NOTICE OF INTENT TO ACT UPON REGULATION

Notice of Hearing for the Adoption, Amendment or Repeal of Regulations of
The Department of Business and Industry, Division of Insurance

The State of Nevada Department of Business and Industry, Division of Insurance ("Division"), (775) 687-0700, will hold a public hearing at **9:30 a.m. on March 8, 2016,** at the office of the Division, 1818 East College Parkway, Suite 103, Carson City, Nevada 89706, in the 1st floor hearing room. Interested persons may also participate through a simultaneous videoconference conducted at the Division's southern office, located at 2501 East Sahara Avenue, Suite 302, Las Vegas, Nevada 89104, in the 3rd floor conference room. The purpose of the hearing is to receive comments from all interested persons regarding the adoption, amendment or repeal of regulations that pertain to **chapter 687B and 695C** of the Nevada Administrative Code ("NAC"). Acting Commissioner Amy L. Parks will preside as Hearing Officer.

The following information is provided pursuant to the requirements of Nevada Revised Statute ("NRS") 233B.0603 and the directives of the Governor:

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

(1) Why is the regulation necessary and what is its purpose? *The proposed regulation outlines the requirements for network plans to apply for and be approved by the Commissioner of Insurance ("Commissioner"). Existing federal[1,2] and state[3] law require health benefit plans utilizing a network plan to prove the adequacy of the number, type, and location of the providers and facilities included within the network.*

(2) What are the terms or substance of the proposed regulation? *The proposed regulation outlines a procedure for a carrier wishing to apply for a network plan to have the application deemed adequate. It also provides for the ability of the Commissioner to declare a network plan adequate in certain instances when the application fails to meet the safe harbor provisions. The proposed regulation also outlines the requirements for network plans to remain in compliance and the potential remedies and penalties for failing to remain compliant.*

[1] 42 U.S.C. § 18031(c)(1)(B)
[2] 45 C.F.R. § 155.230
[3] NRS 687B.490

(3) What is the anticipated impact of the regulation on the problem(s)? *The proposed regulation is anticipated to mitigate some of the issues consumers, providers, facilities and insurers may experience in ensuring adequate access to medical care. Due to disparities in geography and medical care availability, the regulation is not anticipated to solve all issues consumers experience while trying to access medical care.*

(4) Do other regulations address the same problem(s)? *NAC 695C.1255 establishes similar requirements for Health Maintenance Organizations.*

(5) Are alternate forms of regulation sufficient to address the problem(s)? *No.*

(6) What value does the regulation have to the public? *The proposed regulation should help ensure that members of the public who purchase health benefit plans utilizing network plans have adequate access to medical care or other remedies available.*

(7) What is the anticipated economic benefit of the regulation?

a. Public
   1. Immediate: *None anticipated*
   2. Long Term: *None anticipated*

b. Insurance Business
   1. Immediate: *None anticipated*
   2. Long Term: *None anticipated*

c. Small Businesses
   1. Immediate: *None anticipated*
   2. Long Term: *None anticipated*

d. Small Communities
   1. Immediate: *None anticipated*
   2. Long Term: *None anticipated*

e. Government Entities
   1. Immediate: *None anticipated*
   2. Long Term: *None anticipated*

(8) What is the anticipated adverse impact, if any?

a. Public
   1. Immediate: *None anticipated*
   2. Long Term: *None anticipated*

b. Insurance Business
   1. Immediate: *None anticipated*
   2. Long Term: *None anticipated*

c. Small Businesses
   1. Immediate: *None anticipated*
   2. Long Term: *None anticipated*

d. Small Communities
   1. Immediate: *None anticipated*
   2. Long Term: *None anticipated*

e. Government Entities
   1. Immediate: *None anticipated*
   2. Long Term: *None anticipated*

(9) What is the anticipated cost of the regulation, both direct and indirect?

a. Enactment: *No cost anticipated.*

b. Enforcement: *No direct cost to the state anticipated. Statute permits the Division to pass the cost of enforcement to the insurers applying for the approval of a network plan.*

c. Compliance: *No direct cost to the state anticipated. Statute permits the Division to pass the cost of compliance in the form of a market conduct examination to the insurer under examination.*

