PROPOSED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R049-14

DRAFT PROPOSED INCLUDING AMENDMENTS

June 3, 2015

EXPLANATION – Matter in (1) ***blue bold italics*** is new language including amendments.

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AUTHORITY: §§1-13, NRS 679B.130 and 687B.490.

A REGULATION relating to insurance; establishing certain requirements relating to the adequacy of a network plan issued by a carrier; authorizing the Commissioner of Insurance to determine whether a network plan is adequate under certain circumstances; requiring a carrier whose network plan is deemed or determined to be adequate to notify the Commissioner of any material change to its network and take certain actions to correct any deficiency that results; providing for the availability of a network plan to covered persons outside of the approved service area in certain circumstances; and providing other matters properly relating thereto.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 15, inclusive, of this regulation.

Sec. 2. (Definitions)

1. A "Carrier" means an insurer that makes any network plan available for sale in this State in the small employer group or individual market as contemplated by NRS 687B.490.

2. "CCIIO" means the Center for Consumer Information and Insurance Oversight within the Centers for Medicare and Medicaid Services division within the United States Department of Health and Human Services or its successor.

3. The "Centers for Medicare and Medicaid Services" means the Medicare Centers and Medicaid Services Centers within the Centers for Medicare and Medicaid Services division within the United States Department of Health and Human Services.

4. "Covered Persons" has the meaning ascribed to it in NRS 695G.017.

5. An "essential community provider" has the meaning ascribed to it in 45 C.F.R. § 156.235(c).

6. "Established Patterns of Care" means clinically appropriate referral patterns with expected patient travel to a location for treatment for a particular condition.

7. "Exchange" means the Silver State Health Insurance Exchange as defined by NRS 695I.030.

8. A "geographic service area" has the meaning ascribed to it:

(a) For health benefit plans sold to individuals, in NRS 689A.527; or

(b) For health benefit plans sold to small employers, in NRS 689C.072.

9. "Health Care Providers" has the meaning ascribed to it in NRS 695G.070.

10. "Indian Health Services" means the Indian Health Services division within the United States Department of Health and Human Services which is responsible for providing federal health services to American Indians and Alaska Natives.

11. A "material change" in a network plan is any change, or combination of changes taking effect within 30 days of each other, that:

(a) For specialties or categories of health care with more than 10 providers, affects network plan capacity by more than 10 percent in any single specialty or category of health care for which a benefit is offered;

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(b) For specialties or categories of health care with 10 or fewer providers, affects network plan capacity by more than 20 percent in any single specialty or category of health care for which a benefit is offered: or

(c). Does not meet the standards as provided for in section 4 of this regulation.

12. "Medically Necessary Emergency Services" has the meaning ascribed to it in NRS 695G.170.

13. "Telehealth" has the meaning ascribed to it in section 3(3)(c) of AB292 from the 78th (2015) Session.

14. "Unreasonable travel" means a travel distance or time that does not meet the standards as provided for in section 4 of this regulation.

Sec. 3. *A carrier must establish and maintain a network plan that has an adequate number and geographic distribution of contracted providers in each geographic service area covered by the network plan in order to meet anticipated health care needs based upon the benefits offered under the plan.*

Sec. 4. *1. On or before the first Tuesday in January of each year, but no earlier than December 1 of the preceding year, the Commissioner will make available a preliminary list of the minimum number of health care providers and reasonable maximum travel distance or time, by county, for certain specialties and categories of health care. Interested parties may submit comments concerning the preliminary list to the Commissioner no later than January 20 of the applicable year.*

2. On or before January 31, but no earlier than January 21, of each year, the Commissioner will make available a final list of the minimum number of health care providers and reasonable maximum travel distance or time, by county, for certain specialties and

categories of health care. The final list will be applicable to health benefit plans issued or renewed on or after January 1 of the calendar year after the list is issued.

