that the provision reads (addition in bold italics):

> *"The use of telemedicine or telehealth services to supplement or provide an alternative to in-person care,* ***when the plan member consents to receive services by telemedicine or telehealth services.***"

Section 12.5 establishes important consumer protections when a network becomes deficient. We appreciate the new language in Subsection 2, Paragraph (b)(1) relating to balance billing; however, we suggest the addition of the following language to also protect providers:

Sec 12.5, subsection 2(b)(1) ...ensures the covered person will not be subject to a balance bill ***because the carrier will pay the provider all negotiated costs beyond the covered person's total cost share***.

Also in Section 12.5, the provisions of the newly added Subsection 3 are very problematic. A good majority of balance bills are generated through visits to the emergency room (ER). While in the ER, patients have neither the ability to seek preauthorization from a carrier nor the ability to determine if the provider, specialist or service is covered under their insurance plan. We request that Subsection 3, which was not discussed on the public record at the last public hearing on this regulation, **be removed from the regulation**. If Subsection 3 is to remain, patients and providers must be again be held harmless, as the deficient network is the fault of the carrier. To appropriately reflect this burden, if included, Subsection 3 must be revised to state (addition in bold italics):

> *"The provisions of subsection 2 do not apply if the covered person receives care from a non-participating provider without receiving prior authorization from the carrier,* ***unless the covered person is being treated for an emergency medical condition where prior authorization is not possible.***"

Also, we continue to suggest the Division include a requirement for carriers to educate beneficiaries about the financial consequences of using out-of-network providers, specifically related to the requirement that beneficiaries will be subject to and responsible for balance billing.

Section 3, Subsection 2, at its maximum allowable time of January 1 to January 20, only provides 19 calendar days for interested parties to submit comments concerning the annual preliminary list the Commissioner will issue setting forth the minimum number of providers and the reasonable maximum average travel distance or time by county. This provides a very limited time for the public and affected health care providers and facilities to review the preliminary list and make appropriate, informed comments. We again suggest this process be moved back into December to provide ample time for public comment and a public workshop on this issue.

Still absent from the regulation is the establishment of a process that allows plan members to file a complaint with Commissioner about potentially inadequate networks and, further, a description of how such issues will be documented, resolved and reported by the Division. Such a process should be instituted to allow the Commissioner to track and document carriers' possible use of narrow networks that impede access to timely care and tend to increase out-of-pocket expenses for consumers. We suggest adding a new Section to the regulation as follows:

> *"Section X. The Commissioner shall accept complaints regarding the adequacy of a network plan. Upon receiving such a complaint, the Commissioner must examine that specific area of a network plan to determine whether the network is adequate or whether significant changes have occurred which may disrupt patient access to care or indicate a deficient network. The Commissioner shall track and publicly report annually the number of complaints and the resolution thereof regarding the adequacy of networks."*

We have previously recommended that the Commissioner engage experts in health care workforce and health care delivery systems to inform this regulation. If this has not happened, we recommend that the Commissioner consider model concepts proposed by the American Medical Association, including the following (some of which we have discussed in greater detail elsewhere in this and previous letters):

- Health insurers must set forth the geographic and population capacity of a proposed provider network. This includes an evaluation by county of the number of enrollees by age and gender. The health insurer's attestation of adequacy must be accompanied by a report from a certified actuary who calculated the insurer's premium for the specific network offered. The attestation and actuarial report must be made publicly available at the time of its filing.
    - The actuarial report must include a breakdown by type and number of primary care physicians, pediatricians, women's health physicians, geriatric medicine

physicians – by specialty and sub-specialty (if applicable) – who are in the specific plan network.

  - The report must identify whether each physician is accepting new patients.
  - The report must cross-reference each physician with each network in which the physician has contracted.
- The insurer must publically provide the criteria and methodology used to evaluate a physician for network inclusion. If the methodology includes cost considerations, it must also incorporate quality data, and must include proper safeguards (e.g. risk adjustment, adequate sample size, etc.) to ensure the integrity of the data.
- Insurers must develop, and make publicly available, the quality assurance standards used to monitor whether a network(s) is adequate.
- Insurers must develop, and make publically available, the appeals and complaint resolution processes used to help patients and physicians with network issues.
- All quality measurements being used must take into account practice variation and the ability for physicians and patients to determine the best course of treatment.

In analyzing adequacy, **utilization data** collected by the Division must include:

- Prior year comparisons against regional and national benchmarks;
- Number of hospital admissions for chronic conditions;
- Emergency department visits;
- Preventive services provided;
- Out-of-pocket costs incurred by enrollees;
- Out-of-network costs incurred by enrollees;
- Number of out-of-network visits made by enrollees;
- Percent of services received from in-network providers;
- An evaluation of the quality assurance standards used by the insurer;
- Regular provider surveys to help determine network capacity and accessibility of health care services as well as to solicit providers' perspectives and concerns;
- Percentage of total costs for in-network and out-of-network services; and
- Specific corrective actions made against insurers determined to have inadequate networks shall be posted publicly online.

As our previous testimony and written comments have indicated, we continue to have concerns about broad and undefined policy decisions placed on the Insurance Commissioner. The proposed regulation confers on the Commissioner full discretion to make all final determinations, without limitation, on matters dealing with network health service delivery adequacy, to include geographic availability of service providers, without any foundational metrics supporting such determinations relating to populations being served, among other determinations.

For example, Section 2, Subsection 2 requires that "Each year a carrier shall submit, in conjunction with the rate and form filing, a declaration that the network plan meets the requirements of subsection 1 of this section," to wit: each plan must have an adequate number and geographic distribution of providers in each geographic services area covered by the network plan in order to meet the anticipated health care needs of plan enrollees, based upon the benefits offered under the plan. Nothing in Subsection 2 specifies what information the 'declaration' should contain, nor if any is required. Section 3.5 later specifies that carriers must submit 'sufficient data' to the Commissioners to "establish that the proposed network plan has the capacity to adequately serve the anticipated number of enrollees in the network plan." Additional provisions in Sections 2, 3, 4 and 7 require carriers to establish adequate networks, ensure services are available and establish systems to collect data for the purposes of this regulation. However, all of these directions to carriers appear to indicate all determinations and decisions will be made by the Insurance Commissioner. Although ultimately the Commissioner is responsible, there should be some objective criteria available by which policy makers and the public may review and assess the decision of the Commissioner.

