

**SECOND REVISED PROPOSED REGULATION OF THE
COMMISSIONER OF INSURANCE**

LCB File No. R049-14

March 22, 2016

(March 11 Version revised based on comments received as of March 18, 2016)

EXPLANATION – Matter in *italics* is new; matter in *green italics* was added after the hearing; matter in brackets [~~omitted material~~] is material to be omitted.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 18, inclusive, of this regulation.

Sec. 2. *As used in sections 2 to 18, inclusive, of this regulation, unless the context otherwise requires, the words and terms defined in sections 3 to 8, inclusive, of this regulation have the meanings ascribed to them in those sections.*

Sec. 3. *“Carrier” means an insurer who makes a network plan available for sale in this State pursuant to NRS 687B.490.*

Sec. 4. *“Council” means the Network Adequacy Advisory Council established pursuant to section 10 of this regulation.*

Sec. 5. *“Covered person” means a policyholder, subscriber, enrollee or other person participating in a network plan.*

Sec. 6. *“Network plan” has the meaning ascribed to it in NRS 689B.570.*

Sec. 7. *“Provider of health care” has the meaning ascribed to it in NRS 695G.070.*

Sec. 8. *“Qualified health plan” has the meaning ascribed to it in NRS 695I.080.*

Sec. 9. 1. *For the purpose of determining the adequacy of a network plan made available for sale in this State, the Commissioner hereby adopts by reference the standards contained in the 2017 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 that letter may be obtained free of charge at the Internet address <https://www.cms.gov/CCIIO/resources/regulations-and-guidance/>.*

2. *When the ~~If a~~ new annual version of the material adopted by reference in subsection 1 is issued, the Commissioner will determine if the requirements issued pursuant to Section 11 Subsection 3 at least meet the standards established by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services in the new annual version ~~review the new version to determine its suitability for this State. If the Commissioner determines that the requirements issued pursuant to Section 11 Subsection 3 do not at least meet the standards in the new annual version~~ ~~revisions made in the new version are not suitable for this State~~, the Commissioner will hold a public hearing to ~~revise the requirements giving at least 30 days notice of the hearing~~ ~~review the determination and give notice of that hearing within 30 days after the date of the publication of the new version. If, after the hearing, the Commissioner does not revise the determination, the Commissioner will give notice that the revisions in the new version are not suitable for this State within 30 days after the hearing. If the Commissioner does not give such notice, the new version replaces the material adopted by reference in subsection 1.~~*

Sec. 10. 1. *The Network Adequacy Advisory Council is hereby established.*

2. *The Council consists of nine members appointed by the Commissioner. The members of the Council shall be chosen to ensure a fair representation of the ~~, each of whom must represent~~ interests of carriers, providers of health care ~~and~~ consumers of health care. The members of the Council serve at the pleasure of the Commissioner and without compensation.*

3. *If a vacancy occurs in the membership of the Council, the Commissioner will ~~appoint a qualified person to fill the vacancy~~ with a qualified person who represents a similar interest as the person who vacated the position.*

4. *The Council shall meet at least three times each year. The first meeting of the Council must take place by not later than June 15 of each year. Written notice of each meeting of the Council must be given at least 5 working days before the meeting.*

Sec. 11. 1. *The Council shall consider the standards adopted by reference in section 9 of this regulation and any other requirements of this chapter, and ~~may~~ recommend additional ~~or alternative~~ standards for determining whether a network plan is adequate, which are acceptable to the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.*

2. *The recommendations for standards 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:

(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 are available at the Internet address <https://www.cms.gov/CCIIO/programs-and-initiatives/health-insurance-marketplaces/ghp.html> free of charge; and

(2) 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 prescribed in paragraph (b); and

*(d) May propose requiring a network plan to include a greater number of essential community providers, as defined in 45 C.F.R. § 156.235(c), **where available and willing to enter into a letter of agreement with the carrier,** than the number of providers of health care of that type that a network plan is required to include pursuant to the standards adopted by reference in section 9 of this regulation and any other requirements of this chapter.*

