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Agency **Dept of Business and Industry**

Division of Insurance

FOR EMERGENCY
REGULATIONS ONLY

Effective date 9/14/12

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Governor's signature

Classification: ☐ **PROPOSED** ☐ **ADOPTED BY AGENCY** ☑ **EMERGENCY**

Brief description of action Emergency Regulation to amend NAC689B.120 and 695C.190. The amendments help to address an immediate threat to the future viability of certain preferred provider (in-network) rural hospitals designated by CMS as "critical access hospitals" ("Hospital"). The amendments do this by creating an opportunity for such a Hospital that is within 25 miles of another preferred provider (in-network) hospital that is a non-rural hospital, to be reimbursed at an amount not less than the non-rural preferred provider (in-network) hospital for the same covered services. If there is more than one other preferred provider (in-network) hospital within 25 miles of such a Hospital, the Hospital will be reimbursed at not less than the higher reimbursement schedule for the same covered services. While the emergency regulation provides the opportunity for comparable reimbursement, it also provides a consumer safeguard such that, because the Hospital must be in-network, it cannot balance bill for those services.

Authority citation other than 233B **NRS 679B.130 and 233B.0613**

Notice date N/A **Date of Adoption by Agency** September 13, 2012

Hearing date N/A

EMERGENCY REGULATION OF THE

COMMISSIONER OF INSURANCE

September ~~13~~ 14, 2012

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

AUTHORITY: NRS 679B.130 and 233B.0613.

Section 1. NAC 689B.120 is hereby amended to read as follows:

689B.120 A policy of group health insurance issued pursuant to NRS 689B.061:

1. Must include a definition for preferred providers of health care and providers of health care who are not preferred.

2. Must include an explanation of the amount of disincentives to be paid for using the services of providers of health care who are not preferred.

3. Must include in the schedule of benefits the amounts for deductibles and coinsurance payable for preferred providers of health care and providers of health care who are not preferred.

4. Must include a description of the type of plan used for preferred providers of health care and whether it is limited to specific services only, such as services obtained from a physician or hospital or for prescription drugs.

5. Must provide that the services covered, if provided by preferred providers of health care, are the same for providers of health care who are not preferred.

6. Must provide that, if the covered services are provided by a preferred provider facility designated by CMS as a "critical access hospital", the facility shall be

reimbursed at an amount not less than any network hospital within a 25 mile radius for those covered services provided.

~~[6]~~ *7*. Must include a statement that the insured should verify whether a provider of health care is a preferred provider of health care.

~~[7]~~ *8*. Must provide that, if the insured is confined in a facility which is a preferred provider of health care at a time when the facility terminates its agreement with the insurer, coverage will be provided for the period of confinement at the rate negotiated for that facility before it terminated its agreement and at no additional cost to the insured.

~~[8]~~ *9*. Must provide that, if the insured obtains prior authorization for health care services to be rendered by a preferred provider of health care and the provider subsequently terminates his agreement with the insurer, coverage will be provided for those services at the rate negotiated for that provider before he terminated his agreement and at no additional cost to the insured.

~~[9]~~ *10*. May not require that the payments to a provider of health care who is not preferred be based upon the fee schedule or arrangements for preferred providers of health care.

~~[10]~~ *11*. May not provide for more than a 50 percent difference or reduction in any payment of otherwise eligible expenses for not complying with any procedures requiring the prior authorization of care or notification that treatment was received for an emergency.

Sec. 2. NAC 695C.190 is hereby amended to read as follows:

695C.190 Each agreement between a provider and an organization must:

1. Adequately and completely describe the responsibilities of the provider and organization under the agreement.

2. Provide that, if the covered services are provided by a facility designated by CMS as a "critical access hospital", the facility shall be reimbursed at an amount not less than any network hospital within a 25 mile radius for those covered services provided.

~~[2]~~ *3*. Specify that the provider releases the enrollee from liability for the cost of services rendered pursuant to the organization's health care plan except for any nominal payment made by the enrollee or for a service not covered under the evidence of coverage.

~~[3]~~ *4*. Be effective for not less than 1 year, subject to any right of termination stated in the agreement.

~~[4]~~ *5*. Require the provider to participate in the program to assure the quality of health care provided to enrollees by the organization through its providers.

~~[5]~~ *6*. Require the provider to provide all medically necessary services required by the evidence of coverage and the agreement to each enrollee for the period for which a premium has been paid to the organization.

~~[6]~~ *7*. Require the provider to give evidence of a contract of insurance against loss resulting from injuries resulting to third persons from the practice of his or her profession

or a reasonable substitute for it as determined by the organization. The organization may require the provider to indemnify the organization for any liability resulting from the health care services rendered by the provider.

~~[7]~~ *8*. Require a provider who is a physician to transfer or otherwise arrange for the maintenance of the records of enrollees who are his or her patients if the provider leaves the panel of physicians associated with the organization.

The Commissioner of Insurance has made a finding that an emergency affecting the health and safety of the public exists, and that the adoption of the above Emergency Regulation is appropriate.

September 14, 2012.

SCOTT J. KIPPER
Commissioner of Insurance

I, Governor Brian Sandoval, endorse Commissioner of Insurance Scott J. Kipper's statement of emergency.

September 14, 2012.

