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December 30, 2019

Ms. Betsy Gould  
Supervising Legal Secretary  
Nevada Division of Insurance  
1818 East College Parkway, Suite 103  
Carson City, Nevada 89706



Re: LCB File No. R067-19

Dear Ms. Gould,

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

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

Sincerely,

A handwritten signature in black ink that reads "Taylor P. Gardner".

Taylor P. Gardner  
Deputy Legislative Counsel

Bryan J. Fernley  
Senior Principal Deputy Legislative Counsel

Brenda J. Erdoes  
Legislative Counsel

TPG/slj  
Enclosure

SECRETARY OF STATE  
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**Form For Filing  
Administrative Regulations**

Agency

Dept. of Business and Industry

Division of Insurance

R067-19

FOR EMERGENCY  
REGULATIONS ONLY

Effective date \_\_\_\_\_

Expiration date \_\_\_\_\_

\_\_\_\_\_  
Governor's signature

Classification:     PROPOSED         ADOPTED BY AGENCY         EMERGENCY

Brief description of action    Regulation concerning Network Adequacy Plan Year 2020

Authority citation other than 233B    NRS 679B.130 and NRS 687B.490.

Notice date    10/11/2019

Date of Adoption by Agency    11/18/2019

Hearing date    11/14/2019

**APPROVED REGULATION OF THE  
COMMISSIONER OF INSURANCE**

**LCB File No. R067-19**

Filed December 30, 2019

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

AUTHORITY: §§1 and 2, NRS 679B.130 and 687B.490.

A REGULATION relating to insurance; revising provisions relating to the determination by the Commissioner of Insurance that a network plan is adequate for sale in this State; and providing other matters properly relating thereto.

**Legislative Counsel's Digest:**

Existing law authorizes the Commissioner of Insurance to regulate insurance in this State. (NRS 679B.130) Existing law requires a health carrier that offers coverage in the small employer group or individual market to demonstrate to the Commissioner the capacity to deliver services adequately before making any network plan available for sale in this State. (NRS 687B.490) **Section 1** of this regulation revises the minimum requirements that a network plan is required to satisfy for the Commissioner to determine the network plan is adequate for sale in this State by: (1) eliminating the requirement that to be determined adequate, a network plan is required to contain the most recent standards prescribed by the Centers for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services; (2) requiring a network plan to offer contracts in good faith to all available essential community providers in all counties in the service area of the network plan that are designated as counties with extreme access considerations; and (3) revising certain categories of essential community providers.

Existing regulations establish the Network Adequacy Advisory Council and require the Council to make recommendations of additional or alternative standards for the Commissioner to consider when determining the adequacy of a network plan. (NAC 687B.770, 687B.772) **Section 2** of this regulation eliminates the requirement that the Council's recommendations to the Commissioner include recommendations for standards to determine the adequacy of a network plan with regard to the number of providers of health care that practice in a specialty or are facilities that appear on the Essential Community Providers/Network Adequacy Template issued by CMS.

**Section 1.** NAC 687B.768 is hereby amended to read as follows:

687B.768 1. In order for the Commissioner to determine that a network plan made available for sale in this State is adequate, the network plan must contain, at a minimum:

(a) ~~The standards contained in the most recent Letter to Issuers in the Federally facilitated Marketplaces issued by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services. A copy of the letter may be obtained free of charge at the Internet address <https://www.cms.gov/CCHO/resources/regulations-and-guidance/>.~~

~~(b)~~ Evidence that the network plan provides reasonable access to at least one provider in the specialty area listed in the following table for at least 90 percent of enrollees by complying with the area designations for the maximum time or distance standards in the following table:

Specialty Area	Maximum Time or Distance Standards (Minutes/Miles)			
	Metro	Micro	Rural	Counties with Extreme Access Considerations (CEAC)
Primary Care	15/10	30/20	40/30	70/60
Endocrinology	60/40	100/75	110/90	145/130
Infectious Diseases	60/40	100/75	110/90	145/130
Oncology -	45/30	60/45	75/60	110/100

Medical/Surgery				
Oncology - Radiation/Radiology	60/40	100/75	110/90	145/130
<del>Mental Health (Including Substance Use Disorder Treatment)</del>	<del>45/30</del>	<del>60/45</del>	<del>75/60</del>	<del>110/100</del>
<i>Psychiatrist</i>	<i>45/30</i>	<i>60/45</i>	<i>75/60</i>	<i>110/100</i>
<i>Psychologist</i>	<i>45/30</i>	<i>60/45</i>	<i>75/60</i>	<i>110/100</i>
<i>Licensed Clinical Social Workers (LCSW)</i>	<i>45/30</i>	<i>60/45</i>	<i>75/60</i>	<i>110/100</i>
Pediatrics	25/15	30/20	40/30	105/90
Rheumatology	60/40	100/75	110/90	145/130
Hospitals	45/30	80/60	75/60	110/100
Outpatient Dialysis	45/30	80/60	90/75	125/110