The regulation must clearly set forth the deliberative process the office of the Commissioner must and will follow when ascertaining facts and developing findings to support initial or subsequent determinations of network adequacy. In the regulation's current form, the process which the Commissioner will use to make these critical decisions is not readily apparent; neither is there a requirement the Commission disclose the rationale or basis for his determinations. With the magnitude of impact these decisions will have on carriers, plan members, facilities and providers, a transparent and uniform decision-making process is both necessary and vital. This is especially vital to ensure continuity in the application of the regulation, as the person who holds the office of the Insurance Commissioner changes and the decision making process must be consistent and fair.

The parties to these comments acknowledge that the passage of the Patient Protection and Affordable Care Act, imposes significant obligations on the American people, health care providers and carriers to deliver affordable health care services to all citizens in every state. The Act by its very formulation requires that every citizen acquire health care services as a matter of law and that every state assure that each of its citizens are afforded medical care that is accessible and affordable. Thus, Congress imposes upon Nevada and every state the requirement that the public interest be served by exposing every deliberate decision of the Commissioner affecting the health, welfare and lives of the public affected by the Act be exposed to the fullest of scrutiny.

Thank you for considering these additional comments and considering their inclusion in these important and historic regulations.

Sincerely,

Mitchell D. Forman, DO
President
Nevada State Medical Association

Veronica Sutherland, DO
President
Nevada Osteopathic Medical Association

Abdi Raissi, MD
President
Nevada Orthopaedic Society

Adam J. Rovit, MD
President
Nevada Academy of Ophthalmology

Bret W. Frey, MD
Board of Directors, Nevada Chapter
American College of Emergency Physicians

Lesley Dickson, MD
Executive Director/State Legislative Representative
Nevada Psychiatric Association

Dean Polce, DO
President
Nevada State Society of Anesthesiologists

Charles S. Price, MD
Past President
Nevada Psychiatric Association
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Ross H. Golding, MD
Medical Director
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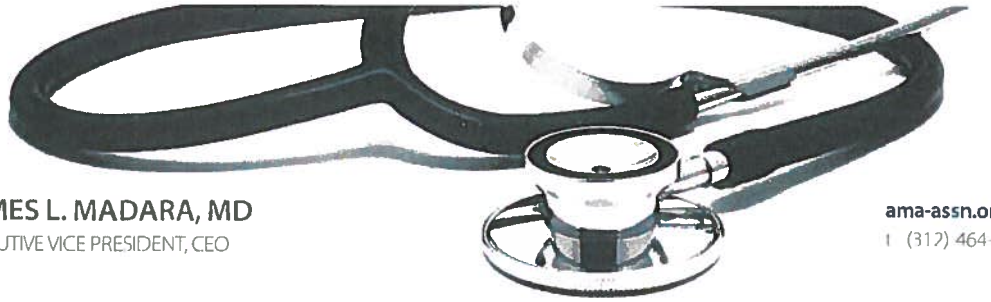
Keith L. Brill, MD
Keith Brill, MD, FACOG, FACS
Chair, Nevada Section
American Congress of Obstetricians
& Gynecologists

Michael Edwards, MD
President, Clark County Medical Society
President
American Society for Aesthetic Plastic Surgery

Karen Massey, Legislative Liaison
Nevada Medical Group Management Association

AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO



ama-assn.org
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November 12, 2014

Adam Plain
Insurance Regulation Liaison
Nevada Division of Insurance
181 E. College Parkway, Suite 103
Carson City, NV 89706

Re: AMA response to solicitation of comments on network adequacy regulation (LCB File No. R049-14) dated November 12, 2014

Dear Mr. Plain:

On behalf of the physician and medical student members of the American Medical Association (AMA), thank you for the opportunity to comment on the proposed regulation (LCB File No. R049-14) dated November 12, 2014, related to the adequacy of network plans. We think the Nevada Division of Insurance (Division) has made significant progress toward establishing a fair and effective process for maintaining adequacy for provider networks; however, we are still concerned about several provisions in the proposed regulation and the impact of those provisions on patients' access to care.

Quantitative measurement

Our first concern with the proposed regulation is that clear, quantitative measures are not delineated in the regulation. Instead, it appears that specific criteria to measure network adequacy are to be established by the Commissioner each year. We are concerned about the lack of consistency and transparency with this proposed method. Instead, the AMA suggests that the final regulation establish quantitative measurements for network adequacy that include (although not necessarily limited to) the following standards:

- Maximum travel time and distance;
- Maximum appointment wait times;
- Provider capacity and admitting of new patients;
- Minimum providers available to meet the needs of patients with limited English proficiency, diverse cultural and ethnic backgrounds, physical and mental disabilities, and complex medical conditions;
- Provider hours and availability;
- Availability of technological and ancillary services; and
- Patient feedback on network access.

Specialists and categories of health care

The AMA is also concerned that Section 3(4), is too limiting in its specialists and categories of health care and may inappropriately exclude many specialists and subspecialists when measuring network adequacy. We urge the Division to include specialists and categories of health care that appear on at least one of the following lists:

- The specialists and subspecialists for which the American Board of Medical Specialties Member Boards offer certification; *or*
- The list of specialties or categories of health care that appear as options in the Network Adequacy Template issued by the Center for Consumer Information and Insurance Oversight.

Additionally, this section should reference specialties and subspecialists certified through the American Osteopathic Association in order to recognize all certified specialists – both allopathic and osteopathic.

Good faith negotiations

With regard to Section 8(1)(b), we do not think the current language defining a "contract offered in good faith" is sufficient to identify fair contracting practices, and as written would allow insurers to side-step many of the important protections this regulation will establish. We support language being offered by the Nevada State Medical Association, the American Academy of Dermatology, and others that defines a contract offered in good faith as a contract offered by the carrier to a provider with terms and conditions that **two-thirds of providers have accepted, including two-thirds of providers in the same specialty or subspecialty if considering contracts offered to physicians or other health care professionals.** We believe such language will help regulators better evaluate good faith efforts by insurers to contract with providers and, ultimately, establish adequate networks.

Patient protections from an inadequate network

Section 12.5 establishes important patient protections in the case of an inadequate network. However, in order for this section to be effective, we think further clarification is needed. Specifically, we ask for language to make clear that the insurer is responsible for all patient costs associated with out-of-network care when the patient is forced to go out-of-network due to network inadequacies. The insurer's responsibility would include the difference between the in-network, discounted rate and the provider's payment amount, as well as any differentials in patient cost-sharing that would normally result from accessing out-of-network care. Moreover, as stated in the proposed regulation, it is important that patients' out-of-pockets costs incurred in these situations count toward their out-of-pocket maximum.

We are also concerned about the language in Section 12.5 that excludes patients from the protections and safeguards offered in this section when the care is not pre-authorized. Specifically, we would like to see such patient protections applied to those patients who are receiving emergency and acute medical care as well.

