PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R049-14

DRAFT PROPOSED AMENDMENT

November 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]~~ ***1.5*** to ~~[13]~~ ***15***, inclusive, of this regulation.

Sec. 1.5 ***As used in this chapter, "geographic service area" has the meaning ascribed to it:***

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

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

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 distribution of***

providers in ~~[each category of health care necessary to serve its members in]~~ 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.

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

~~(a) Cardiology;~~

~~(b) Dermatology;~~

~~(c) Emergency medicine;~~

~~(d) Gastroenterology;~~

~~(e) Hematology and oncology;~~

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

~~(g) Mental health;~~

~~(h) Nephrology;~~

~~(i) Obstetrics and gynecology;~~

~~(j) Ophthalmology;~~

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

~~(l) Otolaryngology;~~

~~(m) Pediatrics, not including pediatric dentistry;~~

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

~~(o) Pulmonology;~~

~~(p) Substance abuse;~~

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

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

~~*(s) Urology.*~~

~~*3. 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.]*~~ *Each year the carrier shall submit, in conjunction with the annual rate and form filing, a declaration that the network plan meets the requirements of subsection 1 of this section.*

3. 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.

Sec. 3. *1. A carrier who applies to the Commissioner for the issuance of a network plan must establish that it has contracts with:*

(a) A sufficient number of providers; and

(b) ~~*[the providers]*~~ *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.*

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 reasonable maximum average travel distance or time, by county, for* ~~*[each category of health care necessary to serve members within network plans]*~~ *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.

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 reasonable maximum average 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.]~~ 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 Member Boards offer certification; and

(b) The list of specialties and categories of health care that appear as options on the Network Adequacy Template issued and periodically updated by the federal Center for Consumer Information and Insurance Oversight.

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

6. A carrier shall ensure that nonemergency services are available and accessible during normal business hours and that emergency services are available at any time.

7. As used in this section "unreasonable travel" means an average travel distance or time that exceeds the standard promulgated by the Commissioner pursuant to this section.

Sec. 3.5. *A carrier applying for the issuance of a network plan shall submit sufficient data, as determined by the Commissioner, to the Commissioner to establish that the proposed network plan has the capacity to adequately serve the anticipated number of 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 and Insurance Oversight.

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]~~ issued a certificate of authority pursuant to chapter 695C of NRS 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. 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.~~*

~~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, or their equivalent, 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 maximum average travel distance or time promulgated pursuant to section 3 of this regulation to contract with the carrier ~~[under reasonable terms and conditions]~~ in good faith. For the purposes of this regulation, a contract offered by the carrier to a provider with terms and conditions that a willing, similarly-situated provider would accept or has accepted is considered a contract offered in good faith;

(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 travel standards promulgated by the Commissioner pursuant to section 3 of this regulation.

~~[3.]~~ 2. The Commissioner will not determine that a network plan is adequate pursuant to subsection ~~[2]~~ 1 if the network plan fails to meet the requirements of section ~~[4 or]~~ 5 of this regulation.

~~[4.]~~ 3. 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]~~ 1. 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 the 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:

(a) Update its provider directory within 72 hours of the effective date of the significant change in network. Any updates to a provider directory resulting from a significant change to a network shall clearly indicate those providers:

(1) That have joined the network since the directory was last updated;

(2) That have left the network since the directory was last updated; and

(3) That are not accepting new patients.

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

3. 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]~~. The posting shall be made to a page that is accessible without a username and password or otherwise permits consumers who are not enrolled in any plan offered by the carrier to view the provider directory; 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.*~~ **(Deleted by amendment)**

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.*~~

~~*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 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).]*~~

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 by more than 10 percent; or

(b) Causes the average travel time or distance associated with a benefit described in subsection 4 of section 3 of this regulation to exceed the reasonable standards under section 3 of this regulation.

Sec. 12.5 *1. If a change in a carrier's network results in a deficiency in the network, the carrier shall notify the Commissioner within 72 hours after the effective date of the change to the network which causes it to be deficient. The notification must include a corrective action plan to resolve the deficiency within 60 days of the effective date of the deficiency in the network.*

2. A carrier with a deficient network shall, during the period the corrective action plan is being implemented and with respect to any covered service to which an applicable category of provider or facility is deficient:

(a) Ensure through referral by the primary care provider or otherwise that a covered person affected by the deficiency may obtain the covered service from a provider or facility within the network at no greater cost to the covered person;

(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:

(1) Negotiate with the non-participating provider and agree upon a total cost of services for the covered person that ensures the covered person will not be subject to a balance bill;

(2) Take appropriate measures 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; and

(3) Treat these services received from a non-participating provider as if the service was provided by a provider or facility within the network. Such treatment shall apply to the

calculation and application of the covered person's deductible, copayment, coinsurance and out of pocket maximum, as applicable; or

(c) Make other arrangements acceptable to the Commissioner.

3. 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.

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 subject to decertification 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).

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 service area.~~*

~~2. A health benefit plan made available outside of the approved 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 service area that the network plan may not provide contracted physicians or facilities within the enrollee's service area; and~~

~~*(b) Is subject to all relevant state and federal laws regarding guaranteed availability of coverage.]*~~ **(Deleted by amendment.)**

Sec. 14. ***1. The provisions of sections 1.5 through 9, inclusive, 12 and 12.5 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 determined to meet the provisions of NRS 687B.490.

3. A network plan determined to meet the provisions of NRS 687B.490 pursuant to subsection 2 that exceeds 1,250 covered lives in any calendar year to which the determination applies shall submit a statement of network capacity to the Commissioner pursuant to 42 U.S.C. § 300gg-1(c).

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

1. A plan issued by a health maintenance organization that enters into a contract with the Department of Health and Human Services to provide services in a Medicaid managed care program pursuant to NRS 422.273;

2. A network plan issued for a health benefit plan regulated under chapter 689B of NRS; or

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

Sec. 16. ***The provisions of this regulation apply to network plans used in conjunction with health benefit plans issued or renewed on or after January 1, 2016.***