(10) Does the regulation establish a new fee or increase an existing fee? *No.*

(11) Provide a statement which identifies the methods used by the agency in determining the impact of the proposed regulation on a small business, prepared pursuant to subsection 3 of NRS 233B.0608. *Attached.*

(12) Provide a description of any regulations of other state or local governmental agencies which the proposed regulation overlaps or duplicates, and a statement explaining why the duplication or overlapping is necessary. If the regulation overlaps or duplicates a federal regulation, state the name of the regulating federal agency. *None known.*

(13) If the regulation is required pursuant to federal law, provide a citation and description of the federal law. *See paragraph (1).*

(14) If the regulation includes provisions which are more stringent than a federal regulation that regulates the same activity, provide a summary of such provisions. *Not applicable.*

Persons wishing to comment upon the proposed action of the Division may appear at the scheduled public hearing or may address their comments, data, views or arguments, in written form, to the Division, 1818 East College Parkway, Suite 103, Carson City, Nevada 89706. **Written submissions must be received by the Division on or before March 1, 2016.** If no person who is directly affected by the proposed action appears to request time to make an oral presentation, the Division may proceed immediately to act upon any written submissions.

A copy of this notice and the regulation will be on file at the State Library, 100 Stewart Street, Carson City, Nevada, for inspection by members of the public during business hours. Additional copies of the notice and the regulation will be available at the offices of the Division, 1818 East College Parkway, Suite 103, Carson City, Nevada 89706, and 2501 East Sahara Avenue, Suite 302, Las Vegas, Nevada 89104, and in all counties in which an office of the agency is not maintained, at the main public library, for inspection and copying by members of the public during business hours. This notice and the text of the proposed regulation are also available in the State of Nevada Register of Administrative Regulations, which is prepared and published monthly by the Legislative Counsel Bureau pursuant to NRS 233B.0653, and on the Internet at **http://leg.state.nv.us/register/**. Copies of this notice and the proposed regulation will be mailed to members of the public upon request. A reasonable fee may be charged for copies if it is deemed necessary. This does not apply to a public body subject to the Open Meeting Law.

Upon adoption of any regulation, the agency, if requested to do so by an interested person, either before adoption or within 30 days thereafter, shall issue a concise statement of the principal reasons for and against its adoption, and incorporate therein its reason for overruling the consideration urged against its adoption.

Notice of the hearing was provided via electronic means to all persons on the agency's e-mail list for administrative regulations, and this Notice of Intent to Act Upon Regulation was posted to the agency's Internet Web site at **http://doi.nv.gov/** and was provided to or posted at the following locations:

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

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

Legislative Building
401 South Carson Street
Carson City, Nevada 89701

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

Blasdel Building
209 East Musser Street
Carson City, Nevada 89701

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

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

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

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

Churchill County Library
553 South Main Street
Fallon, Nevada 89406

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

Elko County Library
720 Court Street
Elko, Nevada 89801

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

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

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

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

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

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

Lyon County Library
20 Nevin Way
Yerington, Nevada 89447

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

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

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

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

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

White Pine County Library
950 Campton Street
Ely, Nevada 89301

Members of the public who would like additional information about the proposed regulation may contact Glenn Shippey, Actuarial Analyst, at (775) 687-0738, or via e-mail to gshippey@doi.nv.gov.

Members of the public who are disabled and require special accommodations or assistance at the hearing are requested to notify the Commissioner's secretary in writing, at 1818 E. College Pkwy., Ste. 103, Carson City, NV 89706, or by calling (775) 687-0700, a day prior to the hearing.

DATED this 1st day of February, 2016.

AMY L. PARKS
Acting Commissioner of Insurance

BRIAN SANDOVAL
Governor

STATE OF NEVADA

BRUCE H. BRESLOW
Director

AMY L. PARKS
Acting Commissioner

DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE
1818 East College Pkwy., Suite 103
Carson City, Nevada 89706
(775) 687-0700 • Fax (775) 687-0787
Website: doi.nv.gov
E-mail: insinfo@doi.nv.gov

Notice of Intent to Act Upon Regulation & Hearing Agenda
LCB File No. R049-14, Network Adequacy

Agenda

Tuesday, March 8, 2016 • 9:30 a.m.

