ADOPTED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R049-14

Effective April 4, 2016

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

AUTHORITY: §§1-9 and 12-18, NRS 679B.130 and 687B.490, as amended by section 28 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 636; §§10 and 11, NRS 679B.130, 679B.160 and 687B.490, as amended by section 28 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 636; §19, NRS 679B.130, 695C.130 and 695C.275.

A REGULATION relating to insurance; adopting by reference certain standards for determining the adequacy of a network plan issued by a carrier; establishing the Network Adequacy Advisory Council to make recommendations concerning additional standards for determining the adequacy of such a network plan; requiring a carrier who applies for approval to issue a network plan to submit certain data and documentation to the Commissioner of Insurance; requiring a carrier to take certain actions in response to a change to its network that results in the network not meeting applicable standards of adequacy; 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 group or individual insurance market to demonstrate the capacity to deliver services adequately before making any network plan available for sale; 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 certain statistics relating to its services. (NRS 687B.490, as amended by section 28 of Assembly Bill No. 292, chapter 153, Statutes of Nevada 2015, at page 636)

Under federal law, a health insurance exchange is a governmental agency or nonprofit entity established by a state that makes health plans that meet certain requirements available to persons and small employers in the state. (42 U.S.C. §§18031, 18032) **Section 9** of this regulation: (1) adopts by reference certain standards prescribed by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services for determining the adequacy of a network plan offered on a health insurance exchange; and (2) provides that those standards are the standards for determining the adequacy of any network plan offered for sale in

this State, including a plan that is not offered on a health insurance exchange. **Section 9** also provides that if a new version of those standards is issued, the Commissioner will determine whether existing requirements concerning network adequacy conform with the new version of those standards. If the Commissioner determines that existing requirements do not conform with the new version of those standards, **section 9** provides that the Commissioner will hold a hearing concerning possible amendments to existing requirements.

Section 10 of this regulation establishes the Network Adequacy Advisory Council and requires the Council to hold at least three annual meetings. **Section 11** of this regulation: (1) requires the Council to propose to the Commissioner recommendations for additional or alternative standards for determining the adequacy of a network plan; and (2) prescribes the content of the recommendations. **Section 12** of this regulation requires each carrier or other person or entity who applies for approval to issue a network plan to submit to the Commissioner with its annual rate filing sufficient data and documentation to establish that the proposed network plan meets the standards for network adequacy prescribed in regulation.

Section 13 of this regulation requires a carrier to update its directory of providers of health care at least once each month and within 5 business days after a change in a network plan that results in the network plan not meeting the standards for adequacy prescribed in regulation. **Section 14** of this regulation requires a carrier to: (1) notify the Commissioner of any such change to its network plan within 3 business days; and (2) provide to the Commissioner within 10 business days a description of the cause and impact of the change and a summary of the measures that the carrier will take to bring the network plan into compliance with the standards. **Section 15** of this regulation requires a carrier to: (1) submit to the Commissioner for approval a corrective action plan to bring the network plan into compliance with the standards; and (2) take certain actions to ensure that covered persons have access to covered services after such a change. **Section 16** of this regulation allows the Commissioner to determine that a network plan is inadequate pursuant to existing law if the Commissioner does not approve a corrective action plan and the network plan fails to comply with the standards. **Section 17** of this regulation excludes a network plan issued by certain smaller carriers from the requirements of **sections 12-16** of this regulation. **Section 18** of this regulation excludes certain other plans from the provisions of this regulation. **Section 19** of this regulation repeals provisions that: (1) require a health maintenance organization or a provider-sponsored organization to define the geographic area it intends to serve and prescribe requirements concerning that geographic area; and (2) require each applicant for a certificate of authority to submit a list of providers in its health care plan.

Section 1. Chapter 687B of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 18, inclusive, of this regulation.

