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Agency

Dept. of Business and Industry

Division of Insurance

T005-18

FOR EMERGENCY
REGULATIONS ONLY

Effective date _____

Expiration date _____

Governor's signature

Classification: PROPOSED ADOPTED BY AGENCY EMERGENCY

Brief description of action Temporary regulation concerning Network Adequacy Plan Year 2020.

Authority citation other than 233B §§1 and 2, 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.

Notice date 11/9/18

Date of Adoption by Agency 12/27/18

Hearing date 12/14/18

ADOPTED

PROPOSED REGULATION OF THE
COMMISSIONER OF INSURANCE

LCB File No. T005-18

November 6, 2018

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

AUTHORITY: §§1 and 2, 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 for sale in this State; and providing other matters properly relating thereto.

Section 1. NAC 687B.768 is hereby amended to read as follows:

1. In order for the Commissioner to determine that a network plan made available for sale in this State is adequate, the network plan must contain, at a minimum:

~~[(a) 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. A copy of the letter may be obtained free of charge at the Internet address <https://www.cms.gov/CCHO/resources/regulations-and-guidance/>]~~

(a) ~~[(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 or distance standards in the following table:

Specialty Area	Maximum Time or Distance Standards (Minutes/Miles)			
	Metro	Micro	Rural	Counties with Extreme Access Considerations (CEAC)
Primary Care	15/10	30/20	40/30	70/60
Endocrinology	60/40	100/75	110/90	145/130
Infectious Diseases	60/40	100/75	110/90	145/130
Oncology - Medical/Surgical	45/30	60/45	75/60	110/100
Oncology - Radiation/Radiology	60/40	100/75	110/90	145/130
[Mental Health] (Including Substance- Use Disorder Treatment)}	[45/30]	[60/45]	[75/60]	[110/100]
<i>Psychiatrist</i>	<i>45/30</i>	<i>60/45</i>	<i>75/60</i>	<i>110/100</i>
<i>Psychologist</i>	<i>45/30</i>	<i>60/45</i>	<i>75/60</i>	<i>110/100</i>
<i>Licensed Clinical Social Works (LCSW)</i>	<i>45/30</i>	<i>60/45</i>	<i>75/60</i>	<i>110/100</i>
Pediatrics	25/15	30/20	40/30	105/90
Rheumatology	60/40	100/75	110/90	145/130
Hospitals	45/30	80/60	75/60	110/100
Outpatient Dialysis	45/30	80/60	90/75	125/110

(b) ~~(e)~~ Evidence that the network plan:

- (1) Contracts with at least 30 percent of the essential community providers in the service area of the network plan that are available to participate in the provider

network of the network plan~~[, as calculated using the methodology contained in the most recent Letter to Issuers in the Federally-facilitated Marketplaces.];~~

(2) Offers contracts in good faith to all available ECPs in all counties designated as Counties with Extreme Access Considerations (CEAC) included in the plan's service area;

(3) Offers contracts in good faith to all available Indian health care providers in the service area of the network plan, including, without limitation, the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations, as defined in 25 U.S.C. § 1603, which apply the special terms and conditions necessitated by federal statutes and regulations as referenced in the Model Qualified Health Plan Addendum for Indian Health Care Providers. A copy of the Model Qualified Health Plan Addendum for Indian Health Care Providers may be obtained free of charge at the Internet address

<https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>;

and

(4) Offers contracts in good faith to at least one essential community provider in each category of essential community provider, *in the following table* ~~[as contained in the most recent Letter to Issuers in the Federally-facilitated Marketplaces]~~, in each county in the service area of the network plan, where an essential community provider in that category is available and provides medical or dental services that are covered by the network plan.

<i>Major ECP Category</i>	<i>ECP Provider Types</i>
<i>Family Planning Providers</i>	<i>Title X Family Planning Clinics and Title X "Look-Alike" Family Planning Clinics</i>
<i>Federally Qualified Health Centers (FQHCs)</i>	<i>FQHCs and FQHC "Look-Alike" Clinics, Outpatient health programs/facilities operated by Indian tribes, tribal organizations, programs operated by Urban Indian Organizations</i>
<i>Hospitals</i>	<i>Disproportionate Share Hospitals (DSH) and DSH-eligible Hospitals, Children's Hospitals, Rural Referral Centers, Sole Community Hospitals, Free-standing Cancer Centers, Critical Access Hospitals</i>
<i>Indian Health Care Providers</i>	<i>IHS providers, Indian Tribes, Tribal organizations, and urban Indian Organizations</i>
<i>Ryan White Providers</i>	<i>Ryan White HIV/AIDS Program Providers</i>
<i>Other ECP Providers</i>	<i>STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically underserved individuals</i>