We also want to emphasize that strong protections for patients in inadequate networks can never substitute for network adequacy, and such protections should never be used as an alternative to an adequate network. Strong network adequacy regulation should result in these protections and processes rarely, if ever, being used.

Transparency of provider selection standards

Additionally, the AMA urges the Division to apply strong transparency requirements to the provider selection standards being used by insurers to assemble their networks, requiring that such information be publicly available to regulators, physicians and other providers, and consumers. This transparency is especially necessary as insurers establish very narrow or tiered networks based primarily on provider costs, but with labels that connote quality such as "high-value" or "high-performing" networks. If quality is a factor that is used in the design of a network, consumers and providers should have information regarding the quality measures. But, if quality measures have not been used, it is critical that consumers, providers and regulators have that information as well.

Furthermore, it is essential that physicians and other health care providers have a full opportunity to challenge their termination or denial of participation in a health insurance product or panel. Such disruptions impact many of the long-standing patient-physician relationships essential to patient care, and affected physicians must be provided a fair process to appeal.

In conclusion, thank you for the opportunity to submit comments on this proposed regulation and engage with you on this important issue. If you have any questions, please contact Emily Carroll, Senior Legislative Attorney, Advocacy Resource Center at emily.carroll@ama-assn.org or 312-464-4967.

Thank you for your consideration.

Sincerely,

James L. Madara, MD

cc: Nevada State Medical Association

Nevada Hospital Association
Network Adequacy - Proposed Regulation: LCB File No. R049-14
November 12, 2014 Hearing

The Nevada Hospital Association (NHA) appreciates the leadership and effort of the Division of Insurance (DOI) to ensure that Nevada's network adequacy regulations protect the consumers' access to high quality and affordable health care. NHA is dedicated to representing the interests of our member hospitals, including general acute care, long-term acute care, rehabilitation and psychiatric hospitals, located in both urban and rural settings all of whom furnish vital health care to Nevadans. With respect to the draft of the proposed regulation (LCB File No. R046-14) circulated on October 10th, 2014, we hope you will take into consideration the following comments:

Specific response to the latest version of the regulation:

Section 3 subsection 4(a) and (b): Minimum Number of Providers per Covered Lives and Distance Requirements:

1. In the most recent draft of the regulation, you have removed the details related provider specialties/ facilities, minimum numbers per covered lives and distance requirements and instead reference external sources that will be updated from time to time which we believe is an improvement on the previous versions. We ask that you consider clarifying the regulation by adding "the combination of:" to the end of Section 3 subsection 4 so that it is clear the lists described in (a) and (b) that follow, refers to the content of both lists combined.
    a. In addition, Section 3 subsection 4 (a) and (b) does not include Emergency Room and/or Trauma care on either list for determining an adequate network. Are these services not considered part of an adequate network? Aren't services such as these the primary reason for the DOI's needed over site of an adequate network? We believe the carrier has the responsibility to protect the patient when seeking emergency care as defined in NRS 695G.170. Proximity is often the key to good outcomes when a patient is seeking medically necessary emergent care.

Section 12.5 subsection 3: While this section applies only to carriers with deficient networks, this section appears to limit the responsibility of the carrier to ensure their members have access to health care (under the in-network terms to which the member and carrier originally agreed) to only planned services since prior authorizations are required for the member protections in section 12.5 subsection 2 (b)(1)-(3) to apply. Is it the DOI's intent to exclude emergency services received at an out of network provider from the protection provided to a patient under section 12.5 subsection 2 (b)(1)-(3) where the carrier's network has been deemed deficient?

Section 12.5 subsection 4(b): The intent of the DOI is not clear in this section related to "submitting a statement of network capacity to the Commissioner" for a plan that has already been deemed deficient and is still deficient at the end of the corrective action time period. What

is the intended consequence of the statement of network capacity if the network is known to be deficient?

Section 15: This section excludes Medicaid managed care, group and blanket health insurance (large groups) and grandfathered plans from network adequacy requirements. Why should these plans not have the same protections (allowing timely access to health care without traveling unreasonable distances) for their members?

Our continued concerns (shared at previous workshops) include:

Consumer Education: While we understand that there are new federal requirements for insurers to provide education to consumers, we believe the importance of educating the consumer can't be stressed enough. Especially as we are adding more layers of complexity and increasing the likelihood of care being provided by an out-of-network provider by allowing for narrow networks which will result in more of the financial risk shifting to the consumer, we believe it would be reasonable for the DOI to reference in Nevada regulation and provide over site to ensure the federal consumer education requirements are met.

Other:

- **Provider Directories:** Section 10. NHA supports the provision in the regulation which requires the insurer to indicate which providers are not accepting new patients. This is essential for a consumer to make an educated decision regarding the purchase of a health plan and to be able to avoid financial problems when the patient is seeking care.
- **Multi-tier network tiers and reference pricing:** When health plans use reference pricing along with a tiered provider network, where enrollees pay different cost-sharing rates for each tier of providers, the lowest cost-sharing tier must include only those providers that accept the reference rate and the health plan should be required to meet network adequacy standards in the first tier alone.

We look forward to continue working with the Division and other stakeholders to assure that the adopted network adequacy rules are effective in providing the patient with timely access to care and protection against financial risk related healthcare decisions out of their control.

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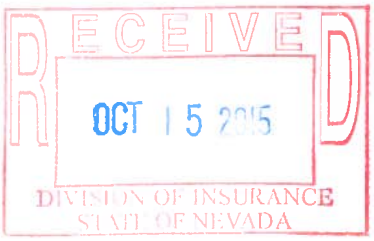

To: Nevada Division of Insurance

From: Elisa Cafferata, President & CEO NAPPA

Re: Comments Regarding Network Adequacy Regs R049-14

Date: October 13, 2015

Background:
Nevada Advocates for Planned Parenthood Affiliates (NAPPA) is the independent, non-partisan, and nonprofit education, policy and advocacy arm of Planned Parenthood's two affiliates (Mar Monte and the Rocky Mountains) in the state.

Planned Parenthood's three Nevada health centers handle over 48,000 patient visits each year. We offer high quality care at affordable rates, in some cases on a sliding fee scale; many of our patients have nowhere else to go for basic health care. We are proud of our long record of compassionate care -- over 35 years in Nevada -- always affordable, confidential, culturally appropriate, and welcoming to our clients.

We have provided comments on network adequacy in the past and are concerned that several elements from the federal guidance on this issue have not been incorporated into the final version of the proposed regulations. We appreciate the opportunity to provide additional comments on LCB File No. R049-14.

Access to non-340B Essential Community Providers (ECPs):

The proposed rule requires health plans to (1) include at least 30 percent of all available ECPs in the service area; and (2) include in their networks at least one ECP from each ECP category listed in the regulation. However, the regulation lists *only* 340B providers - e.g., 340B HIV clinics, 340B FQHCs, 340B family planning providers, and 340B hospitals.