Sec. 2. ***As used in sections 2 to 18, inclusive, of this regulation, unless the context otherwise requires, the words and terms defined in sections 3 to 8, inclusive, of this regulation have the meanings ascribed to them in those sections.***

Sec. 3. *"Carrier" means an insurer that makes a network plan available for sale in this State pursuant to NRS 687B.490.*

Sec. 4. *"Council" means the Network Adequacy Advisory Council established by section 10 of this regulation.*

Sec. 5. *"Covered person" means a policyholder, subscriber, enrollee or other person participating in a network plan.*

Sec. 6. *"Network plan" has the meaning ascribed to it in NRS 689B.570.*

Sec. 7. *"Provider of health care" has the meaning ascribed to it in NRS 695G.070.*

Sec. 8. *"Qualified health plan" has the meaning ascribed to it in NRS 695I.080.*

Sec. 9. *1. For the purpose of determining the adequacy of a network plan made available for sale in this State, the Commissioner hereby adopts by reference the standards contained in the 2017 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/.*

2. 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 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.

Sec. 10. *1. The Network Adequacy Advisory Council is hereby established.*

2. The Council consists of nine members appointed by the Commissioner. The members of the Council will be chosen to ensure fair representation of the interests of carriers, providers of health care and consumers of health care. The members of the Council serve at the pleasure of the Commissioner and without compensation.

3. If a vacancy occurs in the membership of the Council, the Commissioner will appoint a qualified person to fill the vacancy. The person appointed to fill the vacancy must represent interests similar to those represented by the member who is being replaced.

4. The Council shall meet at least three times each year. The first meeting of the Council must take place not later than June 15 of each year. Written notice of each meeting of the Council must be given as provided in NRS 241.020, as amended by section 4 of Senate Bill No. 70, chapter 226, Statutes of Nevada 2015, at page 1056, except that the notice must be given at least 5 working days before the meeting.

Sec. 11. *1. The Council shall consider the standards adopted by reference in 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 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. 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, 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 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. 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 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. 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 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 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. 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 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 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. 16. *If a network plan does not meet the standards adopted by reference in 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).

Sec. 17. *The provisions of sections 12 to 16, inclusive, of this regulation do not apply during any calendar year to a network plan that:*

1. Is issued by a carrier that has been authorized to transact insurance in this State pursuant to chapter 680A of NRS;

2. Had a statewide enrollment of not more than 1,000 persons during the immediately preceding calendar year;

3. Has an anticipated statewide enrollment of not more than 1,250 persons during the next succeeding calendar year; and

4. Is not a qualified health plan.

Sec. 18. *The provisions of sections 2 to 18, inclusive, of this regulation do not apply to:*

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

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

3. A grandfathered plan, as defined in NRS 679A.094; or

4. A plan issued pursuant to Medicare, as defined in NAC 687B.2028, or a Medicare Advantage plan, as defined in NAC 687B.2034.

Sec. 19. NAC 695C.160 and 695C.200 are hereby repealed.

TEXT OF REPEALED SECTIONS

695C.160 Geographic area of service: Definition. (NRS 679B.130, 695C.130, 695C.275)

1. An organization shall clearly define the geographic area it intends to serve which:

(a) In a county having a population of 100,000 or more, must have a radius of not more than 25 miles between the subscriber or individual enrollee and a primary physician and the hospital used by the organization. This subsection does not apply to services rendered pursuant to Medicaid or Nevada Check Up.

(b) In any other county, must be defined by the organization under a plan for the provision of health care services if the organization receives the written approval of the Division for such a geographic area by:

(1) Demonstrating the availability and accessibility of services to its enrollees, including reasonable access to primary physicians, a hospital and to medically necessary services or services in an emergency; and

(2) Submitting a statement concerning the standards within that community regarding the availability and accessibility of other health care services and demonstrating that the organization will meet the community's standards for such services.

2. As used in this section, "Nevada Check Up" has the meaning ascribed to it in NAC 442.688.

695C.200 List of providers: Submission; changes; extension of submission date; excessive reduction. (NRS 679B.130, 695C.070, 695C.275)

1. Each applicant for a certificate of authority shall:

(a) Submit a list of the providers in its health care plan and a description of the type of providers based upon a projected number of enrollees;

(b) Sufficiently describe its list of providers to demonstrate the accessibility and availability of health care to its enrollees; and

(c) Describe a plan for increasing the number of providers based upon increased enrollment.

2. The organization shall notify:

(a) For a health maintenance organization, the Division and the State Board of Health in writing not later than 14 days after the end of each quarter of each calendar year of any changes in its list of providers unless an extension is granted pursuant to this paragraph. On or before the date on which the notification is due, the health maintenance organization may submit a request to the Commissioner for an extension of time in which to provide the notification of not more than 30 days after the date on which the notification is due.