BRIAN SANDOVAL
Governor

BRIAN SANDOVAL
Governor

STATE OF NEVADA

TERRY JOHNSON
Director

SCOTT J. KIPPER
Commissioner

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Statement of Emergency
Pursuant to NRS 233B.0613(1)

September 13, 2012

The Honorable Brian Sandoval
Governor of the State of Nevada
Executive Chambers
101 North Carson Street, Suite 1
Carson City, Nevada 89701

RE: Emergency Regulation of the Commissioner of Insurance[1]

Dear Governor Sandoval:

Nevada Revised Statute ("NRS") 679B.020 designates the Commissioner of Insurance ("Commissioner") as the chief officer of the State of Nevada, Department of Business and Industry, Division of Insurance ("Division"). In this capacity, and pursuant to NRS 678B.120, the Commissioner is responsible for the execution and enforcement of the provisions of NRS Title 57, Nevada's Insurance Code. Pursuant to NRS 679B.130, the Commissioner is permitted to adopt regulations for the administration of any provision of the Insurance Code. This rulemaking authority includes the ability to present to you for endorsement emergency

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[1] NRS 233B.0613(4) and (5)

. . .

4. A regulation adopted pursuant to this section may be effective for a period of not longer than 120 days. A regulation may be adopted by this emergency procedure only once.

5. If an agency adopts, after providing notice and the opportunity for a hearing as required in this chapter, a permanent or temporary regulation which becomes effective and is substantially identical to its effective emergency regulation, the emergency regulation expires automatically on the effective date of the temporary or permanent regulation.

regulations pursuant to NRS 233B.0613. We have determined the need for an emergency regulation amending Nevada Administrative Code ("NAC") 689B.120 and 695C.190.[2]

Certain rural hospitals in Nevada are designated by the Center for Medicare and Medicaid Services ("CMS") as "critical access hospitals". Although a number of these hospitals are in-network providers for major health insurers in Nevada, some ("Hospital") within 25 miles of a non-rural in-network hospital do not have comparable patient occupancy and are not receiving comparable reimbursement for the same services rendered. It has just been brought to the attention of the Commissioner that, in some such cases, this is immediately threatening the future viability of the Hospital. The emergency regulation is necessary in order to immediately provide the opportunity for such an in-network Hospital to receive reimbursement comparable to any in-network hospital within its 25-mile radius for the same covered services rendered. If there is more than one other in-network hospital within 25 miles of such a Hospital, the Hospital will be reimbursed at the higher reimbursement schedule. While the emergency regulation provides the opportunity for comparable reimbursement, it also provides a consumer safeguard such that, because the Hospital must be in-network, it cannot balance bill for those services.

There is no formal definition of "emergency" set forth in chapter 233B of NRS. However, guidance is provided in the Attorney General's Seventh Edition 2012 *Administrative Rulemaking, A Procedural Guide*. Citing NRS 241.020(8)(b) for guidance purposes only, the immediate action must be required to address any impairment of the health and safety of the public. As the proposed emergency regulation is necessary to provide an immediate opportunity for the continuation of health services, your endorsement is requested. Thank you for your consideration and assistance.

Respectfully,

SCOTT J. KIPPER
Commissioner of Insurance

c. Terry Johnson
Director of the Department of Business and Industry

Enclosures: Emergency Regulation
Informational Statement Pursuant to NRS 233B.066(1)(f-j) and (2)

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[2] NAC 689B.120 concerns policies of group health. NAC 695C.190 concerns agreements between providers and organizations.

NAC 695C.060 "Organization" defined. (NRS 679B.130) "Organization" means a health maintenance organization or a provider-sponsored organization.

STATE OF NEVADA
DIVISION OF INSURANCE

INFORMATIONAL STATEMENT
PURSUANT TO NRS 233B.066(1)(f-j) and (2)[1]
RE: EMERGENCY REGULATION

September 13, 2012

The following statement is submitted for the emergency regulation amending Nevada Administrative Code sections 689B.120 and 695C.190.

1. NAC 233B.066(1)(f): The estimated economic effect of the regulation on the business which it is to regulate and on the public. These must be stated separately, and in each case must include:

(1) Both adverse and beneficial effects:
(a) On Business:

Preferred provider critical access hospitals within or in close proximity to urban areas will receive reimbursement comparable to any other network facility within a 25 mile area. This will encourage these facilities to maintain or expand the business relationships established within these communities.

This may be burdensome for insurance companies to administer and could encourage carriers to remove these facilities from their provider networks.

(b) On the Public:

The higher levels of reimbursement will help ensure that these facilities continue meet the critical access needs of their communities.

(2) Both immediate and long-term effects:
(a) On Business:

Critical access preferred provider hospitals will immediately receive higher levels of reimbursement and will have greater opportunity to negotiate network contracts in the future.

(b) On the Public

The higher levels of reimbursement will help ensure that these facilities continue meet the critical access needs of their communities.

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[1] Pursuant to NAC 233B.066(2), the requirements of paragraphs (a) to (e), inclusive, of subsection 1 of NAC 233B.066 do not apply to emergency regulations.

2. NAC 233B.066(1)(g): The estimated cost to the agency for enforcement of the proposed regulation.

   There would be little or no cost to the Division for enforcement of this regulation.

3. NAC 233B.066(1)(h): 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:

   This emergency regulation does not overlap or duplicate any other regulation.

4. NAC 233B.066(1)(i): If the regulation includes provisions which are more stringent than a federal regulation which regulates the same activity, a summary of such provisions: *Not applicable.*

5. NAC 233B.066(1)(j): If the regulation provides 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: *Not applicable.*