REVISED PROPOSED REGULATION OF

THE COMMISSIONER OF INSURANCE

LCB File No. R025-17

September 5, 2017

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

AUTHORITY: §§1-7, NRS 679B.130 and 687B.490, as amended by section 88 of Assembly Bill No. 83, chapter 376, Statutes of Nevada 2017, at page 2355.

A REGULATION relating to insurance; requiring a network plan to satisfy certain requirements before the Commissioner of Insurance can determine that such a network plan is adequate; 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 that offers coverage in the small employer group or individual market to demonstrate the capacity to deliver services adequately before making any network plan available for sale in this State; 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 statistics relating to its operations and services. (NRS 687B.490, as amended by section 88 of Assembly Bill No. 83, chapter 376, Statutes of Nevada 2017, at page 2355)

In 2016, the Commissioner adopted by reference certain standards prescribed by the Centers for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services for determining the adequacy of a network plan made available for sale in this State. (Section 9 of LCB File No. R049-14)

Section 1 of this regulation requires a network plan, in order for the Commissioner to determine that a network plan made available for sale in this State is adequate, to contain: (1) the most recent version of the standards prescribed by CMS; and (2) evidence that the network plan provides reasonable access to at least one provider who practices in the specialty area of pediatrics by complying with the area designations for the maximum time and distance standards.

Sections 2-7 of this regulation make conforming changes.

Section 1. Section 9 of LCB File No. R049-14 is hereby amended to read as follows:

Sec. 9 1. ~~[For the purpose of determining the adequacy of]~~ ***In order for the Commissioner to determine that*** a network plan made available for sale in this State ~~[, the Commissioner hereby adopts by reference the]~~ ***is adequate, the network plan must contain, at a minimum:***

(a) The standards contained in the ~~[2017]~~ ***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/CCIIO/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 and distance standards in the following table:

Specialty Area	***Maximum Time and Distance Standards (Minutes/Miles)***			
	Metro	***Micro***	***Rural***	***Counties with Extreme Access Considerations (CEAC)***
Pediatrics	***25/15***	***30/20***	***40/30***	***105/90***

2. ***If the area designations for the maximum time and 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. Upon the issuance of a new Letter to Issuers in the Federally-facilitated Marketplaces, the Commissioner will determine whether the requirements of sections 2 to 18, inclusive, of this regulation, including, without limitation, the standards ~~[adopted by reference in]~~ ***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 sections 2 to 18, inclusive, of this regulation 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 sections 2 to 18, inclusive, of this regulation and give notice of that hearing in accordance with NRS 233B.060 ***.*** ~~[at least 30 days before the date of the hearing.]~~

4. As used in this section, "maximum time and distance standards" has the meaning ascribed to it in the most recent Letter to Issuers in the Federally-facilitated Marketplaces.

Sec. 2. Section 11 of LCB File No. R049-14 is hereby amended to read as follows:

Sec. 11. 1. The Council shall consider the standards ~~[adopted by reference in]~~ ***required pursuant to*** section 9 of this regulation and any other requirements of sections 2 to 18, inclusive, of this regulation 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:

(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 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 ~~[adopted by reference in]~~ ***required pursuant to*** section 9 of this regulation and any other requirements of sections 2 to 18, inclusive, of this regulation.

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.

Sec. 3. Section 12 of LCB File No. R049-14 is hereby amended to read as follows:

Sec. 12. 1. Each carrier or other person or entity that applies to the Commissioner for approval to issue a network plan pursuant to NRS 687B.490, as amended by section 28 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 636, ***and by section 88 of Assembly Bill No. 83, chapter 376, Statutes of Nevada 2017, at page 2355,*** shall submit to the Commissioner with its annual rate filing sufficient data and documentation to establish that the proposed network plan meets the standards ~~[adopted by reference in]~~ ***required pursuant to*** section 9 of this regulation and any other requirements of sections 2 to 18, inclusive, of this regulation.

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

Sec. 4. Section 13 of LCB File No. R049-14 is hereby amended to read as follows:

Sec. 13. 1. Each carrier shall update its directory of providers of health care at least once each month. Except as otherwise provided in this subsection, each update to the directory must include each provider of health care who, as of the previous month, is no longer in the network plan or has stopped accepting new patients. A carrier shall not be deemed to have violated the provisions of this subsection if a provider of health care fails 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]~~ ***required pursuant to*** section 9 of

this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation, the carrier must update its directory of providers of health care not later than 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 to the directory must be:

(a) Posted to a publicly available Internet website maintained by the carrier not later than 5 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:

(a) "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 part of a network plan.

(b) "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. 5. Section 14 of LCB File No. R049-14 is hereby amended to read as follows:

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]~~ ***required pursuant to*** section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation, notify the Commissioner in writing 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]~~ ***required pursuant to*** section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation, provide to the Commissioner a written 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 and requirements.

Sec. 6. Section 15 of LCB File No. R049-14 is hereby amended to read as follows:

Sec. 15. 1. A carrier shall, within 60 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]~~ ***required pursuant to*** section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation, submit to the Commissioner for approval a written corrective action plan to bring the network plan into compliance with those standards and requirements.

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]~~ ***required pursuant to*** section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation, 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 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. 7. Section 16 of LCB File No. R049-14 is hereby amended to read as follows:

Sec. 16. If a network plan does not meet the standards ~~[adopted by reference in]~~ ***required pursuant to*** section 9 of this regulation or any other requirement of sections 2 to 18, inclusive, of this regulation 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 demonstrating that the carrier meets the conditions described in 42 U.S.C. § 300gg-1(c)(1)(B).