(b) For a provider-sponsored organization, the Division in writing not later than 14 days after the end of each quarter of each calendar year of any changes in its list of providers unless an extension is granted pursuant to this paragraph. On or before the date on which the notification is due, the provider-sponsored organization may submit a request to the Commissioner for an extension of time in which to provide the notification of not more than 30 days after the date on which the notification is due.

(c) An enrollee in writing of the disassociation of his or her primary physician from the organization not later than 30 working days after such disassociation.

3. Based upon the current list of providers of an organization, an overall reduction of more than 30 percent in the number of primary physicians in a geographic area of service or a material change in the panel of specialists shall be deemed by the Division to jeopardize the ability of the organization to meet its obligations to its enrollees, and the Division will so notify the organization, and for a health maintenance organization, the Division will also notify the State Board of Health. The organization may rebut this presumption by providing written information to the Division within 14 days after the notice is sent to the organization.

4. The provisions of subsection 3 do not apply if the organization:

(a) Notifies the Division in writing;

(b) Submits information concerning the number of persons enrolled in the organization and the reasons for any reductions; and

(c) Obtains the approval of the Division in advance for the reduction.

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

LCB FILE NO. R049-14

The following statement is submitted by the Division of Insurance ("Division") for adopted amendments to Nevada Administrative Code ("NAC") Chapter 687B, and repeal of NAC 695C.160 and 695C.200.

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

Nevada Revised Statute 687B.490 requires the Commissioner of Insurance to adopt regulations to 1) ensure insurance carriers that offer coverage in the small group or individual market demonstrate the capacity to deliver services adequately before making any network plan available for sale, 2) address organizational arrangements of network plans and, 3) address the procedure by which network plans will develop, compile, evaluate and report certain information relating to services. See NRS 687B.490(1) and (2). This regulation establishes an advisory council and a public forum where interested persons may participate in the process used to arrive at annual network adequacy requirements.

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 regulation, notices of workshops, notices of intent to act upon the regulation, and small business impact statement to persons on the Division's mailing list who requested notification of proposed regulations. These documents were also made available through the Division's website (http://doi.nv.gov/), mailed to the main library for each county in Nevada, distributed by the office of Assemblyman James Oscarson to interested persons, and posted at the following locations:

Department of Business and Industry
Division of Insurance
1818 East College Parkway, Suite 103
Carson City, Nevada 89706

Department of Business and Industry
Division of Insurance
2501 East Sahara Avenue, Suite 302
Las Vegas, Nevada 89104

Legislative Building
401 South Carson Street
Carson City, Nevada 89701

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

Blasdel Building
209 East Musser Street
Carson City, Nevada 89701

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

The Division distributed drafts of the regulation with each proposed change, from the initial announcement of the proposed regulation in June 2014 until the adoption hearing held on March 22, 2016. Public comment was also solicited at workshops held on July 1, 2014; July 15, 2014; August 12, 2014; September 25, 2014; July 23, 2015, January 28, 2016, and at hearings held on November 12, 2014, October 20, 2015, and March 16, 2016, which was recessed and reconvened on March 22, 2016. The workshops and hearings took place at the offices of the Division, 1818 East College Parkway, Carson City, Nevada 89706, with simultaneous videoconferencing to the Bradley Building, 2501 East Sahara Avenue, Las Vegas, Nevada 89104, with the exception of the workshop held on July 23, 2015, which was held at the Legislative Building, 401 South Carson Street, Room 2135, Carson City, Nevada 89701, with simultaneous videoconferencing to the Grant Sawyer Building, 555 East Washington Avenue, Room 4412E, Las Vegas, Nevada 89101.

(b) A summary of the public response:

During the six workshops and three hearings listed above, the Division received both oral and written comments from various interested persons about specific aspects of the regulation. Public comment centered mainly in the following areas:

(1) Material (significant) change in a network plan resulting in a need to reexamine its adequacy: Some commenters were concerned that the definition of material change was unclear and left too much room for variation. Others wanted a high number, such as a 20% change, to trigger a reexamination, while others wanted something less than 10%. Concern was also expressed about certain time requirements for notifying the Commissioner, consumers, and updating provider directories about changes in the network.