Location of Hearing:
Offices of the Division of Insurance
1818 E. College Pkwy., 1st Floor Hearing Room
Carson City, NV 89706
(Division Offices located in Suite 103)

Available via Videoconference at:
Offices of the Division of Insurance
2501 E. Sahara Ave., 3rd Floor Conference Room
Las Vegas, NV 89104
(Division Offices located in Suite 302)

1. **Call to Order.**

2. **Public Comment.**

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

4. **Public Comment.**

5. **Adjournment.**

Supporting public material for this meeting may be requested from Sue Dummar, Legal Secretary, Nevada Division of Insurance, 1818 E. College Parkway, Carson City, Nevada 89706, by e-mail to sdummar@doi.nv.gov, or by calling (775) 687-0704. In your request, please state that you are requesting meeting materials for LCB File No. **R049-14, Network Adequacy**, and provide the date of the meeting.

Note: Any agenda item may be taken out-of-order; items may be combined for consideration by the public body; and items may be pulled or removed from the agenda at any time. The Hearing Officer, within his/her discretion, may allow for public comment on individual agenda items. Public Comment may be limited to three minutes per speaker.

Members of the public are encouraged to submit written comments for the record.

We are pleased to make reasonable accommodations for attendees with disabilities. Please notify Sheri LeTourneau, Assistant to the Commissioner, at (775) 687-0771, a day prior to the meeting.

NOTICES FOR THIS MEETING HAVE BEEN POSTED IN ACCORDANCE WITH NRS 241 AT THE FOLLOWING LOCATIONS:
Nevada Division of Insurance, 1818 E. College Parkway, Suite 103, Carson City, Nevada 89706
Nevada Division of Insurance, 2501 E. Sahara Avenue, Suite 302, Las Vegas, Nevada 89104
Nevada State Legislative Building, 401 S. Carson Street, Carson City, Nevada 89701
Grant Sawyer State Office Building, 555 E. Washington Avenue, Las Vegas, Nevada 89101
Blasdel State Office Building, 209 E. Musser Street, Carson City, Nevada 89701
Nevada State Capitol, 101 N. Carson Street, Carson City, Nevada 89701
Nevada Department of Employment, Training and Rehabilitation, 2800 E. Saint Louis Avenue, Las Vegas, Nevada 89104
The State of Nevada Website (www.nv.gov)
The Nevada State Legislature Website (www.leg.state.nv.us)
The Nevada Division of Insurance Website (www.doi.nv.gov)

STATE OF NEVADA
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INSURANCE

Determination of Necessity of Small Business Impact Statement
R049-14

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

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

1. BACKGROUND

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

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

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

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

☐ NO ☑ YES

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

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

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

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

02 June 2014
(DATE)

SCOTT J. KIPPER
Commissioner of Insurance

Small Business Impact Statement
R049-14

4. DESCRIPTION OF SOLICITATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

02 June 2014
(DATE)

SCOTT J. KIPPER
Commissioner of Insurance

STATE OF NEVADA
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INSURANCE

Addendum to Small Business Impact Statement
Pursuant to NRS 233B.0608.4

LCB File No. R049-14

The primary revision to this regulation is the creation of an advisory council pursuant to NRS 679B.160, and the establishment of certain deadlines by which submissions to and decisions by the Commissioner must be made. There is no apparent effect on the Impact.

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

1/22/16
(DATE)

AMY L. PARKS
Acting Commissioner of Insurance

REVISED PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R049-14

October 19, 2015

EXPLANATION – Matter in ***green italics*** is new; matter in ~~***red strikethrough italics***~~ is material to be omitted.

AUTHORITY: §§1-29, NRS 679B.130 and 687B.490; §30, NRS 679B.130, 695C.130 and 695C.275.

A REGULATION relating to insurance; establishing certain requirements relating to the adequacy of a network plan issued by a carrier; establishing provisions relating to the determination by the Commissioner of Insurance of whether a network plan is adequate; requiring a carrier to notify the Commissioner of any material change to its network and take certain actions to correct any deficiency that results; providing for the availability of a network plan to persons outside of the approved service area in certain circumstances; ***creating a Network Adequacy Advisory Council;*** and providing other matters properly relating thereto.