In fact, the regulation as written creates additional barriers for non-340B providers by saying:

> "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."

The limited list of ECP types in the proposed rule ignores the federal definition of ECP, which specifically includes non-340B family planning providers. The regulation also fails to recognize that federal HHS guidance to issuers has consistently emphasized importance of access to Title X and "Title X look-alike family planning clinics" (i.e., non-340B family planning clinics). The proposed Nevada ECP standard ultimately sets a baseline that falls below the federal ECP standard in many ways.

But more importantly, this limited list of ECP types undermines women's access to care -- and disproportionately impacts women -- by failing to ensure access to family planning providers, including Planned Parenthood centers, merely because the provider does not participate in the 340B program (even though these providers are ECPs under law).

Federal law is very clear that non-340B family planning providers are recognized as ECPs and must be included in Marketplace plan networks.

Federal regulations at 156.235(c) define ECPs to include

- (1) 340B providers;
- (2) providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act (this was specifically designed to capture family planning providers that do not receive Title X funding); and
- (3) governmental and non-profit family planning service sites that do not receive federal funding including Title X.
- Also, although Nevada is a state-based Marketplace, HHS guidance issued each year for the last 3 years has required issuers in the federally-facilitated Marketplace to offer contracts to "at least one ECP in each ECP category per county" and explicitly stated that a unique ECP category is "Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics".
- See Guidance for 2016; Guidance for 2015; Guidance in 2013

Recommendation regarding access to non-340B providers:

The proposed regulation should either:

- Add a subsection under Section 6(2)(b) stating that plans must include at least one ECP from each category in the following list, including "a governmental family planning service site or not-for-profit family planning service site that does not receive funding under Title X."
- OR Add a subsection under Section 6(2)(b) stating that plans must include at least one ECP from each category in the following list, including "providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act"

The definition of ECP in the NAIC Network Adequacy Model Act (which is a model for state regulators on network adequacy) defines ECP to include 340B providers and "providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act" (these are 340B "look alikes," including family planning providers that do not receive Title X).

Nondiscrimination of women's health providers:

The proposed rule did not include the provider nondiscrimination provision that we have requested.

A federal ECP nondiscrimination provision (45 CFR 155.1050) prevents states and Marketplaces from prohibiting a Marketplace plan (Qualified Health Plan) from contracting with an ECP.

An ACA provision (section 2706 of the Public Health Service Act) prohibits group and individual health plans from discriminating against providers who are acting within the scope of their license or certification. Each state is responsible for enforcing this provision.

Nevada regulations should include a state-level nondiscrimination provision that applies to all carriers (not just QHPs) and protects women's health ECPs. Especially given recent attacks against family planning and women's health providers, this type of non-discrimination provision is critically important to ensuring the women have access to the health care they most need, from the providers they trust.

Recommendation regarding nondiscrimination of women's health providers:

We recommend adding a section to Section 4 that states "A carrier who applies to the Commissioner for the issuance of a network plan may not be prohibited or otherwise restricted from contracting with any essential community provider."

Comments about using telehealth options to circumvent access to local providers:

We are also concerned that some provisions of the regulation may be used to limit access to ECPs by looking at telehealth options offered by other providers inside and outside the service area.

The proposed rule includes a list of factors/criteria that the state Insurance Commissioner (IC) may look at when determining sufficiency of networks. One factor is "availability of telehealth services."

Recommendation regarding telehealth:

- We recommend amending Section 8(1)(D) to state that, when determining sufficiency, the IC may look at "the availability of telehealth services, except that other applicable network adequacy requirements relating to provider access in a service area may not be superseded simply by the availability of telehealth services."

We feel these recommendations together will make the regulation stronger and more consistent with federal guidance. Thank you for your consideration – and please let me know if you have any questions or need additional information.

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Nevada Advocates for Planned Parenthood Affiliates, Inc.

To: Mark Kruger and Kim Everett

From: Elisa Cafferata, President & CEO NAPPA

Re: Comments Regarding Network Adequacy Standards and Essential Community Providers

Date: July 23, 2015

Thanks for the opportunity to provide follow up information on Essential Community Providers (ECPs).

Background:
I've looked through past memos to find the source for our request re: including 340B & 340B look-alikes in the list of ECP types. And I've copied what I found below. I realize this is guidance from April 2013, so I've included more recent guidance below. But at any rate, this is the DHHS guidance we've based this request on in the past.

In our Feb. 27, 2014 memo we refer to the HHS letter "Affordable Exchanges Guidance" available at:
http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf

That "Letter to Issuers" includes this language (key sections are underlined):

> As defined in the statute and regulation, ECPs include providers described in section 340B of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act. Because the number and types of ECPs available varies significantly by location, CMS will use the following approach to evaluate QHP applications for sufficient inclusion of ECPs for the 2014 coverage year. CMS interprets the sufficiency standard found in 45 C.F.R. § 156.235 as being met by the safe harbor standard or minimum expectation described in the following paragraphs. CMS notes that contracted ECPs are subject to applicable issuer credentialing standards for network providers.
>
> • **Safe Harbor Standard**: An application for QHP certification that demonstrates compliance with the standards outlined in this paragraph will be determined to meet the regulatory standard established by 45 C.F.R. § 156.235(a) without further documentation.
>
> First, the application demonstrates that at least 20 percent of available ECPs in the plan's service area participate in the issuer's provider network(s). In addition to achieving 20 percent participation of available ECPs, the issuer offers contracts prior to the coverage year to:
>
> o All available Indian providers in the service area, using the model QHP Addendum for Indian providers developed by CMS; and
> o At least one ECP in each ECP category (see Table 2.1) in each county in the

service area, where an ECP in that category is available.
CMS may verify the offering of contracts after certification.

Table 1.1: ECP Categories and Types in FFEs

Major ECP Category	ECP Provider Types
Federally Qualified Health Center (FQHC)	FQHC and FQHC "Look-Alike" Clinics, Native Hawaiian Health Centers
Ryan White Provider	Ryan White HIV/AIDS Providers
Family Planning Provider	Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics
Indian Providers	Tribal and Urban Indian Organization Providers
Hospitals	DSH and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low-income, medically underserved individuals

In the 2015 letter to Issuers, the evaluation of ECP inclusion makes more sense for Nevada and still uses the direction of "at least one ECP in each ECP category ...where available." (http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf)

i. Evaluation of Network Adequacy with respect to ECPs

ii.