(2) Time/Distance Standards and Geographic Service Regions: Some commenters advocated large service areas so that residents would have more providers available within the area, while others suggested that large areas would increase the time and distance for residents to access care from providers within the area.

(3) Specialists, Subspecialists, and Categories of Health Care: Some commenters wanted data collected and measured for nearly all specialties

included in a network plan, while others wanted very few so that the task of creating an adequate network would be feasible. Those wanting data collected and measured for fewer specialties stressed the lack of specialists and subspecialists in Nevada, particularly in the rural areas.

(4) Provider Directories: Certain timelines and methods for updating carrier provider directories prompted several comments about the logistics of compliance for some carriers.

(5) Mental Health: There were many comments about the need to ensure that mental health parity is addressed in the standards. Commenters expressed concern that there are not enough mental health providers available to meet the needs of consumers.

(6) Appeal Process: Some commenters expressed a need for an appeal process for a provider that is denied membership or is terminated from a carrier's network. Some commenters suggested that network plan designs might try to control costs by including more low cost providers rather than considering the level of services provided.

(7) Commissioner's Network Advisory Council: In December 2015, the concept of creating a Commissioner's "Network Adequacy Advisory Council" pursuant to the regulation was introduced. The proposed regulation presented at the workshop held on January 28, 2016, included provisions for this advisory council. Comments were received regarding the makeup of the council, terms of service of council members, replacement of council members, and criteria to be used by the council in making a recommendation to the Commissioner.

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

A copy of the summary may be obtained by contacting Cliff King, Chief Insurance Examiner, Life and Health Section, at (775) 687-0700 or cking@doi.nv.gov. This summary will also be made available by e-mail request to insinfo@doi.nv.gov, as well as posted on the Division's website: www.doi.nv.gov

3. The number of persons who:

(a) Attended each hearing:	November 12, 2014: 36	October 20, 2015: 29
	March 16, 2016: 21	March 22, 2016: 21
(b) Testified at each hearing:	November 12, 2014: 8	October 20, 2015: 3
	March 16, 2016: 7	March 22, 2016: 1

(c) Submitted to the agency written statements:

27 persons submitted 71 comments

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:

See Exhibit 1.

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

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.

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

Not applicable. The regulation was revised several times before adoption.

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

(1) Both adverse and beneficial effects:

Adverse – Carriers may have to cover certain additional costs of provider services during a period when a network plan fails to meet adequacy requirements.

Beneficial – Carriers will now be able to participate in a more active way, via the advisory council, in the development of network adequacy requirements. This should help them better forecast service needs and design the plan accordingly to minimize events that might cause the network to fail to meet adequacy requirements during the relevant plan year.

(2) Both immediate and long-term effects:

Immediate – Depending on whether the final network adequacy requirements issued by the Commissioner each year include specialties, types and standards not previously required in network plans, the carriers may have to add additional healthcare providers to their current network plan designs.

Long-Term Effects – 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:

Adverse – 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.

Beneficial – It is anticipated that the network adequacy requirements issued each year will generally provide a more broad base of "in network" healthcare providers and access thereto. Timely updates to the carriers' provider directories will also provide policyholders with more current information about the network status of a particular provider.

(2) Both immediate and long-term effects:

Immediate – By providing a more broad base of "in network" healthcare providers and access thereto, policyholders should experience lower out-of-pocket costs.

Long-Term Effects – 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.

Initially, there may be a slight increased cost to the Division to enforce the regulation in order to provide guidance to the advisory council by way of a contracted independent professional facilitator. Such a facilitator will be helpful to the advisory council concerning organizing and focusing discussion topics, as well as providing guidance on process to come to a recommendation to submit to the Commissioner. The cost of the facilitator is currently being built into the Division's budget.

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 other state or federal regulations.

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

There are currently no federal regulations that regulate the same activity 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.

The regulation does not create a new fee.