*3. The Council must submit its recommendations ~~for standards~~ to the Commissioner by not later than September 15. On or before October 15 of each year, the Commissioner will determine whether to accept **any or all of the recommendations of the Council and the action necessary to issue the requirements for determining the adequacy of a network plan applicable***

to the plan year that begins the 1st day of the second following year~~carry out any accepted recommendations.~~

Sec. 12. 1. *Each carrier or other person or entity that applies to the Commissioner for the approval to issue a network plan shall, pursuant to NRS 687B.490, in conjunction with its annual rate filing, submit to the Commissioner sufficient data and documentation to establish that the proposed network plan meets the standards adopted by reference in section 9 of this regulation and any other requirements of this chapter.*

2. The data and documentation submitted to the Commissioner pursuant to subsection 1 must be in a format prescribed by the Commissioner.

Sec. 13. 1. *Each carrier shall update its directory of providers of health care at least once each month. Each update to the directory must include each provider of health care who, within the last month, ~~has left the network plan or~~ is no longer in the network plan or accepting new patients. A carrier shall be deemed to have complied with the provisions of this subsection if the carrier did not properly update its directory because a provider of health care failed to provide information to the carrier which the provider of health care is contractually obligated to provide to the carrier.*

2. If a change occurs to the network plan of a carrier that results in the network plan failing to meet the standards adopted by reference in section 9 of this regulation or any other requirements of this chapter, the carrier must update its directory of providers of health care by not later than ~~3~~5 business days after the effective date of the change and include in the directory a clear description of the change.

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

(a) *Posted to a publicly available Internet website maintained by the carrier by not later than 35 business days after the update is completed;*

(b) *Posted in a manner that allows a person who is not enrolled in any plan offered by the carrier to view the directory; and*

(c) *Made available in a printed format to any person upon request.*

4. *As used in this section, “directory of providers of health care” means a list of physicians, hospitals and other professionals and organizations that provide health care services, including, without limitation, through telehealth, as defined in section 3 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 621, as part of a network plan.*

Sec. 14. *A carrier shall:*

1. *Within 3 business days after the effective date of a change to a network plan that results in the network plan failing to meet the standards adopted by reference in section 9 of this regulation or any other requirements of this chapter, notify the Commissioner of the change; and*

2. *Within 10 business days after the effective date of a change to a network plan that results in the network plan failing to meet the standards adopted by reference in section 9 of this regulation or any other requirements of this chapter, provide to the Commissioner a description of the cause of the change, the impact of the change on the network plan and a*

summary of the measures that the carrier will take to bring the network plan into compliance with those standards.

Sec. 15. *1. A carrier shall, within 60~~45~~ days after the effective date of a change to a network plan that results in the network plan failing to meet the standards adopted by reference in section 9 of this regulation or any other requirements of this chapter, submit to the Commissioner for approval a corrective action plan to bring the network plan into compliance ~~with those standards.~~*

2. Except as otherwise provided in subsection 3, during the period in which the network plan does not meet the standards adopted by reference in section 9 of this regulation or any other requirements of this chapter, the carrier shall, at no greater cost to the covered person:

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

(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 is able to 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, as defined in subsection 3 of NRS 695G.170.

Sec. 16. *If a network plan does not meet the standards adopted by reference in section 9 of this regulation or any other requirements of this chapter and the Commissioner does not approve the corrective action plan submitted pursuant to section 15 of this regulation, the Commissioner may:*

1. For a qualified health plan, determine that the network plan is inadequate pursuant to subsection 5 of NRS 687B.490; or

2. For any network plan other than a qualified health plan, determine that the network plan is inadequate pursuant to subsection 5 of 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. 17. *The provisions of sections 12 to 16, inclusive, of this regulation do not apply to a network plan that:*

1. Is issued by a carrier that has been authorized to transact insurance in this State pursuant to chapter 680A of NRS;

2. Had a statewide enrollment of not more than 1,000 persons during the immediately preceding calendar year;

3. Has an anticipated statewide enrollment of not more than 1,250 persons during the next succeeding calendar year; and

4. Is not a qualified health plan.

Sec. 18. *The provisions of sections 2 to 18, inclusive, of this regulation do not apply to:*

1. A network 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 pursuant to 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. 19. NAC 695C.160 and 695C.200 are hereby repealed.