Because the number and types of ECPs available vary significantly by location, CMS intends to evaluate QHP Applications for sufficient inclusion of ECPs for the 2015 benefit year against the ECP inclusion expectations described below. Specifically, CMS will consider a QHP issuer in compliance with the ECP guideline and will not pursue an enforcement action against an issuer with regards to meeting the ECP regulatory standard if it satisfies the ECP guidelines described below.

ECP Guideline: An application for QHP certification that adheres to the general ECP inclusion standard does not need to provide further documentation. For benefit year 2015, we will utilize a general ECP enforcement guideline whereby if an application demonstrates that at least 30 percent of available ECPs in each plan's service area participate in the provider network, we will consider the issuer to have satisfied the regulatory standard. In addition, and as required for the prior year, we expect that the issuer offer contracts in good faith to:

- All available Indian health providers in the service area, to include the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations, using the recommended model QHP Addendum7 for Indian health providers developed by CMS; and

• At least one ECP in each ECP category (see Table 2.1) in each county in the service area, where an ECP in that category is available.

As part of the issuer's QHP application, we expect that the issuer list the contract offers that it has extended to all available Indian health providers and at least one ECP in each ECP category in each county in the service area. To be offered in good faith, a contract should offer terms that a willing, similarly-situated, non-ECP provider would accept or has accepted. We would expect issuers to be able to provide verification of such offers if CMS chooses to verify the offers.

The updates to the ECP categories and types table have been highlighted:

Table 1.1: ECP Categories and Types in FFEs

Major ECP Category	**ECP Provider Types**
Federally Qualified Health Center (FQHC)	FQHC and FQHC "Look-Alike" Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations
Ryan White Provider	Ryan White HIV/AIDS Program Providers
Family Planning Provider	Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics
Indian Providers	Indian Health Service (IHS providers), Indian Tribes, Tribal organizations, and urban Indian Organizations
Hospitals	Disproportionate Share Hospital DSH and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals
Other ECP Providers	STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, and other entities that serve predominantly low-income, medically underserved individuals

I would add that 111th Congress Public Law 8, Section 221 notes:
(http://www.gpo.gov/fdsys/pkg/PLAW-111publ8/html/PLAW-111publ8.htm)

Sec. 221. (a) In General.--Section 1927(c)(1)(D) of the Social Security Act <<NOTE: 42 USC 1396r-8.>> (42 U.S.C. Sec. 1396r-8(c)(1)(D)), as added by section 6001(d)(2) of the Deficit Reduction Act of 2005, is amended--

(1) in clause (i)--

(A) by redesignating subclause (IV) as subclause (VI); and

(B) by inserting after subclause (III) the following:

``(IV) An entity that--

``(aa) is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Act or is State-owned or operated; and

``(bb) would be a covered entity described in section 340(B)(a)(4) of the Public Health Service Act insofar as the entity provides the same type of services to the same type of populations as a covered entity described in such section provides, but does not receive funding under a provision of law referred to in such section;

Recommendation:
The guidance from the Centers for Medicare and Medicaid Services remains consistent in terms of including "Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics."

I appreciate your willingness to consider our views and incorporate our ideas. Please let me know if you need any additional background information.

Thank you!

Elisa

Elisa Cafferata
President & CEO
Nevada Advocates for Planned Parenthood Affiliates
550 W Plumb Lane c/o UPS Mail #B-104
Reno, NV 89509
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Nevada State
Medical Association
Advocates for high quality care since 1875

October 19, 2015

Ms. Amy Parks, Esq.
Acting Commissioner of Insurance
Division of Insurance, Department of Business and Industry
1818 East College Parkway, Suite 103
Carson City, Nevada 89706

RE: LCB File No. R049-14

Dear Ms. Parks:

The Nevada State Medical Association (NSMA), the Nevada Osteopathic Medical Association (NOMA) and the associations of various specialty groups of physicians have previously submitted letters of concern at each workshop held by the staff of the Division of Insurance and have had numerous conversations with the staff to discuss those concerns. The previous letter was submitted on July 23, 2015, and is attached hereto because the concerns outlined in that letter were not addressed. The major concerns, which we believe are detrimental to the enactment of this regulation, concern violations of chapter 233B of NRS.

Section 4 of LCB File No. R049-14 proposes the adoption of standards in violation of chapter 233B of NRS. The Legislature has adopted the Nevada Administrative Procedures Act which protects the public's interest by generally requiring any regulation being adopted by an agency to follow certain procedures, including a workshop and hearing before being presented for review by the Legislative Commission. According to NRS 233B.038, a regulation includes "an agency rule, standard, directive or statement of general applicability which effectuates or interprets law or policy, or describes the organization, procedure or practice requirements of any agency" and "general application by an agency of a written policy, interpretation, process or procedure to determine whether a person is in compliance with a federal or state statute or regulation in order to assess a fine, monetary penalty or monetary interest." Specifically, the "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" that Section 4 says will be published annually by the Commissioner is, according to this definition, a regulation which is subject to the processes set forth in chapter 233B of NRS. The truncated process in section 4 prohibits meaningful public input and is not a transparent process. For example, a regulation would normally require a 30 day notice before a workshop and an adoption hearing. Section 4 of this regulation provides that the annual list will be published not later than the first Tuesday in January, which will be January 5, 2016, and all comments are due in writing by the 20th of January. This provides 15 days, only 11 business days for a response. The regulation does not provide for a public meeting of any type before adopting the annual list. We continue to oppose this process and the adoption of network adequacy standards through a process which violates the Nevada Administrative Procedures Act.

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Similarly, Section 12 of LCB File No. R049-14 provides for the submission by a carrier of a corrective action plan in the event that a network becomes inadequate. The regulation is not clear as to the process for submission, review, and approval or rejection of such a plan. Furthermore, the regulation does not provide direction as to patient recourse if the corrective action plan proves to be insufficient or the carrier fails to complete the corrective action in a timely manner. The reviews of these corrective action plans are instrumental in protecting the public and patients thereby ensuring continued access during any period of network deficiency. We respectfully request that this process be open and transparent in accordance with chapter 233B of NRS comparable to other types of contested cases.

The NSMA, NOMA and our partner specialty organizations are hopeful that the Division of Insurance will consider these issues and those in the attached letter, which have been repeatedly brought to the attention of the Division. We look forward to continuing work on the vitally important topic of patient access to quality health care. Many members of the provider community will be available at your upcoming workshops to provide further input.