~~(e)~~ (b) Evidence that the network plan:

(1) Contracts with at least 30 percent of the essential community providers in the service area of the network plan that are available to participate in the provider network of the network

plan ; ~~[, as calculated using the methodology contained in the most recent Letter to Issuers in the Federally facilitated Marketplaces.]~~

(2) *Offers contracts in good faith to all available essential community providers in all counties in the service area of the network plan that are designated pursuant to subsection 3 as Counties with Extreme Access Considerations;*

(3) Offers contracts in good faith to all available Indian health care providers in the service area of the network plan, including, without limitation, the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations, as defined in 25 U.S.C. § 1603, which apply the special terms and conditions necessitated by federal statutes and regulations as referenced in the *Model Qualified Health Plan Addendum for Indian Health Care Providers*. A copy of the *Model Qualified Health Plan Addendum for Indian Health Care Providers* may be obtained free of charge at the Internet address

<https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy> ~~[ ]~~; and

~~[(3)]~~ (4) Offers contracts in good faith to at least one essential community provider in each category of essential community provider ~~[, as contained in the most recent Letter to Issuers in the Federally facilitated Marketplaces.]~~ *in the following table*, in each county in the service area of the network plan, where an essential community provider in that category is available and provides medical or dental services that are covered by the network plan ~~[ ]~~:

<i>Major ECP Category</i>	<i>ECP Provider Types</i>
<i>Family Planning Providers</i>	<i>Title X Family Planning Clinics and Title X</i>

	<i>“Look-Alike” Family Planning Clinics</i>
<i>Federally Qualified Health Centers (FQHCs)</i>	<i>Federally Qualified Health Centers and Federally Qualified Health Center “Look-Alike” Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations</i>
<i>Hospitals</i>	<i>Disproportionate Share Hospitals (DSH) and DSH-eligible Hospitals, Children’s Hospitals, Rural Referral Centers, Sole Community Hospital, Freestanding Cancer Centers, Critical Access Hospitals</i>
<i>Indian Health Care Providers</i>	<i>Indian Health Service providers, Indian Tribes, Tribal organizations, and urban Indian Organizations</i>
<i>Ryan White Providers</i>	<i>Ryan White HIV/AIDS Program Providers</i>
<i>Other ECP Providers</i>	<i>STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically</i>

	<i>underserved individuals</i>
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2. ~~[[If the area designations for the maximum time or distance standards required pursuant to paragraph (b) of subsection 1 are changed by the most recent Letter to Issuers in the Federally facilitated Marketplaces, the Commissioner will post on the Internet website maintained by the Division notice of such changes.~~

~~—3.]~~ To offer a contract in good faith pursuant to paragraph ~~[(e)]~~ (b) of subsection 1, a network plan must offer contract terms comparable to the terms that a carrier or other person or entity which issues a network plan would offer to a similarly situated provider which is not an essential community provider, except for terms that would not be applicable to an essential community provider, including, without limitation, because of the type of services that an essential community provider provides. A network plan must be able to provide verification of such offers if the ~~[Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services]~~ *Commissioner* requests to verify compliance with this policy.

~~[4.—Upon the issuance of a new Letter to Issuers in the Federally facilitated Marketplaces, the Commissioner will determine whether the requirements of NAC 687B.750 to 687B.784, inclusive, including, without limitation, the standards required pursuant to subsection 1, conform with any similar standards prescribed in the new Letter to Issuers in the Federally facilitated Marketplaces. If the Commissioner determines that the requirements of NAC 687B.750 to 687B.784, inclusive, do not conform with any similar standards prescribed in the new Letter to Issuers in the Federally facilitated Marketplaces, the Commissioner will hold a public hearing~~

~~concerning possible amendments to NAC 687B.750 to 687B.784, inclusive, and give notice of that hearing in accordance with NRS 233B.060.~~

~~5.] 3. For the purposes of this section, the area designations for the maximum time or distance standards are based upon the population size and density parameters of individual counties within the plan's service area. The population and density parameters applied to determine county type designations are listed in the following table:~~