Legislative Counsel's Digest

Existing law authorizes the Commissioner of Insurance to adopt reasonable regulations for the administration of the Nevada Insurance Code and as required to ensure compliance with federal law relating to insurance. (NRS 679B.130) Existing law also requires: (1) a carrier who offers coverage in the group or individual market to demonstrate the capacity to deliver services adequately before making any network plan available for sale; and (2) the Commissioner to promulgate regulations concerning the organizational arrangements of the network plan and the procedure established for the network plan to develop, compile, evaluate and report certain statistics relating to its services. (NRS 687B.490)

This regulation establishes certain requirements for a carrier who applies to the Commissioner for the issuance of a network plan. **Section 17** of this regulation requires a carrier who applies for the issuance of a network plan to establish that the carrier has contracted with an adequate number and geographic distribution of providers of health care. **Section 18** of this regulation requires the Commissioner to make a preliminary and a final list of the minimum number of providers of health care and the maximum travel distance or time, by county, which is presumed to be reasonable for certain specialties and categories of health care. **Section 19** of this regulation requires a carrier to gather and present sufficient data to establish the adequacy of its network plan to the Commissioner in conjunction with its annual rate and form filing. **Section 20** of this regulation requires a carrier who applies for the issuance of a network plan to establish that the carrier has a sufficient number and geographic distribution of essential community providers. **Section 21** of this regulation requires a carrier who offers a network plan on the Silver State

Health Insurance Exchange to use its best efforts to ensure that American Indians and Alaskan Natives who are members of the network plan have access to health care services and facilities that are part of the Indian Health Service. **Section 22** of this regulation establishes criteria the Commissioner may use to determine whether a network plan is adequate. **Section 23** of this regulation requires a carrier to monitor the ability and clinical capacity of its providers of health care. **Section 24** of this regulation requires a carrier to update its provider directory at least once a month and to post each update on its Internet website. If a material change to a network plan occurs, **section 24** requires a carrier to update its directory within 3 business days and notify all covered persons affected by the material change. **Section 25** of this regulation requires a carrier to notify the Commissioner of any material change to its network plan within 3 business days. **Section 26** of this regulation requires a carrier to take certain actions to correct any deficiency in its network plan that results from such a material change. **Section 27** of this regulation allows the Commissioner to declare a network plan inadequate pursuant to existing law if it remains deficient at the end of the time period allowed for corrective action. **Section 28** of this regulation excludes a network plan issued by certain smaller carriers from the provisions **sections 20-22, 26 and 27** of this regulation and deems such a network plan to satisfy the requirements of existing law. **Section 29** of this regulation excludes certain other plans from the provisions of this regulation.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to ***28*~~29~~**, inclusive, of this regulation.

Sec. 2. ***As used in sections 2 to 28~~29~~, inclusive, of this regulation, unless the context otherwise requires, the words and terms defined in sections 3 to 16, inclusive, of this regulation have the meanings ascribed to them in those sections.***

Sec. ***3. "Access plan" means a plan submitted by a carrier which describes how access to health care will be provided when a network plan fails to meet a specific standard including, but not limited to, any relevant established patterns of care.***

Sec. 4. "Carrier" means an insurer who makes a network plan available for sale in this State pursuant to NRS 687B.490.

~~***"Center for Consumer Information and Insurance Oversight" means the Center for Consumer Information and Insurance Oversight of the Centers for Medicare and Medicaid Services.***~~

Sec. 5. ***"Centers for Medicare and Medicaid Services" means the Centers for Medicare***

and Medicaid Services of the United States Department of Health and Human Services.

Sec. 6. *"Covered person" means a policyholder, subscriber, enrollee or other person participating in a network plan.*

Sec. 7. *"Essential community provider" has the meaning ascribed to it in 45 C.F.R. § 156.235(c).*

Sec. 8. *"~~Established pattern of care" means a clinically appropriate pattern for the referral of a patient to a location for treatment for a particular condition, including, without limitation, the travel expected for the patient.~~*

~~Sec. 9. "Exchange" means the Silver State Health Insurance Exchange established by NRS 695I.200.~~

~~Sec. 10. "~~Geographic service area" means a network plan's geographic area~~, as approved annually by the Commissioner~~, within which a carrier is authorized to provide coverage~~.

