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December 19, 2017

Sue Bell
Legal Secretary
State of Nevada Division of Insurance
1818 East College Parkway, Suite 103
Carson City, Nevada 89706-7986

Re: LCB File No. R025-17

Dear Ms. Bell:

Regulation, R025-17, adopted by the Commissioner of Insurance has been filed today with the Secretary of State pursuant to NRS 233B.067 or 233B.0675, as appropriate. As provided in NRS 233B.070, this regulation becomes effective upon filing, unless otherwise indicated.

Enclosed are two copies of the regulation bearing the stamp of the Secretary of State which indicates that it has been filed. One copy is for your records and the other is for delivery to the State Library and Archives Administrator pursuant to subsection 6 of NRS 233B.070.

Sincerely,

Allan L. Amburn
Deputy Legislative Counsel

R. Rene Yeckley
Senate Legal Counsel and Bill Drafting Advisor

Brenda J. Erdoes
Legislative Counsel

ALA/slj
Enclosure

SECRETARY OF STATE
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Agency

Dept. of Business and Industry

Division of Insurance

R025-17

FOR EMERGENCY
REGULATIONS ONLY

Effective date _____

Expiration date _____

_____
Governor's signature

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

Brief description of action Regulation concerning Network Adequacy Plan Year 2018

Authority citation other than 233B NRS 679B.130

Notice date 9/14/17 **Date of Adoption by Agency** 11/6/17

Hearing date 10/18/17

APPROVED REGULATION OF

THE COMMISSIONER OF INSURANCE

LCB File No. R025-17

Effective December 19, 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).

LEGISLATIVE REVIEW OF ADOPTED REGULATIONS
INFORMATIONAL STATEMENT AS REQUIRED BY NRS 233B.066

LCB FILE NO. R025-17

The following statement is submitted by the State of Nevada, Department of Business and Industry, Division of Insurance ("Division"), for adopted amendments to Nevada Administrative Code ("NAC") Chapter 687B.

1. A clear and concise explanation of the need for the adopted regulation.

The regulation is necessary to comply with the requirement that the Commissioner issue the network adequacy standards required of all network plans. See NRS 687B.490 and R049-14. The purpose of the regulation is to establish adequacy standards for network plans for plan year 2018.

2. A description of how public comment was solicited, a summary of public response, and an explanation of how other interested persons may obtain a copy of the summary.

(a) A description of how public comment was solicited:

Public comment was solicited by e-mailing the proposed regulation, notice of workshop, notice of intent to act upon the regulation, and small business impact statement to persons on the Division's mailing list requesting notification of proposed regulations. The documents were also made available on the website of the Division, http://doi.nv.gov/, mailed to the main library for each county in Nevada, and posted at the following locations:

Nevada Division of Insurance
1818 East College Parkway, Suite 103
Carson City, Nevada 89706

Nevada Division of Insurance
3300 West Sahara Avenue, Suite 275
Las Vegas, Nevada 89102

Legislative Building
401 South Carson Street
Carson City, Nevada 89701

Nevada State Business Center
3300 West Sahara Avenue
Las Vegas, Nevada 89102

Blasdel Building
209 East Musser Street
Carson City, Nevada 89701

Grant Sawyer Building
555 East Washington Avenue
Las Vegas, Nevada 89101

Capitol Building
101 North Carson Street
Carson City, Nevada 89701

Nevada Department of Employment,
Training and Rehabilitation
2800 E. Saint Louis Avenue
Las Vegas, Nevada 89104

Public comment was also solicited at the workshop held on October 3, 2017, and at the hearing held on October 18, 2017. The public meetings took place at the offices of the Division, 1818 East College Parkway, Carson City, Nevada 89706, with simultaneous videoconferencing to the Nevada State Business Center, 3300 West Sahara Avenue, Las Vegas, Nevada 89102.

(b) A summary of the public response:

The Division of Insurance received no comments related to this regulation.

(c) An explanation of how other interested persons may obtain a copy of the summary:

The summary in part 2(b) above reflects the comments and testimony that transpired with regard to regulation R025-17. A copy of said summary may be obtained by contacting Jeremey Gladstone, at (775) 687-0729 or jgladstone@doi.nv.gov. This summary will also be made available by e-mail request to insinfo@doi.nv.gov.

3. The number of persons who:

(a) Attended each hearing: Public: 1 Division of Insurance Staff: 4

(b) Testified at each hearing: 1

(c) Submitted to the agency written statements: 0

4. A list of names and contact information, including telephone number, business address, business telephone number, electronic mail address, and name of entity or organization represented, for each person identified above in #3 (b) and (c), as provided to the agency:

Name	**Entity/Organization Represented**	**Business Address**	**Telephone No./ Business Telephone No.**	**E-Mail Address**
Brandi Planet	Ferrari Public Affairs	8863 W. Flamingo Road, Suite 102 Las Vegas, NV 89147-8718	(702)340-9227	brandi@ferraripa.com
Rhonda Kelly	Division of Insurance (Las Vegas)	3300 W. Sahara Ave., Suite 275 Las Vegas, NV 89102	(702) 486-4060	rkelly@doi.nv.gov
Sue Bell	Division of Insurance (Carson City)	1818 E. College Pkwy, Suite 103 Carson City, NV 89431	(775) 687-0704	suebell@doi.nv.gov
Kim Everett	Division of Insurance (Carson City)	1818 E. College Pkwy, Suite 103 Carson City, NV 89431	(775) 687-0735	keverett@doi.nv.gov

Jeremey Gladstone	Division of Insurance (Carson City)	1818 E. College Pkwy, Suite 103 Carson City, NV 89431	(775) 687-0729	jgladstone@doi.nv.gov

5. A description of how comment was solicited from affected businesses, a summary of their responses, and an explanation of how other interested persons may obtain a copy of the summary.