Sincerely,

Tomas Hinojosa, MD
President
Nevada State Medical Association

Lesley Dickson, MD
Executive Director/State Legislative Representative

Isaac J. Hearne, MD
President
Nevada Academy of Ophthalmology

Abdi Raissi, MD
President
Nevada Orthopaedic Society

Veronica Sutherland, DO
President
Nevada Osteopathic Medical Association

Attachment: NSMA Network Adequacy Letter- July 17, 2015

3700 Barron Way
Reno, NV 89511
(775) 825-6788

Nevada State Medical Association
Advocates for high quality care since 1875

July 17, 2015

Ms. Amy L. Parks, Esq.
Acting Commissioner
Nevada Division of Insurance
1818 East College Parkway, Suite 103
Carson City, NV 89706

RE: LCB File No. R049-14

Dear Ms. Parks,

The Nevada State Medical Association (NSMA) and our partner specialty medical societies submit these comments regarding the proposed regulation titled LCB File No. R049-14, relating to adequacy of network plans. The comments herein address the draft dated June 3, 2015 that was circulated with the workshop notice.

We are grateful to the staff of the Division of Insurance for your clear re-organization of the original draft of the regulation and the "map" of the sections of each version which made possible an easy comparison. The NSMA and its partners submitted comments to previous drafts, but we note that a number of the issues raised in our previous correspondence and testimony are still not fully addressed in the current language. We have continuing concerns in the areas described below.

Our comments are based on policy adopted at the national level by the American Medical Association, which sets forth the following precepts regarding **model network adequacy legislation and regulation. These national policies draw on the experience and expertise of providers from across the country and should be used to guide the discussions surrounding R049-14. Those policies are:**

1. **Provider networks must include a full range of primary, specialty and subspecialty providers for all covered services for children and adults.**
2. **Regulators must actively review and monitor all networks using appropriate quantitative and other measurable standards. Determinations of network adequacy must be the responsibility of regulators, utilizing strong quantitative and objective measures that take into consideration geographic challenges and the entire range of consumers' health care needs.**
3. **Appeals processes must be fair, timely, transparent and rarely needed. Policy must make clear that out-of-network arrangements and procedures are not an acceptable alternative to plans having an adequate network.**

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4. **The use of tiered and narrow provider networks and formularies must be regulated. Specific patient protections must be included for networks that are tiered or are limited in scope and number of providers in order to prevent unfair discrimination based on health status.**
5. **Insurers must be transparent in the design of their provider networks. It is critical that consumers have clear information regarding the design of their plan's provider network.**
6. **Provider directories must be accurate and up-to-date. Consumers must have access to robust provider directories to enable them to determine which providers are in-network when they purchase their plans, and, in the event their medical needs change, when they need new providers.**

Public Interest

NRS 687B.490 confers the authority to the office of the Commissioner to make final determinations on all matters dealing with network adequacy. While exercising this discretion, we believe, the Commissioner must acquire facts and evidence, as referenced in subsection 2(c) of NRS 687B.490, that balance the interests of the insured, the insurance carriers, the health care delivery professionals and the health care facilities.

The magnitude of the Commissioner's decisions is significant, making a transparent and uniform decision-making process both necessary and vital. The regulation must clearly set forth the deliberative process the office of the Commissioner must follow when ascertaining facts and developing findings to support initial determinations of or subsequent changes to network adequacy. That process is not clearly outlined in R049-14.We suggest a new section in R049-14 to read thus:

The Commissioner assures, whenever any determination is being made respecting an insurance product or changes thereto, to be offered to the public, that the insurance product provides for an adequate health care delivery network. In making such a determination respecting an adequate health care delivery network resulting from introduction of an insurance product or changes thereto, the Commissioner must acquire facts and evidence to support findings that the insurance product or changes thereto balances the interests of the insured, the insurance carriers, the health care delivery professionals and the health care facilities and does not negatively impact the health care delivery network.

In addressing the public interest, the Commissioner shall acquire and examine utilization data to support a determination of the adequacy of a health care delivery network. The Commissioner shall consider data, without limitation, showing, on an annual basis:

- *Prior year comparisons against regional and national benchmarks;*
- *Number of hospital admissions for chronic conditions;*
- *Emergency department visits;*
- *Preventive services provided;*
- *Total in-network visits, by specialty;*
- *Total out-of-network visits, by specialty;*
- *Out-of-pocket costs incurred by enrollees;*
- *Out-of-network costs incurred by enrollees;*
- *Percentage of total costs for in-network and out-of-network services;*
- *An evaluation of the quality of assurance standards used by the insurer; and*
- *Results of regular provider surveys to help determine network capacity and accessibility of health care services as well as to solicit providers' perspectives and concerns.*

Developing Standards

We assess that the adoption of certain standards and guidance via a Bulletin, with a truncated process for annually adjusting those standards, is contrary to the requirements outlined in NRS 233B. We respectfully request that the standards be set via the regulatory process.

We have studied the provisions of Bulletin 14-005. Neither that Bulletin nor R049-14 as currently drafted defines the process and criteria that the Commissioner shall use to make critical decisions related to provider-to-patient ratios or time and distance requirements. There is no narrative in the Bulletin that describes the Commissioner's rationale, methodology or calculations.

Sec 4.1 and Sec 4.2 of the draft regulation establish a maximum allowable time of less than a month, after the Commissioner annually issues a preliminary list, for interested parties to submit comments concerning minimum number of providers and the reasonable average travel distance or time by county. This allows only a very limited time for the public, insurance carriers and affected health care providers and facilities to review the preliminary list and make appropriate, informed comments.

In fact, there are now "additional" provider types posted on the DOI website as being added to the "un-validated Network Adequacy Template." Three of those five provider types are not included in Bulletin 14-005.

We would like to point out that the definition of "regulation" in NRS 233B.038 includes:

(a) An agency rule, standard, directive or statement of general applicability which effectuates or interprets law or policy, or describes the organization, procedure or practice requirements of any agency;
(b) A proposed regulation;
(c) The amendment or repeal of a prior regulation; and
(d) The general application by an agency of a written policy, interpretation, process or procedure to determine whether a person is in compliance with a federal or state statute or regulation in order to assess a fine, monetary penalty or monetary interest.

We assess that the adoption of certain standards and guidance via aBulletin, with a truncated process for annually adjusting those standards, is contrary to the requirements outlined in NRS 233B. We respectfully request that the standards be set via the regulatory process.

Contracting with Providers

Sec. 8.1(b) of R049-14 now states that the Commissioner should consider the "ability of a carrier to enter into a contract with health care providers...." We suggest that the language should read:
The Commissioner shall require documentation from carriers of their efforts to negotiate in good faith, under reasonable terms and conditions, with providers and facilities ...."

The concepts of "in good faith" and "reasonable terms and conditions" can be defined by incorporating language from the AMA's model legislation on adequate networks, which includes these concepts:

- **Due Process Protections:** provide providers full opportunity to challenge termination or denial of participation in a health insurance product or panel. Despite the reason for termination or denial of participation, such disruptions impact many of the long-standing patient-physician relationships essential to patient care, and affected providers must be provided a fair process to appeal.