~~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-}~~ 2. To offer a contract in good faith pursuant to paragraph ~~{(e)}~~ (b) of subsection 1, a network plan must offer contract terms comparable to the terms that a carrier or other person or entity which issues a network plan would offer to a similarly situated provider which is not an essential community provider, except for terms that would not be

applicable to an essential community provider, including, without limitation, because of the type of services that an essential community provider provides. A network plan must be able to provide verification of such offers if the *Commissioner of Insurance* [~~Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services~~] requests to verify compliance with this policy.

~~[4. Upon the issuance of a new Letter to Issuers in the Federally-facilitated Marketplaces, the Commissioner will determine whether the requirements of NAC 687B.750 to 687B.784, inclusive, including, without limitation, the standards 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 NAC 687B.750 to 687B.784, inclusive, 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 NAC 687B.750 to 687B.784, inclusive, and give notice of that hearing in accordance with NRS 233B.060.]~~

~~[5.]~~ 3. As used in this section:

- (a) “Essential community provider” or “ECP” are defined as providers that serve predominantly low-income, medically underserved individuals, and specifically include health care providers defined in section 340B(a)(4) of the Public Health Service (PHS) Act; entities described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act (SSA), including State-owned family planning service sites, governmental family planning service sites, not-for-profit family planning service sites that do not receive 340B-qualifying funding, including under Title X of the PHS

Act; or Indian health care providers, unless any of the above providers has lost its status under either section, 340(B) of the PHS Act or 1927 of the Act, as a result of violating Federal law. ~~[has the meaning ascribed to it in the most recent Letter to Issuers in the Federally-facilitated Marketplaces.]~~

(b) *“Maximum time or distance standards” ~~[has the meaning ascribed to “maximum time and distance standards” in the most recent Letter to Issuers in the Federally-facilitated Marketplaces.]~~ are defined as the maximum time or distance an individual should have to travel to see a provider based on the area designation.*

(c) *Area designations for the maximum time or distance standards required pursuant to paragraph (a) of subsection 1 are based upon the population size and density parameters of individual counties within the plan’s service area. The population and density parameters applied to determine county type designations are listed in the following table:*

<i>County Type</i>	<i>Population</i>	<i>Density</i>
<i>Metro</i>	$\geq 1,000,000$	$10 - 999.9/mi^2$
	$500,000 - 999,999$	$10 - 1,499.9/mi^2$
	$200,000 - 499,999$	$10 - 4,999.9/mi^2$
	$50,000 - 199,999$	$100 - 4,999.9/mi^2$
	$10,000 - 49,999$	$1,000 - 4,999.9/mi^2$
<i>Micro</i>	$50,000 - 199,999$	$10 - 49.9/mi^2$
	$10,000 - 49,999$	$50 - 999.9/mi^2$
<i>Rural</i>	$10,000 - 49,999$	$10 - 49.9/mi^2$
	$< 10,000$	$10 - 4,999.9/mi^2$
<i>CEAC</i>	<i>Any</i>	$< 10/mi^2$

Sec. 2. NAC 687B.772 is hereby amended to read as follows:

1. The Council shall consider the standards required pursuant to NAC 687B.768 and any other requirements of NAC 687B.750 to 687B.784, inclusive, 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/CCHO/programs-and-initiatives/health-insurance-marketplaces/qhp.html> free of charge, which is hereby adopted by reference; and]~~

~~[(2) Are]~~ *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 required pursuant to NAC 687B.768 and any other

requirements of NAC 687B.750 to 687B.784, inclusive.

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. This regulation becomes effective on January 1, 2020.

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

LCB FILE NO. T005-18

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 temporary 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 NAC 687B.768. The purpose of the temporary regulation is to establish adequacy standards for network plans for plan year 2020.

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 December 3, 2018, and at the hearing held on December 14, 2018. The public workshop and hearing 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 did not receive any public response in favor of or against the temporary regulation. The Division received two written comments related to network adequacy. One of the comments requested information pertaining to how network adequacy analysis would be conducted and the other urged the Division to expand the number of providers required under regulation as well as expand the metrics of determining network adequacy beyond time and distance.