Sec. 9. ~~Sec. 11. "Indian Health Service" means the Indian Health Service of the United States Department of Health and Human Services.~~

~~Sec. 12. "~~Material change" means any change ~~to a network plan, or a combination of changes~~ that results in a deficiency in the adequacy~~take effect within 30 days of each other, which:~~

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

~~1. For a specialty or category of health care with 10 or fewer providers of health care, affects the capacity of the network plan by more than 20 percent in any single specialty or category of health care for which a benefit is offered; or~~

~~*2. Does not otherwise satisfy the requirements of a final list issued by the Commissioner pursuant to subsection 2 of section 18 of this regulation.*~~

Sec. *10~~13~~.* ***"Medically necessary emergency services" has the meaning ascribed to it in subsection 3 of NRS 695G.170.***

Sec. 11. "Network Adequacy Advisory Council" means the council established by the Commissioner pursuant to Section 17.

Sec. 12. ~~**Sec. 14.**~~ ***"Network plan" has the meaning ascribed to it in subsection 2 of NRS 689B.570.***

Sec. *13.* ~~**15.**~~ ***"Provider of health care" has the meaning ascribed to it in NRS 695G.070.***

Sec. 14. "Qualified health plan" has the meaning ascribed to it in NRS 695I.080.

Sec. 15.

~~***Sec. 16.***~~ ***"Reasonable travel" means travel that satisfies the requirements for distance or time*** ~~***provided in the preliminary and final lists***~~ ***issued by the Commissioner*** ~~***pursuant to section 18 of this regulation***~~***.***

Sec. 16. "Standard" means a quantifiable metric including, but not limited to, reasonable travel or provider ratios commonly used in the health care industry to measure network adequacy.

~~***Sec. 17. A carrier who applies to the Commissioner for the issuance of a network plan must establish that the network plan has contracted with an adequate number and geographic distribution of providers of health care in each geographic service area covered by the network plan to meet the anticipated health care needs of its members based upon the benefits offered under the network plan.***~~

Sec. 17. 1. The Network Adequacy Advisory Council is hereby created pursuant to NRS 679B.160. The purpose of the Council is to develop and submit a recommendation to the

Commissioner each year, pursuant to Section 19, as to the network adequacy requirements for the relevant network plan year.

2. The Council shall consist of nine persons. The members of the Council shall be appointed by the Commissioner and shall serve at the discretion of the Commissioner. Vacancies on the Council shall be filled in the same manner as initial appointments. The Council shall consist of representatives of carriers, health care providers, and consumers.

Sec. 18. Meetings and Notice. The Council shall conduct at least three meetings each year. The first meeting of the Council shall occur no later than June 15th of each year. The final meeting of the Council shall contain an action item to adopt a recommendation pursuant to Section 19 to submit to the Commissioner no later than September 15th of each year. Notice of each meeting will be posted:

1. At least five business days prior to the date of the meeting, not counting the day of the meeting;

2. At a minimum, at the offices of the Division of Insurance, the Legislative Building, the Grant Sawyer State Office Building, and on the State's and Division of Insurance's websites; and

3. Interested parties may also contact the Division of Insurance to be added to its notification list.

Sec. 19. Recommendation of the Council; Failure to Make Recommendation. 1. The recommendation of the Council shall include:

(a) The specialties and categories of health care which:

~~*(1)* Sec. 18. 1. On or before the first Tuesday in January of each year, but not earlier than December 1 of the preceding year, the Commissioner will make available a preliminary list of the minimum number of providers~~

~~*of health care and maximum travel distance or time presumed to be reasonable, by county, for the specialties and categories of health care described in subsection 3. The Commissioner will allow any interested person to submit comments concerning the preliminary list to the Commissioner until January 20 of the applicable year.*~~

~~*(2) On or before January 31, but not earlier than January 21, of each year, the Commissioner will make available a final list of the minimum number of providers of health care and maximum travel distance or time presumed to be reasonable, by county, for the specialties and categories of health care described in subsection 3. The final list will be applicable to any network plan 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 referenced by subsections 1 and 2 are those which:*~~

~~*(4)*~~*(1) Appear ~~as options~~ on the Network Adequacy Template issued and periodically updated by the Centers for Medicare and Medicaid Services; ~~and~~*

(2) Are mandated under Nevada State law; and

(b) Standards which are acceptable to the Centers for Medicare and Medicaid Services for qualified health plans.