The Division of Insurance drafted a survey requesting respondents self-identify as a statutory small business and provide feedback concerning the effects of the proposed regulation on business. The survey consisted of the following questions:

1. "Do small businesses offer a health insurance plan with an in-network benefit to their employees? If so, what is the percentage of small businesses that offer this type of product to their employees?"
2. "Do small businesses plan to offer a health insurance plan with an in-network benefit to their employees for plan year 2018? If so, what is the percentage of small businesses that plan to offer this type of product to their employees for plan year 2018?"

The survey was sent out to the Chambers of Commerce throughout the state of Nevada for distribution to their members. The Division did not receive any response to the survey from the Chambers. The Division will continue to solicit comments from the small business community during the workshop and hearing process. The Division will update the small business impact during this process to include any feedback received.

Further, during the two-year process of promulgating the network adequacy regulation, which involved numerous parties, comments, and meetings, the Division received no comments which suggest that quantifying network adequacy standards in a regulation would impact small businesses. The Division has also conducted extensive analysis and research of network adequacy standards to determine its reach.

6. If after consideration of public comment the regulation was adopted without changing any part of the proposed regulation, a summary of the reasons for adopting the regulation without change.

The regulation, LCB Draft of Revised Proposed Regulation R025-17, dated September 5, 2017, was adopted without change because there were no comments received from the public at the hearing or in writing.

7. (a) The estimated economic effect of the adopted regulation on the business which it is to regulate:

(1) Both adverse and beneficial effects:

The adverse impact of the regulation is that health insurance carriers will be required to demonstrate the adequacy of their network plans based on the standards in the regulation. Carriers will likely have to adjust their network plans to meet these standards which could include adding additional healthcare providers and facilities to their current network plan designs.

The benefit for health insurance carriers is over time they will be able to better measure members' needs and use of providers to better plan their networks.

(2) Both immediate and long-term effects:

The immediate adverse impact is that the health insurance carriers will be required to demonstrate the adequacy of their network plans based on the network adequacy standards in the regulation. Carriers will likely have to adjust their network plans to meet member needs. Carriers may have to add additional healthcare providers to their current network plan designs.

Once carriers establish the relevant number and types of healthcare providers necessary to meet the network adequacy requirements, the long term impact on carriers will be better known. Data will be gathered by the Division through its annual review of performance of a carrier's network plan. This data can then be studied to better predict long-term effects of certain network adequacy requirements.

The Division does not anticipate an immediate economic benefit to health insurance carriers from the regulation. Long term, health insurance carriers will be able to better measure members' needs and use of providers to better plan.

(b) The estimated economic effect of the adopted regulation on the public:

(1) Both adverse and beneficial effects:

The adverse economic effect on the public from the regulation is that there may be a learning curve with the health insurance carriers which may impact members' abilities to access care as quickly as hoped. Additionally, although the standards will be in place, this does not guarantee that every healthcare provider sought by a policyholder will always be an "in-network" provider.

The economic benefit for the public is that once implemented, members should be able to more reasonably access appropriate care with in-network providers. As the network adequacy requirements are updated each year health insurance carriers should provide a broader base of "in-network" healthcare providers.

(2) Both immediate and long-term effects:

Looking at the immediate adverse impact, as carriers obtain experience data, there may be a learning curve that may impact members' abilities to access care as quickly as hoped. In the long term, although network adequacy requirements will be issued each year, this does not guarantee that every healthcare provider sought by a policyholder will always be an "in-network" provider. As a result, the policyholder may still be responsible for paying some additional amounts out-of-pocket for an "out-of-network" provider.

Looking at the immediate benefit, once implemented, members should be able to more reasonably access appropriate care with in-network providers. In the long term, as the network adequacy requirements are updated and issued each year, they will generally provide a more broad base of "in network" healthcare providers and access thereto. By providing a more broad base of "in network" healthcare providers and access thereto, policyholders should experience lower out-of-pocket costs.

8. The estimated cost to the agency for enforcement of the adopted regulation.

There is no additional cost to enforce this regulation.

9. 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.

The regulation does not duplicate or overlap federal regulation but does require that a network plan must contain, at a minimum, the standards contained in the 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.

10. If the regulation includes provisions that are more stringent than a federal regulation which regulates the same activity, a summary of those provisions.

The proposed regulation includes additional standards for the specialty area of pediatrics which are more stringent than the standards included in the 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.

11. If the regulation establishes 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.

No new or additional fees are established.