- **Provider Profiling and Network Determination:** require that all profiling programs, including those used to determine tiered or narrow networks, incorporate quality measures and risk adjustment, while providing providers the opportunity to review and appeal their profiles.
- **Provider Choice of Health Insurance Product and Panel:** prevent insurers from requiring a provider who is contracted to be in one network to also be in all of the plans' networks.

Additional language to clarify these concepts includes:
The Commissioner shall collect and evaluate information from insurance carriers regarding the criteria and methodology used to evaluate providers and facilities for network inclusion.
The Commissioner shall require an insurer to make publicly available on its website the criteria and methodology used to evaluate a provider of health care for network inclusion. If the methodology includes cost considerations, it must also incorporate quality data and must provide proper safeguards including, but not limited to risk adjustment and adequate sample size, to ensure the integrity of the data. All quality measurements must take into account practice variation and the ability for patients and providers of health care to determine the best course of treatment.
Further:

As each insurer files its annual attestation of adequacy, the Commissioner shall make such filings available to the public on the DOI website. Each attestation filed by an insurer shall be accompanied by a report from the third party contractor retained by the Division as described in testimony to the Senate Committee on Commerce, Labor and Energy on June 2, 2013 regarding AB 425. This report should include, without limitation:

- *a breakdown of providers by type and number, including health care providers, hospitals, laboratories, diagnostic facilities and other facilities that are contracted to provide services in the network plan; and*
- *whether each provider of health care in the plan network is accepting new patients.*

Complaint Process and Satisfaction Surveys

We acknowledge that the Division currently has a process by which covered persons can file a complaint with the Insurance Commissioner regarding an insurance-related problem. A fully transparent complaint and complaint resolution process is vital to protecting consumers. To that end, we believe that language highlighting this process should be inserted as a new Subsection 2 in Section 3 of the regulation and include the following concepts:

- *In order to assure and monitor that patient access to care is not unduly or unnecessarily delayed or denied, the Commissioner shall accept complaints regarding the adequacy of a network plan from enrolled members of the network plan.*
- *Upon receiving such a complaint, the Commissioner must examine within 15 business days that specific area of a network plan to determine whether the network is adequate or whether significant changes have occurred which may disrupt patient access to care or indicate a deficient network.*
- *The Commissioner shall post on the Division's website all complaints received pursuant to this Section together with findings and the Commissioner's determinations related thereto.*

We also believe the Commissioner should monitor patient satisfaction on an on-going basis. Regulatory language should include the following:
The Commissioner shall monitor established health care delivery networks that the Commissioner has determined to be adequate, requiring reports be made available to the public that show, without limitation, the

following:

- *The results of regular patient surveys conducted for each plan; the results of these should surveys be compared against other network survey results;*
- *The bi-annual results of an insurer's report demonstrating that enrollees have had access to timely and convenient medical care, including all essential health care benefits and emergency services;*
- *The monthly totals of providers of health care accepting new patients for each network, and the total number of providers of health care in each network;*
- *Monthly reports of complaints against insurers relating to network adequacy including steps and measures the insurer and the Commissioner made to resolve the complaints.*

Finally, we believe the reports compiled and posted by the Commissioner should disaggregate the information by carrier.

During a Network Deficiency Period

Section 12 deals with deficiencies in network plans, but questions still arise.

In Sec. 12.1, a carrier is required to "submit a corrective action plan to resolve the deficiency within 60 days after the effective date of the material change...."

- Must the carrier submit the plan within 60 days? Or must the carrier submit a plan whereby the deficiency will be resolved within 60 days?
    - This needs to be clarified and a period of compliance should be enumerated for both the submission and the resolution.
- In either case, how will patients know there is a deficiency awaiting corrective action and that they should contact their plan to make arrangements to receive care from another source, either in or out of network? Notice to patients should be included as part of the corrective action plan.

A related issue exists in Section 7. While this section deals with the Indian Health Service, Sec. 7.2 states that "*nothing in this section prohibits a health benefit plan from limiting coverage to those health care services that meets 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.*" Does this language indicate that carriers will be allowed to pay only in-network fees? Does this put the burden of paying a "balance bill" on the enrolled patient? If so, carriers must be held responsible to inform their enrolled patients of the potential of incurring significant out-of-pocket expenses.

Telehealth

The topic of telehealth/telemedicine needs to be more completely developed in the draft regulation. During the 2015 session, legislators passed AB 292, dealing with telehealth. The bill:

- Requires insurers to pay for services provided via telehealth in the same amount as if the services were provided in person.
- Requires the Commissioner of Insurance to consider services provided through telehealth when defining insurance network adequacy.

Section 8 of R049-14 lists elements the Commissioner may consider when determining whether a network is adequate.

- In the June 3, 2015 version of the regulation that was attached to the workshop announcement, Sec. 8.1(d) reads "the availability of telehealth services".
- In the June 3, 2015 version that was circulated at the Commissioner's Advisory Committee on Health Care and Insurance, Sec. 8.1(d) reads "the use of telemedicine or telehealth services to supplement or provide an alternative to in-person care in the network plan".

Bulletin 14-005 states several times that "telemedicine may be utilized in order to provide accessible care **in addition to** the above network adequacy ratios and travel standards." (Emphasis added.)
The regulation should clarify that telemedicine services are not part of the metrics in determining adequacy of a network but are seen as an enhancement to an otherwise adequate network. Other clarifications should include whether telemedicine may be part of the determination if every provider in the service is in-network, which should include the originating site, the distant site and all providers who will bill for services.

The Nevada State Medical Association and our partner specialty organizations are pleased to continue the dialogue with the Division of Insurance on the vitally important topic of patient access to quality health care. Many members of the provider community will be available at your upcoming workshops to provide further input.