2. The Council may include in the recommendation:

(a) Other provider types, and

(b) A number of essential community providers greater than the minimum percentage

required by the Centers for Medicare and Medicaid Services for qualified health plans.

3. Failure of the Council to make a recommendation does not prevent the Commissioner from issuing final requirements in his or her discretion.

Sec. 20. Not later than October 15th of each year, the Commissioner shall issue the requirements that will be used for determining the adequacy of network plans to be submitted for the relevant plan year.

~~*(a)*~~ *Sec. 21. Unless the Commissioner specifies a different submission date, a*~~*Are offered for certification by the American Osteopathic Association or the member boards within the American Board of Medical Specialties.*~~

~~*2. For the purposes of subsections 1 and 2, a change to the specialties and categories of health care described by subsection 3 which occurs after the Commissioner issues a final list pursuant to subsection 2 is deemed to be effective for the preliminary and final lists issued in the calendar year which follows the year in which the change is made.*~~

~~*Sec. 19. A*~~ *carrier who applies to the Commissioner for the issuance of a network plan shall, in conjunction with its annual rate* ~~*and form*~~ *filing,* ~~*collect, compile, evaluate, report and*~~ *submit* ~~*sufficient data,*~~ *in a format determined by the Commissioner, sufficient data and documentation* ~~*to the Commissioner*~~ *to establish that its*~~*the*~~ *proposed network plan* ~~*has the capacity to adequately serve the anticipated number of covered persons in the network plan.*~~

~~**Sec. 20. 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 area covered by the network plan.**~~

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

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

~~*(b) At least one essential community provider from each category as follows:*~~

~~*(1) An entity described in 42 U.S.C. § 256b(a)(4)(A);*~~

~~*(2) An entity described in 42 U.S.C. § 256b(a)(4)(C);*~~

~~*(3) An entity described in 42 U.S.C. § 256b(a)(4)(D);*~~

~~*(4) An entity described in 42 U.S.C. § 256b(a)(4)(I); and*~~

~~*(5) An entity described in 42 U.S.C. § 256b(a)(4)(L), 256b(a)(4)(M), 256b(a)(4)(N) or 256b(a)(4)(O),*~~

~~*↵ shall be deemed sufficient.*~~

~~*3. An essential community provider is deemed to satisfy the requirements of paragraph (b) of subsection 2 if:*~~

~~*(a) The carrier follows the 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 Center for Consumer Information and Insurance Oversight, regardless of whether the essential community provider is an entity described in subparagraphs (1) to (5), inclusive, of paragraph (b) of subsection 2; or*~~

~~*(b) The essential community provider is described in subparagraph (4) of paragraph (b) of subsection 2 and the carrier and the essential community provider enter into a letter of agreement.*~~

~~**Sec. 21.** *1. A carrier who offers a network plan through the Exchange must use its best efforts to establish and maintain arrangements to ensure that American Indians and Alaskan Natives who are members within the network plan have access to health care services and facilities that are part of the Indian Health Service at no greater cost to the member than if the*~~

~~*services were obtained from a provider of health care that is part of the network plan.*~~

~~*2. Nothing in this section prohibits a carrier from limiting coverage for the health care services described in subsection 1 that meet the carrier's 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 provider or facility that is part of the network plan.*~~

~~*3. A carrier is not responsible for examining the credentials of a provider of health care who:*~~

~~*(a) Is part of the Indian Health Service; and*~~

~~*(b) Does not have a contract with the carrier to provide health care services as part of the network plan offered by the carrier through the Exchange.*~~

~~**Sec. 22. 1. To determine whether a network plan** **is adequate**~~**., ~~*the Commissioner may consider, without limitation:*~~**

~~*(a)*~~ ***Sec. 22.*** ~~*The relative availability of providers of health care in the geographic service area covered by the network plan, including, without limitation:*~~

~~*(1) The operating hours, or their equivalent, during which the providers of health care are available; and*~~

~~*(2) Any established patterns of care;*~~

~~*(b) The ability of the carrier to enter into a contract with a provider of health care which allows for reasonable travel for covered persons;*~~

~~*(c) The system for the delivery of care to be furnished by the providers of health care under contract with the carrier in the network plan;*~~

