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Testimony of Adam Plain, Insurance Regulation Liaison
on behalf of the Nevada Division of Insurance

RE: LCB File No. R049-14
A proposed regulation relating to network plans

Thank Madame Hearing Officer. My Name is Adam Plain and I am the Insurance Regulation Liaison for the Nevada Division of Insurance of the Department of Business and Industry. I have the pleasure of presenting LCB File No. R049-14, a proposed regulation relating to network plans, to you today.

Background

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 a Health Maintenance Organization ("HMO") or Preferred Provider Organization ("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. Prior to January 1, 2014 the Nevada State Board of Health was required to determine the adequacy of provider networks for HMOs in the state.[1]

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

[1] 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.

Insurance conducting rate and form review), the Board of Health and SSHIX agreed to 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.

Provisions

The proposed regulation consists of twelve substantive sections:

Section 2 establishes that network plans must have adequate numbers of providers in certain categories of health care, excepting that health benefit plans not providing coverage for a pediatric dental benefit do not need to have a sufficient number of pediatric dentistry providers.

Section 3 requires carriers to show that providers are situated within an allowable proximity to enrollees. The Commissioner will publish a list of allowable proximities annually, which will apply to network plans issued or renewed on the next subsequent January 1.

Section 4 details requirements for network plans to contract with certain federally-recognized essential community providers.

Section 5 establishes the requirements for carriers to pay for certain services provided by members of the Indian Health Service.

Section 6 sets forth additional requirements for HMOs utilizing network plans, as the HMO model typically has greater control over managing the care of enrollees.

Section 7 establishes a data collection requirement for carriers in conjunction with NRS 687B.490(2)(c).

Section 8 establishes a safe harbor provision under which network plans meeting all of the requirements of the regulation are deemed to be adequate. It also outlines a process whereby network plans not deemed to be adequate may petition to have a determination of adequacy made after proper explanation of the reasons the network plan has failed to meet the regulatory requirements.

Section 9 requires carriers to continually monitor the capacity of their network plans to ensure that enrollees can receive care in a timely fashion.

Section 10 details the requirement for carriers to maintain an up-to-date provider directory for the benefit of consumers.

Section 11 establishes an attestation requirement for continued compliance with the regulation.

Section 12 details the procedures necessary when a network plan becomes inadequate during the course of a calendar year.

Section 13 permits a health benefit plan utilizing a network plan to be sold outside of the approved service area with proper disclosure to consumers that enrollment in the plan may require additional travel.

Small Business Impact

The Division has prepared a comprehensive small business impact report and analysis, provided separately as part of the workshop documents. In summary, the Division anticipates that the proposed regulation will have an economic effect on small businesses, defined in NRS 233B.0382 as one with fewer than 150 full- or part-time employees and which is conducted for-profit. An attempt was made to contact entities which may qualify as small businesses and which would be directly regulated by the proposed regulation. Of the thirteen businesses identified, only two responses were received: one respondent indicated they were not a statutory small business and the other respondent indicated that they were a statutory small business that would be affected by the proposed regulation.

Absent additional response from statutory small businesses, the Division does not have adequate information to properly assess the economic impact of the proposed regulation.

Public Comments

The Division received one formal public comment to the proposed regulation as part of the workshop process. The Division also received one formal comment from an affected statutory small business.

Prior to providing notice of the public workshop, Division personnel held community outreach sessions in Reno (Renown Regional Medical Center), Carson City (Carson-Tahoe Regional Medical Center), Elko (Northeaster Nevada Regional Hospital), Pahrump (Desert View Hospital), Caliente (Grover C. Dils Medical Center), North Las Vegas (North Vista Hospital), and Las Vegas (Summerlin Hospital Medical Center, Dignity Health St. Rose Dominican – San Martin Campus, and Department of Employment, Training and Rehabilitation).

On February 7, 2014 the Division released an issue brief and solicitation of comments on network adequacy. The issue brief identified and requested comment from the public on three topics of concern related to network adequacy:

- Structural differences in networks between HMO and non-HMO health benefit plans;
- Access to care and network sufficiency in rural communities; and
- Limited networks, often referred to as "skinny" or "narrow" networks.

Amendment

Based on comments received through all venues discussed, the Division is contemplating an amendment to the proposed regulation. The amendment is not being offered to the hearing officer for consideration at this time but is being exposed for comment by the public. The provisions of the amendment consist of:

- Clarifying that references to "geographic area" instead refer to "geographic service area", a term which is statutorily defined and distinct from a "geographic rating area."
- Amending the proposed date for publication of a list of minimum providers or maximum travel distances from April 1 of each year to a date between January 1 and January 5 of each year.
- Adding a new section (3.5) reinforcing that the Division will be looking specifically at network capacity in the determination of network adequacy.
- Amending the requirements for inclusion of essential community providers to coincide with the current federal standards.
- Clarifying that carriers reimbursing for services provided by a member of the Indian Health Service are not required to credential that provider so long as no network service contract exists between the carrier and provider.
- Adding a new section (7.5) stipulating the dates by which network plans must be submitted for approval.

- Expanding the allowance under subsection 4 of section 8 to allow the Commissioner to determine a network plan to be adequate if the network plan can show good cause for not being in compliance with the minimum requirements relating to essential community providers.
- Removing the provision under section 8 wherein a network plan that is not determined to be adequate may still be offered.
- Defining the terms "reasonable" and "clinical safety."
- Removing the attestation requirements of section 11.
- Clarifying that the provisions of paragraph (a) of section 12, subsection 3 apply to the cost share of the consumer.
- Removing the requirement under paragraph (a) of section 12, subsection 4 that a QHP using an inadequate network be decertified. Such decertification may have harmed consumers by requiring them to be moved to another plan or product, which may adversely affect their coverage, deductibles and out of pocket limits. The new language, requiring a carrier to submit a statement of network capacity, forces the carrier to cease taking new enrollees in the respective market without forcing existing enrollees to move plans or products.
- Adding provisions in section 14 which clarify how the Division intends to charge carriers for the approval of network plans, pursuant to NRS 687B.490(6), when the carrier uses a "rental network."
- Adding provisions in section 15 which permit network plans issued by carriers with limited enrollment to be exempt from the standards for economic reasons.

That concludes my testimony; I would be happy to answer any questions of the hearing officer and look forward to a productive discussion with the interested parties concerning this proposed regulation.