<i>County Type</i>	<i>Population</i>	<i>Density</i>
<i>Metro</i>	$\geq 1,000,000$	$10 - 999.9/mi^2$
	$500,000 - 999,999$	$10 - 1,499.9/mi^2$
	$200,000 - 499,999$	$10 - 4,999.9/mi^2$
	$50,000 - 199,999$	$100 - 4,999.9/mi^2$
	$10,000 - 49,999$	$1,000 - 4,999.9/mi^2$
<i>Micro</i>	$50,000 - 199,999$	$10 - 49.9/mi^2$
	$10,000 - 49,999$	$50 - 999.9/mi^2$
<i>Rural</i>	$10,000 - 49,999$	$10 - 49.9/mi^2$
	$< 10,000$	$10 - 4,999.9/mi^2$
<i>Counties with Extreme Access Considerations or CEAC</i>	<i>Any</i>	$< 10/mi^2$

4. As used in this section:

(a) “Essential community provider” ~~[has the meaning ascribed to it in the most recent Letter to Issuers in the Federally facilitated Marketplaces.]~~ or “ECP” means a provider of healthcare that serves predominantly low-income, medically underserved individuals. The term includes, without limitation:

(1) Health care providers described in section 340B(a)(4) of the Public Health Service Act, 42 U.S.C. § 256b(a)(4), as amended;

(2) Entities described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, 42 U.S.C. § 1396r-8(c)(1)(D)(i)(IV), as amended, including, without limitation, state-owned family planning service sites, governmental family planning service sites or not-for-profit family planning service sites that do not receive funding that qualifies the service for the drug pricing program established pursuant to section 340B of the Public Health Service Act, 42 U.S.C. § 256b, as amended, without limitation, funding pursuant to Title X of the Public Health Service Act, 42 U.S.C. § 300 et seq., as amended; or

(3) Indian health care providers,

↪ unless any of the providers or entities listed in subparagraphs (1), (2) and (3) has lost its status as a provider described in section 340B(a)(4) of the Public Health Service Act, 42 U.S.C. § 256b(a)(4), as amended, or as an entity described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, 42 U.S.C. § 1396r-8(c)(1)(D)(i)(IV), as amended, as a result of violating Federal law.

(b) “Maximum time or distance standards” ~~[has the meaning ascribed to “maximum time and distance standards” in the most recent Letter to Issuers in the Federally facilitated Marketplaces.]~~

*means the maximum time or distance an individual should have to travel to see a provider of health care based on the area designation determined pursuant to subsection 3.*

**Sec. 2.** NAC 687B.772 is hereby amended to read as follows:

687B.772 1. The Council shall consider the standards required pursuant to NAC 687B.768 and any other requirements of NAC 687B.750 to 687B.784, inclusive, and may recommend additional or alternative standards for determining whether a network plan is adequate.

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

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

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

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

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

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

(d) May, if a sufficient number of essential community providers, as defined in 45 C.F.R. § 156.235(c), are available and willing to enter into an agreement with a carrier to participate in

network plans, propose requiring a network plan to include a greater number of such providers than the number of providers of health care of that type that a network plan is required to include pursuant to the standards required pursuant to NAC 687B.768 and any other requirements of NAC 687B.750 to 687B.784, inclusive.

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

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

LCB FILE NO. R067-19

The following statement is submitted by the State of Nevada, Department of Business and Industry, Division of Insurance (“Division”) for adopted amendments to Nevada Administrative Code (“NAC”) Chapter(s)687B.

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

*The regulation is necessary to comply with the requirement that the Commissioner issue the network adequacy standards required of all network plans. See NRS 687B.490 and NAC 687B.768. The purpose of the regulation is to make permanent the network adequacy standards for network plans for plan year 2020 which were adopted under temporary regulation T005-18.*

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

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

*Public comment was solicited by e-mailing the proposed regulation, notice(s) of workshop, notice(s) of intent to act upon the regulation, and small business impact statement to persons on the Division’s mailing list requesting notification of proposed regulations. The documents were also made available on the website of the Division, <http://doi.nv.gov/>, mailed to the main library for each county in Nevada, and posted at the following locations:*

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

*Nevada Division of Insurance  
3300 West Sahara Avenue, Suite 275  
Las Vegas, Nevada 89102*

*Legislative Building  
401 South Carson Street  
Carson City, Nevada 89701*

*Nevada State Business Center  
3300 West Sahara Avenue  
Las Vegas, Nevada 89102*

*Blasdel Building  
209 East Musser Street  
Carson City, Nevada 89701*

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

Capitol Building  
101 North Carson Street  
Carson City, Nevada 89701

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

Public comment was also solicited at the workshop held on October 29, 2019, and at the hearing held on November 14, 2019. The public workshop and hearing took place at the offices of the Division, 1818 East College Parkway, Carson City, Nevada 89706, with simultaneous videoconferencing to the Nevada State Business Center, 3300 West Sahara Avenue, Las Vegas, Nevada 89102.