3. Unless otherwise approved in writing by the Commissioner, the specialties and categories of health care providers referenced in subsections 1 and 2 of this section shall be those specialties and categories of health care that:

(a) Appear as options on the Network Adequacy Template issued and periodically updated by the Centers for Medicare and Medicaid Services; and

(b) Are offered as a certification by:

(1) Member Boards within the American Board of Medical Specialties; or

(2) The American Osteopathic Association.

4. A change to either list of specialties and categories of health care in subsection 3 of this section made after the Commissioner issues the final list of the minimum number of health care providers and maximum travel distance or time pursuant to subsection 2 of this section shall not be reflected until the next following calendar year's list of minimum number of health care providers and maximum travel distance or time is issued.

Sec. 5. *A carrier shall, in conjunction with the annual rate and form filing, collect, compile, evaluate, report and submit sufficient data, in a format as determined by the Commissioner, to the Commissioner to establish that the proposed network plan has the capacity to adequately serve the anticipated number of covered persons in the network plan.*

Sec. 6. *1. A carrier must establish that the carrier has a sufficient number and geographic distribution of essential community providers, where available, within the network plan to ensure reasonable and timely access to a broad range of such essential community*

providers for low-income, medically underserved members in each geographic service area covered by the network plan.

2. For the purposes of subsection 1, a network plan that includes:

(a) At least 30 percent of the available essential community providers in each geographic service area covered by the network plan; and

(b) At least one essential community provider from each category in the following list:

(1) 42 U.S.C. § 256b(a)(4)(A);

(2) 42 U.S.C. § 256b(a)(4)(C);

(3) 42 U.S.C. § 256b(a)(4)(D);

(4) 42 U.S.C. § 256b(a)(4)(I); and

(5) 42 U.S.C. § 256b(a)(4)(L), 42 U.S.C. § 256b(a)(4)(M), 42 U.S.C. § 256b(a)(4)(N), or 42 U.S.C. § 256b(a)(4)(O).

shall be deemed sufficient.

3. For the purposes of meeting the 30 percent inclusion requirement in subsection 2, a carrier may use an essential community provider that does not meet the requirements to be included in any of the categories contained in paragraph (b) of subsection 2 so long as the carrier follows the write-in procedure for essential community providers outlined in the most current "Letter to Issuers in the Federally-facilitated Marketplaces", as issued and updated periodically by CCIIO .

4. For the purposes of satisfying paragraph (b)(4) of subsection 2 of this section, a carrier may utilize a letter of agreement with the applicable essential community provider.

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Sec. 7. ***1. A carrier who offers a network plan on the Exchange must use its best efforts to establish and maintain arrangements to ensure that American Indians and Alaskan Natives who are members within the network plan have access to health care services and facilities that are part of the Indian Health Service at no greater cost to the member than if the services were obtained from a health care provider that is part of the network plan.***

2. Nothing in this section prohibits a health benefit plan from limiting coverage to those health care services that meet its standards for medical necessity, care management and claim administration or from limiting payment to that amount payable if the health care services were obtained from a health care provider that is part of the network plan.

3. Carriers are not responsible for credentialing health care providers that:

(a) Are part of the Indian Health Service; and

(b) Do not have a contract with the carrier to provide services as part of the carrier's network plan.

Sec. 8. ***1. In determining whether a network plan is adequate, the Commissioner may, but is not limited to, consider:***

(a) The relative availability of health care providers in the geographic service area covered by the network plan, including, without limitation, the:

(1). Operating hours, or their equivalent, of available health care providers; and/or

(2). Established patterns of care;

(b) The ability of a carrier to enter into a contract with health care providers within the travel standards provided pursuant to section 4 of this regulation;

(c) The system for the delivery of care to be furnished by the health care providers contracted by a carrier in the network plan;

(d) The availability of telehealth services;

(e) The availability of health care providers located outside of the network plan's geographic service area but within the travel standards provided pursuant to section 4 of this regulation; and

(f). The availability of nonemergency services accessible during normal business hours and medically necessary emergency services accessible at any time.