Exhibit 1
to Informational Statement
R049-14

March 22, 2016 Hearing – Person who testified:

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Jack Kim	United Healthcare	P.O. Box 15645 Las Vegas, NV 89114-5645	702-240-8890	Jack.Kim@uhc.com

March 16, 2016 Hearing – Persons who testified:

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Jeannette Belz	Nevada Psychiatric Association	10580 N. McCarran Blvd, #115-222 Reno, NV 89503	775-329-0119	jb@jkbelz.com
ott Heinze	Prominence Health Plan	1510 Meadow Wood Lane Reno, NV 89502	775-770-9327	Scott.heinze@uhsinc.com
James Wadhams, Esq.	Fennemore Craig Jones Vargas	300 S. Fourth Street Suite 1400 Las Vegas, NV 89101	702-692-8000	jwadhams@fclaw.com
Keith Lee, Esq.	Nevada Association of Health Plans	1941 Rolling Brook Reno, NC 89519	775-829-1400	Not legible
Joan Hall	Nevada Rural Hospital Partners	4600 Kietzke Lane Suite I-209 Reno, NV 89502	775-827-4770	joan@nrhp.org
Catherine O'Mara	Nevada State Medical Association	Not given	775-742-6170	Catherine@nevadadoctors.org
Bill Welch	Nevada Hospital Association	5190 Neil Rd. Ste. 400 Reno, NV 89502	775-827-0184	bill@nvha.net

October 20, 2015 Hearing – Persons who testified:

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Jeannette Belz	Nevada Psychiatric Association	10580 N. McCarran Blvd, #115-222 Reno, NV 89503	775-329-0119	jb@jkbelz.com
David Brewster	American Academy of Dermatology Association	1445 New York Ave. NW Washington, D.C.	202-340-2875	dbrewster@aad.org
Sara Partida	Nevada State Medical Association	631 N. Stephanie St., Ste. 202 Henderson, NV	Not furnished	sara@theperkinsco.com

November 12, 2014 Hearing – Persons who testified:

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Jack Kim	United Healthcare	P.O. Box 15645 Las Vegas, NV 89114-5645	702-240-8890	Jack.Kim@uhc.com
Stacy Woodbury	Nevada State Medical Association	3660 Baker Lane, #101 Reno, NV 89509	775-825-6788	stacy@nsmadocs.org
Kristin Viswanathan	Biotechnology Industry Organization (BIO)	1201 Maryland Ave SW Washington, D.C. 20024	Not furnished	kviswanathan@bio.org
Bill Welch	Nevada Hospital Association	5250 Neil Road, Suite 302 Reno, NV 89502	775-827-0184	bill@nvha.net
David Brewster	American Academy of Dermatology Association	1445 New York Ave. NW Washington, D.C.	202-340-2875	dbrewster@aad.org
Joan Hall	Nevada Rural Hospital Partners	4600 Kietzke Lane Suite I-209 Reno, NV 89502	775-827-4770	joan@nrhp.org
James Wadhams, Esq.	Fennemore Craig Jones Vargas	300 S. Fourth Street Suite 1400 Las Vegas, NV 89101	702-692-8000	jwadhams@fclaw.com
Linda Ash-Jackson	Hometown Health	830 Harvard Way Reno, NV 89502	775-982-3000	Not given

Persons who provided written statements:

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Grace Campbell	AHIP (America's Health Insurance Plans)	601 Pennsylvania Ave, NW South Building Suite Five Hundred Washington, DC 20004	202-778-3200	gcampbell@ahip.org
Katie Ryan Lisa Farnan	Dignity Health/ St. Rose Dominican	3001 St. Rose Pkwy. Henderson, NV 89052	702-616-5000	Katie.ryan@dignityhealth.org Not given
Chris Ferrari	Ferrari Public Affairs	4741 Caughlin Parkway, Suite 2 Reno, NV 89519	702-574-8781	chris@ferraripa.com
Dwight Hansen Bill Welch	Nevada Hospital Association (NHA)	5190 Neil Rd. Ste. 400 Reno, NV 89502	775-827-0184	Not given