(b) A summary of the public response: *The Division did not receive any public response in favor of or against the regulation.*

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

*The Division did not receive any public response in favor or against the regulation. Any inquiries pertaining to this regulation can be directed to Jeremy Gladstone, Assistant Chief Insurance Examiner of the Life and Health section at (775) 687-0729 or [jgladstone@doi.nv.gov](mailto:jgladstone@doi.nv.gov).*

3. The number of persons who:

- (a) Attended the **hearing**: 2
- (b) Testified at the **hearing**: 0
- (c) Submitted to the agency written statements: 0

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

Testified at the hearing:

*There was no testimony given at the hearing for the regulation.*

Submitted to the agency written statements:

*There were no written statements submitted to the agency.*

5. A description of how comments were solicited from affected businesses, a summary of their responses, and an explanation of how other interested persons may obtain a copy of the summary.

- (a) A description of how comments were solicited from affected businesses:

*Comments were solicited from affected businesses in the same manner as they were solicited from the public. Please see the description, summary and explanation provided above in response to question #2. The Division also solicited comments from the Chambers of Commerce throughout the state of Nevada and requested that the solicitation be forwarded to members of the Chambers.*

- (b) A summary of the responses from affected businesses:

*The Division did not receive direct comments from any affected businesses.*

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

*Refer to #2(c): The summary in part 5(b) above reflects the public comments and testimony that transpired with regard to regulation R067-19. The Division did not receive any business response in favor or against the regulation. Any inquiries pertaining to this regulation can be directed to Jeremey Gladstone, Assistant Chief Insurance Examiner of the Life and Health section at (775) 687-0729 or [jgladstone@doi.nv.gov](mailto:jgladstone@doi.nv.gov).*

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

*The Division did not receive any direct comment from the public or affected businesses.*

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

- (1) Both adverse and beneficial effects:

*Benefits: Health insurance carriers will be able to better measure members needs and use of health care providers to design network plans.*

*Adverse: The health carriers will be required to demonstrate the adequacy of their network plans based on the network adequacy standards in the regulation. Carriers will likely have to adjust their network plans to meet policyholder needs. Carriers may have to add additional healthcare providers to their current network plan designs.*

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

*better predict long-term effects of certain network adequacy requirements.*

(2) Both immediate and long-term effects:

*The immediate and long-term effects of the regulation overlap and a summary of the overall effects is provided. Health insurance carriers will be able to better measure members needs and use of health care providers to design network plans.*

*The health carriers will be required to demonstrate the adequacy of their network plans based on the network adequacy standards in the regulation. Carriers will likely have to adjust their network plans to meet policyholder needs. Carriers may have to add additional healthcare providers to their current network plan designs.*

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

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

(1) Both adverse and beneficial effects:

*Benefits: Once implemented, policyholders should be able to more reasonably access appropriate care with in-network providers. As the network adequacy requirements are updated each year, they should provide a more broad base of "in network" healthcare providers and access thereto. By providing a more broad base of "in network" healthcare providers and access thereto, policyholders should experience lower out-of-pocket costs.*

*Adverse: As health insurance carriers obtain experience data, there may be a learning curve that may impact members' abilities to access care as quickly as hoped. Additionally, although network adequacy requirements will be issued each year, this does not guarantee that every healthcare provider sought by a policyholder will always be an "in network" provider. As a result, the policyholder may still be responsible for paying some additional amounts out-of-pocket for an "out of network" provider.*

(2) Both immediate and long-term effects:

*The immediate and long-term effects of the regulation overlap and a summary of the overall effects is provided. Once implemented, policyholders should be able to more reasonably access appropriate care with in-network providers. As the network adequacy requirements are updated each year, they should provide a more broad base of "in network" healthcare providers and access thereto. By*

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

*As health insurance carriers obtain experience data, there may be a learning curve that may impact members' abilities to access care as quickly as hoped. Additionally, although network adequacy requirements will be issued each year, this does not guarantee that every healthcare provider sought by a policyholder will always be an "in network" provider. As a result, the policyholder may still be responsible for paying some additional amounts out-of-pocket for an "out of network" provider.*

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

*The Division anticipates no additional costs. NRS 67B.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. A description of any regulations of other state or government agencies which the proposed regulation overlaps or duplicates, and a statement explaining why the duplication or overlapping is necessary. If the regulation overlaps or duplicates a federal regulation, the name of the regulating federal agency.

*There are no other regulations that overlap or duplicate the regulation.*

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

*There are no federal regulations that address the requirements in the regulation for all network plans in the individual and small group markets.*

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

*The regulation does not create a new fee or increase an existing fee.*