~~*(d) The availability of services that may be provided through telehealth;*~~

~~*(e) The availability of providers of health care located outside of the geographic service area of the network plan but which would allow for reasonable travel for covered persons; and*~~

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

~~*2. As used in this section, "telehealth" has the meaning ascribed to it in section 3 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 621.*~~

~~**Sec. 23.** *A carrier shall, on an ongoing basis, monitor the ability and clinical capacity of the providers of health care included in its network plan to provide health care services to covered persons.*~~

~~**Sec. 24.**~~ *1. A carrier shall update its directory of providers of health care at least once each month. Each update to the directory shall indicate each provider of health care which has left the network plan or is no longer accepting new patients. A carrier is deemed to have complied with this subsection if it fails to update its directory as a result of the failure of a provider of health care to provide information to the carrier which the provider of health care is contractually obligated to provide.*

2. If a material change to its network plan occurs, a carrier shall update~~*:*~~

~~*Update*~~ *its directory of providers of health care within 3 business days after the effective date of the material change and provide*~~*including*~~ *a description*~~*clear indication*~~ *of the providers of health care which:*~~

~~*Have left the network plan since the directory was last updated; and*~~

~~*Are no longer accepting new patients.*~~

~~*Notify all covered persons who are affected by the*~~ *material change*~~*. that the material change has occurred. Such a notice must indicate how a covered person may receive more information regarding the material change to the network plan. A notice may be sent via electronic mail if the carrier has received affirmative permission from a covered person to communicate in that manner.*~~

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

(a) Posted to a publicly available~~the Internet~~ website maintained by the carrier within 3 business days after the update which ~~is made to a page on the website that is accessible without a username and password or which otherwise~~ allows a person who is not enrolled in any plan offered by the carrier to view the directory; and

(b) Made available in a printed format upon request.

Sec. 23~~25~~. *A carrier shall, within 3 business days after the effective date of a material change in its network plan, notify the Commissioner of the material change. Within 10 business days after~~Such notice must indicate~~ the effective date of the material change in its network plan, the carrier must provide to the Commissioner a description of~~and describe~~ the cause of the material change, ~~and~~ the impact of the material change on the network plan, and a summary of the steps being taken to cure the~~.~~*

~~*Sec. 26. 1. If a material change in a carrier's network plan results in a*~~ *deficiency.*

Sec. 24. 1. The~~ in the network plan, the~~ carrier shall, within 45~~60~~ days after the effective date of the material change, submit its~~a~~ corrective action plan to the Commissioner for approval to resolve the deficiency.

2. Except as otherwise provided in subsection 3, during the period of the deficiency~~in which the corrective action plan is being implemented~~, the carrier shall, at no greater cost to the covered person:

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

(1) Within the network plan; or

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

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

3. The provisions of subsection 2 do not apply to services received from a nonparticipating provider of health care without the prior authorization of the carrier unless the services received are medically necessary emergency services.

Sec. *25~~27~~.If ~~a network plan is deemed deficient by~~ the Commissioner does not approve~~at~~ the ~~end of the time period for a~~ corrective action plan and the network plan is still deficient, the Commissioner may:*

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

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

Sec. *26~~28~~. 1. Unless otherwise determined by the Commissioner, the~~The~~ provisions of sections ~~20,~~ 21 through 25~~, 22, 26 and 27~~ of this regulation do not apply to a network plan issued by a carrier ~~which:~~*

~~Is~~ licensed pursuant to chapter 680A of NRS, which:~~;~~

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

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

2. ~~A network plan described in subsection 1 is deemed to satisfy the requirements of NRS~~

~~687B.490.~~

~~Sec. 29.~~ ***The provisions of this Section do not apply to qualified health plans.***

Sec. 27. The provisions of sections 2 to 26~~29~~, inclusive, of this regulation do not apply to:

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

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

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

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

Sec. *28~~30~~.* NAC 695C.160 and 695C.200 are hereby repealed.

TEXT OF REPEALED SECTIONS

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

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

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

(b) In any other county, must be defined by the organization under a plan for the provision

of health care services if the organization receives the written approval of the Division for such a geographic area by:

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

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

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

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

1. Each applicant for a certificate of authority shall:

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

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

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

2. The organization shall notify:

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

than 30 days after the date on which the notification is due.

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

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

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

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

(a) Notifies the Division in writing;

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

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