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Mitchell Forman Stacy Woodbury Veronica Sutherland Abdi Raissi Adam Rovit Dodge Slagle Lesley Dickson Dean Polce Ross Golding Charles Price Michael Edwards Bret Frey Keith Brill Karen Massey Tomas Hinojosa Isaac Hearne	Nevada State Medical Association (NSMA)	3660 Baker Lane #101 Reno, NV 89509	775-825-6788	Not given
Jeremy Van Haselen	DaVita HealthCare Partners	2000 16th Street Denver, CO 80202	303-876-6000	Not given
Air Methods Government Relations	Air Methods	7211 S. Peoria Englewood, CO 80112	303-792-7400	Ruthie.hubka@airmethods.com
Jack Kim	Health Plan of Nevada	2724 N. Tenaya Way Las Vegas, NV 89128	702-240-8890	Not given
Gregory Skuta Daniel Briceland Cindy Bradford Michael Repka	American Academy of Ophthalmology (AAO)	Suite 400 20 F Street, NW Washington, DC 20001-6701	202-737-6662	Not given
James Madara, MD	American Medical Association (AMA)	330 N. Wabash Ave. Suite 39300 Chicago, IL 60611-5885	312-464-5000	Not given
Tracey Woods	Anthem Blue Cross and Blue Shield	9133 W. Russell Road Las Vegas, NV 89148	Not given	Tracey.Woods@anthem.com
Elisa Cafferata	Nevada Advocates for Planned Parenthood Affiliates, Inc. (NAPPA)	550 W. Plumb Lane, c/o UPS Mail #B-104 Reno, NV 89509	775-412-2087	ecafferata@NevadaAdvocates.org
Not given	American Academy of Dermatology and AAD Association	Not given	Not given	Not given
Tom McCoy	American Cancer Society Cancer Action Network	691 Sierra Rose Drive Suite A Reno, NV 89511	775-828-2206	Tom.mccoy@cancer.org

Name	**Entity/Organization Represented**	**Business Address**	**Telephone No./ Business Telephone No.**	**E-Mail Address**
Erin Estey Hertzog	Biotechnology Industry Organization (BIO)	1201 Maryland Avenue SW Suite 900 Washington DC 20024	202-962-9200	ehertzog@bio.org
George Hruza Lisle Thielbar	American Society for Dermatologic Surgery Association (ASDSA)	Not given	847-956-9126	Not given lthielbar@asds.net
Brett Coldiron Mark Lebwohl	American Academy of Dermatology (AADA)	1445 New York Ave., NW Suite 800 Washington, DC 20005-2134	202-842-3555	Not given
Ty Windfeldt	Hometown Health	830 Harvard Way Reno, NV 89502	775-982-3000	Not given
Saul Levin	American Psychiatric Association	1000 Wilson Blvd. Suite 1825 Arlington, VA 22209	703-907-7300	Not given
Lawrence LaMotte Emily Hovermale	Immune Deficiency Foundation (IDF)	40 West Chesapeake Ave. Suite 308 Towson, MD 21204	800-296-4433	Not given ehovermale@primaryimmune.org
Not given	Nevada Hospital Association (NHA)	Not given	Not given	Not given
Joan Hall	Nevada Rural Hospital Partners	4600 Kietzke Lane Suite I-209 Reno, NV 89502	775-827-4770	joan@nrhp.org
Scott Heinze	Prominence Health Plan	1510 Meadow Wood Lane Reno, NV 89502	775-770-9327	Scott.heinze@uhsinc.com
Linda Cooper	AETNA	Not given	Not given	CooperL3@aetna.com
Barry Ziman	Hospital Based Physician Specialties	1350 I Street, NW Suite 590 Washington, DC 20005	800-392-9994 ext. 7117	bziman@cap.org
Isaac Hearne	Nevada Academy of Ophthalmology (NAO)	20 F. Street, NW Suite 400 Washington, DC 20001-6700	202-737-6662	Not given

Name	Entity/Organization Represented	Business Address	Telephone No./ Business Telephone No.	E-Mail Address
Karen Sartell	Nevada Patient Access Coalition Members as follows: Arthritis Foundation, Pacific Region American Academy of Pain Management Colors of Lupus Nevada National MS Society National Patient Advocate Foundation Power of Pain Foundation US Pain Foundation	Not given	702-371-5577	k.sartell@sncrf.org
Rev. Diane Drach-Mienel	Religious Alliance in Nevada	Not given	Not given	Not given
John Albertini	American College of Mohs Surgery	Not given	Not given	Not given