Sincerely,

Tomas Hinojosa, MD
President
Nevada State Medical Association

Lesley Dickson, MD
Executive Director/State Legislative Representative

Isaac J. Hearne, MD
President
Nevada Academy of Opthalmology

Abdi Raissi, MD
President
Nevada Orthopaedic Society

Veronica Sutherland, DO
President
Nevada Osteopathic Medical Association

Cc: Mark Kruger, Division of Insurance
Kim Everett, Division of Insurance

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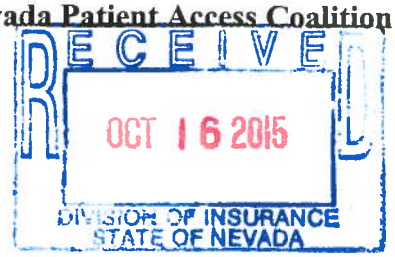
Patient Access Coalition

Nevada Patient Access Coalition



October 13, 2015

The Honorable Amy L. Parks, Acting Commissioner
Nevada Division of Insurance
Office of the Commissioner
1818 E. College Parkway
Carson City, NV 89706

Comments sent by e-mail to: insinfo@doi.nv.gov and sletourneau@doi.nv.gov

Re: Proposed Regulation for LCB File NO. R049-14: Network Adequacy

Acting Commissioner Parks:

The Nevada Patient Access Coalition is concerned that the proposed regulation does not address the needs of people who live in rural Nevada or those who require specialized care. The proposed regulations do not define reasonable or maximum travel. As written, it is possible that one may have health coverage but, in practical terms because of the time and/or distance involved, no access to care.

The Nevada Patient Access Coalition is very supportive that the proposed regulations mandate that the health care provider directory be posted to an internet website accessible to the general public. This provides transparency so that those who are not part of the plan are able to view the health care provider directory (Section 9.3). We ask that this portion of the proposed regulation remain as written.

In conclusion, the Nevada Patient Access Coalition has concerns regarding the access to care for those in rural areas or those in need of specialized care. Thank you very much for the opportunity to express our viewpoint.

Sincerely,
Nevada Patient Access Coalition Members:

The Rev. Dixie Drach-Meinel, President
Religions Alliance in Nevada.

October 20, 2015

Ms. Amy L. Parks, Esq.
Acting Commissioner, Nevada Division of Insurance
1818 E. College Pkwy., Suite 103
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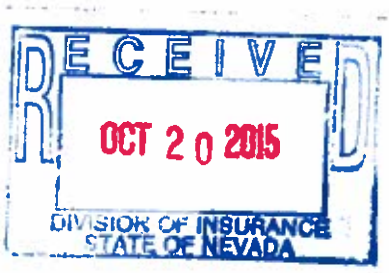

Re: Regulation R049-14, Network Adequacy

Dear Acting Commissioner Parks:

On behalf of the undersigned organizations, representing approximately 15,000 dermatologists nationwide, we appreciate the opportunity to comment on proposed draft regulations that would establish network adequacy requirements. We support the Nevada Division of Insurance's ("Division") decision to amend the draft proposal of Regulation R049-14 as we continue to have concerns with several sections of the proposal. As such, we request the following amendments:

Recommendation #1: Section 4, subsection 3 would limit the physicians who must be included in the network plan to:

> 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 certification by :
>
> (1) Member Boards within the American Board of Medical Specialties; or
> (2) The American Osteopathic Association

The proposed language would limit the Division's evaluation of provider access primarily to the general specialty for most specialties; however, adequate access to subspecialties should also be ensured where deemed appropriate. Dermatology has several sub-specialties, including Mohs Micrographic Surgery and Pediatric Dermatology, which without adequate access, care could be delayed or deferred, and resulting in higher costs.

We request the Division consider additional specialty or subspecialty categories of physicians for evaluation based on the needs of the population when determining the requisite categories of providers for evaluation by changing Section 4, subsection 3 to read:

> 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 certification by:
    (1) Member Boards within the American Board of Medical Specialties or
    (2) The American Osteopathic Association

or

(c) Any additional specialty or subspecialty deemed appropriate by the commissioner.

Recommendation #2: Section 8.1 details the criteria the Commissioner will evaluate when determining the availability of providers within the network. We recommend several additional criterion to reflect the current draft of the National Association of Insurance Commissioners (NAIC) Model Legislation and Centers for Medicare and Medicaid Services (CMS) regulations.

The criterion provides the Commissioner an ability to evaluate a practice's hours of operation in network adequacy calculations. If a physician practices in multiple locations, each office may be open for administrative purposes more hours than the physician sees patients. We recommend this criterion be amended to account for hours of operation a physician is available to see patients.

The second criterion appears to put the burden to justify network inclusion or exclusion on the provider, whereas frequently the determination for inclusion or exclusion from network is made by the carrier. Additionally, we are concerned that as currently worded the Division creates a "race to the bottom" in which a provider can accept below market rates which become the terms and conditions all other providers must accept or be considered not negotiating in "good-faith". We thank the Division for removing references to "similarly-situated" providers in this criterion as we were concerned that too narrow of a definition would have left practices with a high-risk patient population at a disadvantage when negotiating their contracts.

The fourth criterion appears to allow a carrier to utilize telehealth services to meet network adequacy requirements. Due to the wide spectrum of services provided by physicians, including in-office procedures, access to telemedicine cannot replace the need for patients to receive in-office services and treatments. Until the healthcare community has a better idea of the utility, accuracy, and scope of service that is appropriate for remote services, telemedicine should not be utilized to meet network adequacy standards for a healthcare plan.

In addition to the criteria listed in Section 8.1.a, we also recommend the Commissioner evaluate the provider-to-covered-person ratio by specialty which would be consistent with how CMS determines network adequacy for Medicare Advantage plans. As a part of this calculation we also recommend the Carrier or Commissioner calculate the Full-Time Equivalent (FTE) of available physicians when determining the provider-to-covered-person's ratio.

Additionally, we recommend the Division add an additional criterion that accounts for whether the provider is accepting new patients. This provision will align the regulation with CMS policy.

To account for these concerns, we recommend Section 8.1 read:

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~~ health care provider to enter into a contract with ~~health care providers~~ carrier with 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;

(g) Provider-covered person full-time equivalent ratios by specialty and subspecialty; and

(h) The number of providers accepting new patients.

Recommendation #3: Finally, we again request that the Division include language that would provide physicians with a meaningful appeal whenever a physician is terminated from a network, regardless of how the plan characterizes the termination. The appeal review should consider whether the removal of the physician from the network would result in network inadequacy, and this should be a basis for reinstatement. Additionally, beneficiaries should always be provided reasonable and adequate notice of physician termination, and should be allowed to stay with a physician until the next open enrollment period if the provider is eliminated "without cause" from a network mid-year.

Conclusion

We commend the Nevada Division of Insurance for its effort to ensure the citizens of Nevada have access to needed health care services in a timely fashion and urge the Division to include the proposed amendments described above. Should you have any questions, please contact David W. Brewster, Assistant Director for Practice Advocacy for the American Academy of Dermatology Association at 202-842-3555 or dbrewster@aad.org.

Sincerely,

Mark Lebwohl, MD, FAAD
President
American Academy of Dermatology Association

John G. Albertini., MD, FACMS
President
American College of Mohs Surgery

George J. Hruza, MD, MBA, FAAD
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James A. Schiro, MD, FAAD
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