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

The summary in #2(b) above reflects the public comments and testimony that transpired with regard to regulation T005-18. A copy of said summary may be obtained by contacting Jeremy Gladstone, Assistant Chief, Life and Health Section, 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 the hearing: 3
- (b) Testified at the hearing: 0
- (c) Submitted to the agency written statements: 2

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:

Testified at the hearing:

There was no testimony given at the hearing for the temporary regulation.

Submitted to the agency written statements:

Name	Entity/Organization Represented	Business Address	Telephone	E-Mail Address
Alan Matarasso, MD, FACS	American Society of Plastic Surgeons	444 E. Algonquin Rd. Arlington Heights, IL 60005	847-228-3331	phermes@plasticsurgery.org

Richard Baynosa, MD	Mountain West Society of Plastic Surgeons	444 E. Algonquin Rd. Arlington Heights, IL 60005	847-228-3346	phermes@plasticsurgery.org
Katie Rogers	Silver Summit Health Plan	13221 SW 68th Pkwy, Ste. 300 Tigard, OR 97223	531-329-8581	Katie.L.Rogers@SilverSummitHealthPlan.com

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

(a) A description of how comments were solicited from affected businesses:

Comments were solicited from affected businesses in the same manner as they were solicited from the public. Please see the description, summary and explanation provided above in response to question #2. The Division also solicited comments from the Chambers of Commerce throughout the state of Nevada and requested that the solicitation be forwarded to members of the Chambers.

(b) A summary of the responses from affected businesses:

The Division did not receive direct comments from any affected businesses beyond the information provided in question #2(b).

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

The summary in #5(b) above reflects the comments and testimony that transpired with regard to regulation T005-18. A copy of said summary may be obtained by contacting Jeremy Gladstone, Assistant Chief, Life and Health Section, 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.

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 Division received written comments urging the Division to expand the number of providers required under regulation as well as expand the metrics of determining network adequacy beyond time and distance. The Division feels this is a matter best addressed by the Network Adequacy Advisory Council given their expertise on the subject matter. The current regulations require the Council to meet annually to make recommendations for network adequacy to the Commissioner of Insurance. The written comments will be presented to the Council at their first meeting for Plan Year 2021 and, at the discretion of the Council, can become part of the Council's recommendations to the Commissioner.

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

(1) Both adverse and beneficial effects:

Beneficial: Health insurance carriers will be able to better measure members' needs and use of health care providers to design network plans.

Adverse: The health carriers will be required to demonstrate the adequacy of their network plans based on the network adequacy standards in the temporary regulation. Carriers will likely have to adjust their network plans to meet policyholder 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 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.

(2) Both immediate and long-term effects:

The immediate and long-term effects of the temporary regulation overlap and a summary of the overall effects is provided. Health insurance carriers will be able to better measure members' needs and use of health care providers to design network plans.

The health carriers will be required to demonstrate the adequacy of their network plans based on the network adequacy standards in the temporary regulation. Carriers will likely have to adjust their network plans to meet policyholder 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 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.

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

(1) Both adverse and beneficial effects:

Beneficial: Once implemented, policyholders should be able to more reasonably access appropriate care with in-network providers. As the network adequacy requirements are updated each year, they should 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.

Adverse: As health insurance carriers obtain experience data, there may be a learning curve that may impact members' abilities to access care as quickly as hoped. Additionally, 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.

(2) Both immediate and long-term effects:

The immediate and long-term effects of the temporary regulation overlap and a summary of the overall effects is provided. Once implemented, policyholders should be able to more reasonably access appropriate care with in-network providers. As the network adequacy requirements are updated each year, they should 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.

As health insurance carriers obtain experience data, there may be a learning curve that may impact members' abilities to access care as quickly as hoped. Additionally, 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.

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

The Division anticipates no additional costs. NRS 67B.490(6) requires that any expense borne by the Division in determining the adequacy of a network plan be assessed against the insurance carrier applying for the network plan approval.

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.

There are no regulations of other state or government or federal agencies that the temporary regulation overlaps or duplicates.

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

Not applicable, as there are no federal regulations that address the requirements in the temporary regulation for all network plans in the individual and small group markets.

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.

Not applicable, as the regulation does not create a new fee or increase an existing fee.