Sec. 9. ***A carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network plans' health care providers to furnish health care services to covered persons.***

Sec. 10. ***1. A carrier shall update its health care provider directory at least once a month. Any updates to a health care provider directory shall indicate those health care providers which have left the network plan or are no longer accepting new patients.***

2. A carrier with a material change to its network plan shall:

(a) Update its health care provider directory within 3 business days of the effective date of the material change in network plan. Any updates to a health care provider directory resulting from a material change to a network plan shall clearly indicate those health care providers:

(1) That have left the network plan since the health care directory was last updated; and

(2) That are not accepting new patients.

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(b) Notify affected covered persons that a material change in network plan has occurred. The notice shall inform covered persons of how they may receive more information regarding the material change in network plan. The notice may be sent via electronic mail in instances where the carrier has received affirmative permission from the covered person to communicate in that manner.

3. The health care provider directory and each update thereto must:

(a) Be posted to the Internet website maintained by the carrier within 72 hours after the update is made. The posting shall be made to a page that is accessible without a username and password or otherwise permits covered persons who are not enrolled in any plan offered by the carrier to view the health care provider directory; and

(b) Be made available in a printed format upon request.

Sec. 11. *1. A carrier shall notify the Commissioner, within 72 hours of the effective date of a material change in its network plan, of:*

(a) The effective date of the material change in its network plan; and

(b) A description of the cause and impact of the material change in its network plan.

Sec. 12. *1. If a material change in a carrier's network plan results in a deficiency in its network plan, the carrier shall submit a corrective action plan to resolve the deficiency within 60 days after the effective date of the material change in its network plan.*

2. During the period the corrective action plan submitted pursuant to subsection 1 is being implemented, a carrier shall:

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(a) Ensure that a covered person affected by the material change may obtain the covered service from a health care provider:

(1) Within the network plan, at no greater cost to the covered person; or

(2) Not within the network plan, by entering into an agreement with the non-participating health care provider pursuant to NRS 695G.164; or

(b) Make other arrangements approved by the Commissioner to ensure that a covered person affected by the material change may obtain service.

3. The provisions of subsection 2 are not applicable if the covered person receives care from a non-participating health care provider without receiving prior authorization from the carrier unless the covered person receives medically necessary emergency services.

Sec. 13. *1. If the network plan is deficient at the end of the time period for the corrective action plan as provided for in section 11 the Commissioner may:*

(a) For a network plan containing a health benefit plan made available for purchase on the Exchange, declare the network plan inadequate pursuant to NRS 687B.490, and the health benefit plan will be declared deficient pursuant to 42 U.S.C. § 18031(c)(1) and subject to decertification pursuant to 45 C.F.R. § 156.290; or

(b) For any other network plan, declare the network plan inadequate pursuant to NRS 687B.490, and the carrier shall submit a statement of network capacity to the Commissioner pursuant to 42 U.S.C. § 300gg-1(c).

Sec. 14. *1. The provisions of sections 6, 7, 8, 12 and 13 of this regulation do not apply to a network plan issued by a carrier that:*

(a) Is licensed pursuant to chapter 680A of NRS;

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(b) Had a statewide enrollment of 1,000 covered persons or fewer in the prior calendar year; and

(c) Has an anticipated statewide enrollment of 1,250 covered persons or fewer in the next upcoming calendar year.

2. A network plan meeting the requirements of subsection 1 shall be determined to meet the provisions of NRS 687B.490.

Sec. 15. ***The provisions of this regulation do not apply to:***

1. A plan issued pursuant to NRS 422.273 for the purpose of Medicaid managed care program services on behalf of the Department of Health and Human Services;

2. A network plan issued for a health benefit plan regulated under chapter 689B of NRS and that is not available for sale to small employers as defined by NRS 689C.095; or

3. A grandfathered plan as defined in NRS 679A.094

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